GWYNEDD AND ANGLESEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT INTO THE MURDER OF TINA IN JULY 2017

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DATE: 6th of January 2023

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ACKNOWLEDGEMENT

In producing such a report as this we are looking at the circumstances of the life and murder of Tina - someone who was much loved, highly valued, and dear to her family members, who are left to deal with their shock and sorrow. The Panel also acknowledge that during the domestic homicide review process (DHR), the family have had to deal with the further loss of Shaun who died whilst in prison. The Panel recognise that Shaun, though identified as the perpetrator in the context of this report, was also a valued and much-loved family member.

Whilst we have endeavoured to see whether there are any lessons to be learned from the tragic loss of Tina, we do hope that this process has not added to the family's distress. So, in the production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality; balancing the need to maintain the privacy of the family and the need for agencies to learn lessons related to practice, which have been identified during the review of this case, also of course acknowledging that this report will become public as required by the Home Office.

1.0 THE CIRCUMSTANCES THAT LED TO THIS REVIEW

1.0.1 For the purposes of this review report the victim will be known as Tina, and the offender as Shaun.

1.0.2 This report of a domestic homicide review examines how agencies responded to and supported Tina, a resident of Gwynedd.

1.0.3 Tina and Shaun moved from Ireland to Bangor North Wales over 30 years ago. They settled at a property in a local housing estate in Bangor. They have two adult children.

1.0.4 In late July 2017, Shaun, travelled from his flat in a nearby village to the family home where Tina was residing. On entering the house, Shaun greeted his daughter's boyfriend and then proceeded into Tina's bedroom where he fatally stabbed her in the chest, resulting in her murder.

1.0.5 Later the same morning Shaun was arrested, detained, and subsequently tried for Murder at the Crown Court. He was sentenced to life imprisonment with a recommendation that he serve a minimum of 14 years imprisonment for the murder of Tina before being eligible for parole – with the Judge commenting that parole was by no means automatic.

1.0.6 In July 2018, just over six weeks after his sentencing, the Ministry of Justice confirmed that Shaun was found dead in his cell.

1.0.7 Within this Review the Panel examined any previous indications or reports of domestic abuse by Tina or others on her behalf. The Panel sought to identify whether support was available and accessed within the community to identify any barriers faced by those seeking help in the community.

1.0.8 The purpose of this DHR is to identify learning that can be adopted by professionals and agencies so as to reduce the risk of this happening again.

1.1 TIMESCALES

1.1.1 Tina's murder was committed in 2017. The Police informed the Community Safety Partnership (CSP) three days later in August. The chair of the CSP decided to undertake the review six days later in August and the Home Office were informed on that date. The coroner was informed on the 31st of July 2017.

1.1.2 The Panel first met in October 2017 - two months after the incident. During that time, organisations had been contacted and informed of the duty to lockdown

information. A scoping exercise was undertaken to identify which agencies had contact with the victim or then alleged perpetrator. The DHR Panel agreed that the period under review in terms of the victim Tina was from 2009 up until the time of her murder committed in July 2017. The Panel identified that the period under review for the perpetrator Shaun was from 2002 until July 2017. These timeframes were identified based on the information from the initial scoping exercise and reflected the earliest records submitted via the IMR's.

1.1.3 The DHR Panel met 12 times between October 2017 and May 2021.

1.1.4 The review was submitted to the Home Office in July 2020.

1.1.5 There were a number of delays, including, during the initial stages, the appointed author being unable to proceed, and a new author being commissioned. However as noted, all organisations with known prior family contact had been informed and instructed to undertake internal management reviews (IMR's) but not submit them at that stage.

1.1.6 At the first meeting the Senior Investigating Officer (SIO) gave the Panel an overview of the circumstances and shared the identified issues. The Panel made a decision to delay the review until after the criminal court process was concluded. The Home Office were informed we would not achieve the 6month completion target.

1.1.7 The criminal court proceedings took place in May of 2018, and although the Panel had met during the period in between to decide parameters and family contact etc. the review proper began in earnest at that stage. Unfortunately, family contact was disrupted shortly afterwards when the perpetrator died in custody. An inquest took place in March 2022. The jury's conclusion stated: "It is extremely likely that [Shaun hanging himself] was done deliberately, with intent to take his own life."

1.1.8 The core work therefore took approximately 2 years to complete, and it is acknowledged that there were unfortunate delays during that period, mainly in relation to the availability of key individuals who needed to contribute to the work, and the difficulties in achieving timely responses from some contributors.

1.2 CONFIDENTIALITY

1.2.1 The content and findings of this Domestic Homicide Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the DHR has been

approved for publication by the Home Office Quality Assurance Panel. Drafts of this review have been marked Restricted.

1.2.2 To protect the identity of the deceased, their family and friends, Tina will be used as a pseudonym to identify the deceased hereafter and throughout this report. The person responsible for her murder will be referred to as Shaun. The daughter and son will be known as Louise and David, and the daughter's partner, as Lee.

1.2.3 The family were consulted on the choice of pseudonyms and chose the names that appear in the review.

1.2.4 At the time of the incident Tina was 52 and Shaun was 53. Both were of White Irish background. They had lived their adult lives in North Wales.

1.3 TERMS OF REFERENCE

Domestic Homicide Review Terms of Reference	
This Domestic Homicide Review is being completed to consider agency involvement with Tina, following her murder on 31.07.2017. Also contacts with the perpetrator Shaun during the last ten years.	
The Review will work to the following Terms of Reference:	
1.	To explore the potential learning from this homicide and not to seek to apportion blame to individuals or agencies
2.	To review the involvement and events of each individual agency, statutory and non- statutory, for Tina during the period from 2009 up until the time of her murder in 2017. And also, for Shaun during the period from 2002 until the date of the murder in 2017. These timeframes were identified based on the information submitted in the IMR's.
3.	To summarise agency involvement prior to the end of July 2017
4.	The contributing agencies to be as follows: REVIEW

4.1	National Probation Wales
4.2	North Wales Police

4.3	Betsi Cadwaladr University Health Board – all associated health provision, including GP
4.4	Fire and rescue Service
4.5	Any relevant third sector provider (as identified)
4.6	Local authority services (as identified)
5.	Each contributing agency to provide a chronology of their involvement with both named above during the relevant time period
6.	Each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted
7	Each contributing agency to provide an Individual Management Review: identifying the facts of their involvement with both named above critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.
7.1	To consider issues of activity in other geographical area (if applicable) and review impact in this specific case.
8.	In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
8.1	Analyse the communication, procedures, and discussions, which took place between agencies, including consideration of potential confusion in terminology
8.2	Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family

8.3	Analyse the opportunity for agencies to identify and assess domestic abuse risk
8.4	Analyse agency responses to any identification of domestic abuse issues
8.5	Analyse organisations' access to specialist domestic abuse agencies
8.6	Analyse the training available to the agencies involved on domestic abuse issues

8.7	Consider if more could be done in the local area to raise awareness of services available to victims of domestic violence
8.7	And therefore:
8.7.1	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
8.7.2	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;
8.7.3	Apply these lessons to service responses including changes to policies and procedures as appropriate; and
8.7.4	Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and interagency working.
9.	To sensitively involve the family of the victim in the review if it is appropriate to do so in the context of ongoing criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process
10.	To coordinate with any other review process concerned with the children of the victim and/or perpetrator

11.	To commission a suitably experienced and independent person to chair the Domestic Homicide Review Panel, (jointly funded by responsible partners as required) coordinating the process, quality assuring the approach and challenging agencies where necessary; and to subsequently produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference
12.	To establish a clear action plan for individual agency implementation as a consequence of any recommendations
13.	To establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report
14.	To provide an executive summary
15.	To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Community Safety Partnership.
16.	Contact with the family of the victim will be undertaken by - Chair and author, via Police, accompanied by other appropriate personnel who speak Welsh, if this is required. The family to be updated of progress on a regular basis
17.	The agency responsible for undertaking all press releases and press enquiries will be Gwynedd Local authority

1.4 METHODOLOGY

1.4.1 It is important to state that a DHR is not an enquiry into how a victim died or into who is culpable, as those matters are for Coroners and criminal courts to determine. DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges during the course of a DHR, which indicates that disciplinary action should be initiated, then the established agency disciplinary procedures should be undertaken separately to the DHR process.

1.4.2 Tina was murdered at the end of July 2017. The Gwynedd Community Safety Partnership (CSP) was advised of the murder by North Wales Police three days later, in August. Discussions (via e mails and phone) followed between the Community Safety Manager for Gwynedd Local Authority, the police and chair of the community safety partnership. A decision to undertake a DHR was made in August 2017 and the Home Office informed on that same day.

1.4.3 In the immediate aftermath, steps were taken to ensure that all local services (known or likely to have been involved with the family) were notified of the intention and told to lock down their information and prepare for the DHR.

1.4.4 An independent chair and report author were appointed in September. The family were notified by the Family Liaison Officer (FLO) of the intention to conduct a DHR, they were also contacted directly by the Advocacy after Fatal Domestic Abuse (AADFA) advocate who liaised with the DHR chair, and the official letter and leaflet from the Panel were given to the family by the FLO in October 2017.

1.4.5 The first review Panel meeting was held at the beginning of October. Following a discussion between the Panel members and senior investigating officer (SIO) who presented the case, it was agreed that the review would proceed in limited scope until the criminal justice process was completed.

1.4.6 Police statements/Independent management review's (IMR's) and various policy and procedure documents were used to take forward the review. Interviews were held with, family members, General Practitioner (GP) two
Safeguarding Managers, a Mental Health Service Manager, and an Assistant Medical Director from the Health Board

1.5 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

1.5.1 Tina and Shaun shared a grown-up daughter and son with wider extended family residing in Ireland. Their daughter and son known as Louise and David for the purposes of this review were noted as being the contacts for the purpose of the review. Louise and David were approached initially by the FLO who liaised with the Panel (via community safety link officer on the panel). The FLO shared with them a letter of condolences and explained why the panel were required to undertake this review and shared an information leaflet prepared by AAFDA in October 2017. However, the panel were aware by that time that an AAFDA advocate had already made contact with Louise and with the Panel Chair.

1.5.2 The AAFDA advocate became an invaluable contributor to the family contact and was present at each of the meetings between the Chair/author and family, of which

there were three, the advocate also liaised on specific developments between the family and Panel and contributed constructively to the report development. The final draft prior to submission to the Home Office was shared via the advocate.

1.5.3 Tina's son – David, was living and working in the North West of England at the time that the DHR started and initially was unable to meet with the Chair and the author. In 2019 David relocated back to the area where he grew up and has been able to meet with the Chair and the author and fully engage in the process.

1.5.4 The Terms of Reference were shared with the family by the advocate on the Panel's behalf. The Panel were able to provide regular updated information with both Louise and David ensuring that Tina's voice was central to the understanding of events. David on his return to the area became more involved in the process. Louise and David had the opportunity at the final draft
stage to ensure the review was factually correct and truly reflected their parent's lives.

1.5.5 The Panel ensured that the family were able to converse in the language of their choice. As per the requirement of the Welsh Language Act, all work undertaken is required to be in both languages. In this instance the Panel were able to meet the needs of the family within those parameters.

1.5.6 As per the DHR requirement, the Panel sought to identify any contacts which could illuminate the journey of abuse within the context of this case. The initial information came from the Police investigation, which included thorough interviews with work colleagues and friends of the family. These statements were shared with the author and chair and together with the family contribution, provided a clearer 'picture' of the relationships. It was clear that Tina and Shaun had maintained a very private lifestyle, with little if any, indication to work colleagues or friends that domestic abuse was a factor in their lives. The children agreed with this position.

1.5.7 The Panel used all the information gleaned from these sources and only followed up if there were indicators that further information was needed. In this instance, the workplaces of both were looked at in more depth, and those enquiries are reflected in the report.

1.5.8 The Panel was intending to interview Shaun, and arrangements were in progress with the prison to arrange a meeting, however, Shaun took his own life not long after beginning his prison sentence.

1.6 CONTRIBUTORS TO THE REVIEW

1.6.1 Independent Management Reviews (IMR's)

1.6.2 IMR's were received from the following agencies who were involved with Tina and/or Shaun. The IMR's provide detail of recorded contact with the individual agencies.

- Betsi Cadwaladr University Health Board (BCUHB)
- North Wales Police (NWP)
- Gorwel (Third sector DA specialist provider)
- British Transport Police (BTP)
- North Wales Fire and Rescue Service (NWF&RS)
- Adult Social Care, Gwynedd Council (ASC)
- Welsh Ambulance Services NHS Trust (WAST)
- The Crown Prosecution Service (CPS)

1.6.3 The information from the IMR's were amalgamated into one comprehensive chronology relating to both Tina and Shaun. Supplementary questions to the agencies were prepared by the author and further meetings with the authors of the Independent Management Reviews were held.

1.6.4 Police statements arising from the criminal investigation were also made available to the Chair and author. These included police statements from family, friends of the family and work colleagues.

1.6.5 The initial scoping revealed the following agencies had no contact with the family during the period covered by the Review:

- Probation Service
- Children's Social Services, Gwynedd County Council
- Parabl (The Parabl Talking Therapies Partnership aims to promote recovery and empowerment to individuals with mild to moderate mental health needs.)
- Bangor Women's Aid
- North Wales Victim Hub
- Relate

1.6.6 Sources of Information upon which this Review has relied

1.6.7 This review has relied upon the following information as evidence for the production of this report:

- The Internal Management Reviews provided to the DHR Panel by the agencies described above
- Subsequent Chronology derived from IMR's
- An interview with family member Louise and Advocate and meeting with Louise, David, and Advocate
- Meeting and interview with families Medical Practice GPs
- Meeting and interview with CMHT Manager 1
- Statements and documents released by NWP
- Documentation from The Crown Prosecution Service

1.6.8 All IMR authors were able to confirm their independence on the basis that prior to the review they had not had any direct contact with the family, nor did they have any immediate line management responsibility for any staff named in the IMR's.

1.7 THE REVIEW PANEL MEMBERS

1.7.1 The Panel met a total of 12 times. All the below listed members were independent members, in that they had no direct or line management involvement with the family prior to the incident.

Name	Panel Role	Employment Details
Alwyn Jones (AJ)	DHR Panel Chair	Head of Adult Services, Isle of Anglesey County Council
Phil Hughes (PH)	Independent Reviewer/author	Phil Hughes Consultant Ltd (Independent Investigating Officer)
Catherine Roberts (CR)	Supporting Officer and formal link between Panel and CSP.	Community Safety Delivery Manager Gwynedd and Anglesey Councils
Delyth Crisp (DC)	Solicitor and Legal Advisor to the Panel	Solicitor Conwy County Borough Council

Frances Millar (FM)	Representing Betsi Cadwaladr University Health Board	Senior Manager Safeguarding West (BCUHB)
Michael Taggart (MT) (George Howat initially attended)	Representing North Wales Police	(MT) – Strategic domestic abuse officer Police Constable, North Wales Police
Lowri Owen (LO)	Representing National Probation Service	North Wales Multi-Agency Public Protection Arrangements (MAPPA) coordinator
Gwyneth Williams (GW)	Representing Gorwel – Third sector domestic violence specialist providers (including - independent domestic abuse advisors IDVA's)	Service Manager Grŵp Cynefin (Gorwel)
Gwyn Jones (GJ)	Representing North Wales Fire and Rescue Service	Community Safety Manager
Mannon Trappe (MT)	Representing Gwynedd Adult safeguarding – Social Care	Senior Manager Adult Safeguarding, Quality Assurance and Mental Health

1.8 DOMESTIC HOMICIDE REVIEW CHAIR AND AUTHOR OF THE OVERVIEW REPORT

INDEPENDENT AUTHOR

1.8.1 The independent author of the report is Philip Hughes, BSc Hons, Environmental Health, Dip Acoustics. Phil Hughes has over 25 years' experience of working in the local authority sector and is an experienced selfemployed investigator, working for a variety of public sector clients across Wales and the Northwest of England. His investigation experience stems from his qualification and role as an environmental health practitioner, which has developed into a career as a full-time self-employed Investigating Officer. Phil Hughes is also registered as an

Independent Investigating Officer with North Wales Social Services consortium who regularly engage his investigation services.

1.8.2 Over the last 10 years the author has been commissioned to undertake a range of specialist reviews many of which involve participation and attendance of multi-agency safeguarding proceedings both regarding child protection and vulnerable adults.

1.8.3 The author routinely conducts investigations into disciplinary proceedings, and statutory enquiries into professional misconduct. Much of this work requires a thorough knowledge of safeguarding process and procedure within these sectors.

1.8.4 In preparing for the role of author, Phil Hughes undertook the government domestic homicide review (DHR) online learning as well as reviewing a series of publications about Domestic Abuse and Violence.

1.8.5 Phil Hughes is not currently employed by any of the statutory agencies involved in the review (as identified in section 9 of the Act) and have had no previous involvement or contact with the family or any of the other parties involved in the events under review.

INDEPENDENT CHAIR

1.8.6 The DHR Panel was chaired by Alwyn Jones, who at the start of the process was Head of Adult Services in Anglesey County Council and now is Chief Officer, Social Care at Wrexham County Borough Council. He has worked in Health & Care services for the last 26 years and specifically in Adult Services for over 15 years. In Adult Services he has been involved in the Strategic and Operational Management of Safeguarding Services and is the County's Representative on the North Wales Regional Adults Safeguarding Board.

1.8.7 Alwyn has experience of chairing a number of Safeguarding cases involving domestic violence in his career in social care and has been accountable for the work of safeguarding teams in Wrexham, Flintshire, and Anglesey for over 13 years.

1.8.8 Alwyn has significant knowledge of Domestic Abuse & Violence Services and the expectation of organisations to support victims of domestic abuse & violence.

1.8.9 Alwyn has worked in Adult Social Care for over 15 years, as part of his Safeguarding responsibilities he has overseen and provided guidance in individual cases where domestic abuse & violence has been a predominant feature. Alwyn has utilised Gov.uk on-line DHR learning.

1.8.10 The Independent Chair had no previous involvement with the subjects of the report.

1.9 PARALLEL REVIEWS

1.9.1 There were no reviews running parallel with this DHR.

1.9.2 Early contact was made with the local coroner who confirmed that an inquest had been opened and adjourned. Following the criminal proceedings in May 2018 and following conviction, the coroner confirmed that no inquest would be required.

1.10 EQUALITY AND DIVERSITY

1.10.1 Throughout this review process the Review Panel has considered the issues of equality in particular the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.10.2 In terms of the Protected Characteristics the review has no information to suggest that Tina, prior to her meeting Shaun, had any specific needs relating to victimisation, discrimination, or disability. Tina was not receiving services from any agency, outside of that which is usual, for instance the health service. It is not possible to ask Shaun or Tina about their upbringing in Ireland. It may have been helpful to understand more about their religious and racial upbringing in Ireland, to make sense of their Irish heritage and cultural values regarding relationships and their decision to move to Wales.

1.10.3 In terms of the Protected Characteristics Shaun had sought help relating to his mental wellbeing, which is well documented. Shaun's Mental Health issues did not constitute a disability as defined by the Equality Act 2010. Shaun's episodes of mental ill health were short lived and had no long-term impact on his ability to conduct daily tasks. However, although Shaun was not diagnosed with a

specific mental health condition, he was still referred for a Mental Health Assessment by the GP. This was in accordance with practice as outlined within the NICE guidance (Psychosis and schizophrenia in adults: prevention and management 2014)

1.10.4 Shaun's misuse of alcohol does not meet the definition of a disability. The Disability Act 2010, addiction to, or dependency on, alcohol, nicotine, or any other substance (other than in consequence of the substance being medically prescribed) is considered exempt from the definition of disabled (sec A12 Equality Act 2010 Guidance – Office for disability issues)

1.10.5 The Panel acknowledge that gender is always a consideration in DHRs as women are more often the victims of domestic homicide than men. Half of female adult victims aged 16 and over were killed by their partner or expartner (82 homicides) in the year ending March 2017. In contrast, only 3% of male victims aged 16 and over were killed by their partner or ex-partner (13 offences) Homicide in England and Wales: year ending March 2017.

1.10.6 It is also acknowledged that there will be an under reporting of female perpetrated domestic abuse against males as men generally find it harder to disclose such abuse for reasons of shame, embarrassment, and reluctance to identify as a victim of female abuse, so more statistical information relates to women as victims by males.[1]

1.11 DISSEMINATION

1.11.1 Prior to submission to the Home Office the final version of this Overview report was shared with the following:

- The Family – via the advocate
- Statutory partners of Gwynedd and Anglesey Community Safety Partnership
- Organisations represented on the Review Panel

1.11.2 The family engaged in the process and all family comments were relayed back to the panel via the advocate and were given full consideration when compiling the report.

1.11.3 Following Home Office approval, the report will also be shared with

- The Office of the Police and Crime Commissioner for North Wales
- The family, accompanied by the final response letter of the Home Office
- The report will be placed on the Community Safety Partnership portal on the Local Authority website

- Also, the report will be shared with the project leads for the Welsh Government initiative on developing a Single Unified Review process

2.0 BACKGROUND INFORMATION (THE FACTS)

2.0.1 Tina and Shaun moved from Ireland to North Wales over 30 years ago. They settled at a property in a local housing estate in Bangor. They have two children – David aged early 30's and Louise aged mid 20's. Both children grew up in the family home with Tina and Shaun. David had left the family home to work and reside in the North West of England and in 2019 returned to the area where he grew up.

2.0.2 Louise was in a relationship with Lee at the time of the events. Louise has always remained in the area where she grew up.

[1] Research Summary on male victims of domestic abuse Dr Liz Bates (Principal Lecturer in Psychology and Psychological Therapies at the University of Cumbria) Taylor et al 2021

2.0.3 Shaun was employed by a major telecommunications company and worked locally as a trainer in customer services. Tina worked in a local Council owned residential home.

2.0.4 The picture of the family externally was that of a loving family with some people commenting on how envious they were of such a supportive and happy family. Shaun was well regarded in the community of his local housing estate where he had undertaken work with community groups.

2.0.5 Louise described her father as a "functioning alcoholic", stating that he would drink in the evenings and at weekends and 3 or 4 times a year would drink to excess such that he would be unable to attend work and would ring in sick.

2.0.6 Medical records detail Shaun self-referring to CMHT in October 2002. It is not clear how much time elapsed before Shaun began drinking again.

2.0.7 There is now no relevant records of contact with agencies by Tina or Shaun until March 2016.

2.0.8 In March 2016, Louise returned home to find Tina and Shaun arguing. Tina disclosed that she had been assaulted by Shaun two days prior. Shaun also claimed that he

had been assaulted by Tina. Louise informed the police and Shaun was arrested and taken to a local Custody Suite where he was later charged with the offence of Section 39 Common Assault.

2.0.9 The next day March 2016 Shaun was released from Custody to appear at Local Magistrates at the end of April 2016 with bail conditions: -

- Not to contact Tina or Louise directly or indirectly for any reason
- Not to enter the family home, Bangor
- Not to attend at Tina's workplace for any reason

2.0.10 Later that evening Shaun rang his son David stating that he was going to take his own life by jumping in front of a train. NWP informed the BTP who located Shaun on the railway track in a tunnel. BTP dealt with the issue of trespass by means of a community resolution, and due to Shaun's presentation, the decision was made to detain him under a Section 136 of the Mental Health Act for his own safety whereupon he was taken to hospital where he was assessed and then discharged the next day.

2.0.11 Whilst on the railway track Shaun rang Louise and Tina asking them to retract their statements. Louise and Tina then contacted the Police and retracted their statements at Shaun's behest.

2.0.12 After some consideration the Crown Prosecution Service dropped the charges against Shaun, and he was not required to attend court. This was on the basis that Tina and Louise had retracted their statements and that the Police view was that it was inappropriate to compel the victim and her daughter to attend against their wishes.

2.0.13 The case was therefore discontinued on evidential grounds April 2016.

2.0.14 Whilst still living away from the family home in B&B accommodation, Shaun gave up drinking alcohol and became a regular attendee of Alcoholics Anonymous. Louise believed that he refrained from alcohol consumption for around 18 months.

2.0.15 Gorwel records note Tina's comments in May 2016 advising that Shaun had returned home, and that Tina wanted to give Shaun another chance.

2.0.16 A year later in May 2017 Shaun begins a series of medical appointments with the local GP practice presenting as 'difficulty sleeping feeling irritable/ paranoid at times intrusive thoughts wife having affair.' There followed a number of further assessments, with the GP prescribing medication, signing Shaun off work, leading up to a final assessment three weeks before the murder in late July

2017. It was recorded that Shaun was showing notable improvement and that he had made the decision to move out of the family home.

2.0.17 Two days before the murder Shaun and Tina arranged to attend a horse racing event together. Whilst at the races Shaun saw Tina's former work colleague who he believed was involved in an affair with Tina. CCTV evidence showed Shaun shouting and gesturing towards Tina at the entrance of the races. Shaun had formed a view that Tina had somehow arranged for her former work colleague to be at the race meeting. After the race meeting Shaun and Tina returned to the family home.

2.0.18 The next day Shaun left his home in the early hours of the morning to purchase 8 cans of Guinness and a bottle of Brandy.

2.0.19 The next day on the morning of the murder Lee (boyfriend of Louise) woke up at approximately 07.30 and went downstairs to the kitchen to make Louise some breakfast as she was working that morning. Louise went to work at about 08.20 and Lee went back to bed. Some 10 minutes later Lee heard the front door opening and footsteps coming up the stairs. At this time, he saw his bedroom door opening and Shaun stood in the doorway who said "hiya Lee are you ok" to which Lee replied "yes spot on thank you" at which point Shaun left and closed the door behind him.

2.0.20 Lee said that within 5 seconds of Shaun leaving his bedroom he heard a scream. Lee went to investigate and saw Tina coming out of her bedroom stating that she had been stabbed.

2.0.21 Lee stated that there was bleeding from the left side of Tina and that her clothing was saturated in blood. Shaun was stood behind Tina still in the main bedroom.

2.0.22 Lee helped Tina down the stairs, her condition was worsening, and she was going pale.

2.0.23 Lee called the emergency services and an ambulance attended and took Tina to a local hospital. Sadly, attempts to resuscitate Tina failed and she was later pronounced dead in hospital.

2.0.24 A search for Shaun and his car was commenced by police immediately which ended when his vehicle was seen 5 miles from the family home on the same day.

2.0.25 Shaun was arrested on suspicion of the murder of Tina by a Police Constable of the Armed Response Unit. Shaun made no reply following caution.

2.0.26 In May 2018 Shaun was sentenced at Crown Court. He was sentenced to life imprisonment with a recommendation that Shaun serve a minimum of 14

years imprisonment for the murder of Tina before being eligible for parole – with the Judge commenting that parole was by no means automatic.

3.0 CHRONOLOGY

3.0.1 Tina and Shaun had been born in Ireland and moved to North Wales 30 years ago where they have raised their son and daughter. Louise stated that there had been heated arguments between her parents and on occasion violent exchanges over a number of years. The arguments would be about finances or one party accusing the other of infidelity and this was a repeated theme of arguments over the years. This was rarely displayed publicly and there were long periods without arguments where the relationship was loving and happy. During interview Louise recalled that from the age of 6 or 7 she witnessed her mother and father arguing, and that the arguing was commonplace throughout the years. Louise stated that both parties were responsible for the arguments, with both parties being able to provoke the other and start an argument. Louise recalls a range of physically abusive behaviours within the home and disclosed this included pushing, prodding, or poking. These physical assaults were known by Louise to occur once or twice a year. From the information provided by Louise it would suggest that verbally abusive behaviour and physical violence had become part of an established pattern of behaviour within the family home. It is not unreasonable to consider that this was more frequent and what Louise describes are the incidents that she saw, but not all of them that actually took place. Information shared by Louise suggests that Shaun had siblings who were heavy drinkers so it is possible to hypothesise that Shaun may have viewed drinking excessively as the norm in his family. It was confirmed that he was still able to perform his job role and seems to have gone largely unchallenged in the workplace, although this is not corroborated by the employer.

3.0.2 Additional disclosures are made by Louise and David within statements obtained by the Police shortly after their mothers' murder which provide further evidence of a long-standing culture of Tina being the victim and Shaun the perpetrator of domestic abuse and violence within the home. They however saw their mother Tina also being physically abusive to Shaun. These incidents include:

- Shaun starting arguments with Tina usually after Shaun had consumed alcohol.
- Shaun accusing Tina of having numerous extra-marital affairs.
- Shaun starting arguments about finances.

- Shaun starting arguments in relation to Tina's family affairs, particularly regarding Shaun's belief that Tina had given away a house that was left to her as an inheritance.
- Shaun starting arguments because he believed Tina had a sizable sum of money saved in an account which she was keeping from him. Both Louise and David recalled that it was the arguments that led to physical exchanges.

3.0.3 Louise stated that it was Shaun who was the more aggressive with Tina having a much calmer demeanour. In a statement to the Police following a domestic abuse incident Tina stated that she is scared of Shaun when he is drunk as he is very aggressive and violent. David recalled that on occasions Shaun had physically assaulted Tina by means of punches (sometimes to the abdomen or ribs), kicks, scratching, pushing, and hair pulling – on one occasion pulling Tina to the ground by her hair. David acknowledged the violent exchanges could be from both parties but on reflection he thought the majority of violence came from Shaun.

3.0.4 This pattern of their father being abusive and violent to their mother impacted on them as children. David recalled that as a young boy he was not able to intervene in the arguments and exchanges and would try to block out the noise by turning his music up or putting a pillow over his head. David did recall that as he got older there were several occasions where he did intervene, recalling grabbing Shaun to move him away from Tina – often being harshly criticised by his father for taking his mother's side. On one occasion David recalled intervening and dragging his father outside of the house to have a fight with him. David stated that he knew that his parents would not want neighbours or the local community to know what went on within the household. Louise stated that she recalled Shaun accusing Tina of having affairs with various men over a number of years albeit Louise believed that Shaun had no evidence to support his accusations and that she did not believe Tina had ever had an affair. David and Louise stated that they had been told that Shaun had had an affair many years ago and had left the family home temporarily before returning to Tina. As touched on above, it was only when David was older did he feel able to intervene for the reasons of being powerless as a child. Notably the behaviour was not reported and the likely reason was to avoid humiliating mum or dad publicly.

3.0.5 Agencies, friends, and the wider community appeared to be unaware of this history of Shaun being abusive and violent to Tina. The earliest contact recorded within the chronology is in October 2002 when Shaun receives support from an Alcohol Community Psychiatric Nurse (CPN) as a part of an alcohol detox programme. There is limited information available, albeit the information indicates that Shaun did engage with the detox programme and did receive support from the local CMHT. The local CMHT combined social

work, nursing, occupational therapy, psychiatry, and psychology professionals. The recording from that time is informative as it describes Shaun's ongoing alcohol dependency and the impact of this on his relationship with Tina as the record states "Shaun stated that he had a long history of alcohol misuse and noted that his wife Tina had played a major role in him seeking help as she had stated that I am not going to take this crap any longer".

3.0.6 Records of this time describe the dynamic in the relationship between Tina and Shaun "Patient usually goes on a few days bender resulting in his wife requesting he leave the family home – patient leaves, then returns sick and sore, says sorry. Does his penance, wears sack cloth and ashes for a few days. Does what he is told and gets back into the family. The control factor is a major factor in their relationship." The case is closed in January and whilst the year is not stated the Panel accept this was in 2003. From 2003 to 2013 there appear some GP contact that is not related to mental health issues or Domestic Abuse. Louise described her father as a "functioning alcoholic", stating that he would drink in the evenings and at weekends and on some bank holiday weekends he would drink to excess such that he would be unable to attend work and would ring in sick. Though his employer declined to be involved in the review they had noted in a Police statement that Shaun's sickness record was not an issue, but that alcohol had been smelt on his breath.

3.0.7 Tina was employed in ASC at a residential home, she did not give any indication that there were issues relating to domestic abuse in the home. Tina had some periods off work in 2013 after seeing her GP with back trouble but her sickness record was not out of the ordinary. Tina was recognised as having an excellent work ethic and she felt able to communicate with her managers. She did not raise any personal or domestic issues. Tina was a private person and a police statement from one of Tina's colleagues, who was also a friend outside of work, stated that Tina rarely discussed her private life and did not talk about her relationship with Shaun.

3.0.8 In late March 2016 Louise reported a domestic assault on behalf of Tina. In her Police statement Tina stated that she was assaulted at her home by her husband Shaun. She stated that he had pulled her off her chair in the living room, resulting in her falling to the floor where Shaun has then kneeled over her and poked her to the chest repeatedly. Tina alleged he then punched her to the left side of her body, making contact with her left arm and shoulder causing bruising. Tina injured her right knee, by burning it on the carpet when she fell to the floor. This description of the assault echoes Louise's childhood experiences of the abuse and violence inflicted by her father on her mother. Tina told officers that Shaun would have a red mark on his face after she struck him to defend herself. The injuries Tina sustained were bruising to her arm, breast, and shoulder with a burn to her knee. Following Louise's report of the alleged assault of Tina by Shaun he was arrested within 20 minutes.

3.0.9 Shaun was escorted to a local Custody Suite where during the early hours of the next day NWP undertook a suspect interview. Later that morning, Shaun was released from Custody, bailed to appear at the Magistrates Court in a months' time. The Police Bail Conditions were.

- Not to contact Tina or Louise directly or indirectly for any reason
- Not to enter the family home, Bangor
- Not to attend at Tina's workplace for any reason

3.0.10 During that day Louise and Tina were interviewed and gave statements to the Police Officers and a CID 16 was completed providing a DASH score of 8 and therefore graded as medium risk. The attending Police Officer provided Tina with a Z card - a bilingual information signposting cards which are given to all victims.

3.0.11 The CID 16 was then shared with Gorwel the specialist Domestic Abuse provider, Adult Social Care, and the Domestic Abuse Officer (DAO). The DAO correctly graded the risk assessment as medium and made contact with Tina to see if she required further support, which she subsequently declined. The CID 16 was shared with Gorwel and they contacted Tina immediately. Tina had expressed a wish to be supported through the Criminal Justice process but did not wish to pursue a Restraining Order. The Independent Domestic Abuse Advisor (IDVA) (identified as IDVA 1 for the purposes of this report) shared this information with the Police.

3.0.12 At 20.22 that day NWP received a call from Greater Manchester Police to advise that they had received information from Shaun's son. David stated his father had made contact with him by telephone and said that he was going to take his own life by jumping in front of a train. David had stated that he could hear trains in the background whilst his father was on the phone. This information was relayed to the BTP. NWP Officers attended Bangor Railway Station as did BTP, Shaun was seen walking into the train tunnels in the direction of Holyhead. BTP Officers took charge of the incident in that they were the ones who went on the track and detained Shaun. BTP updated NWP and informed officers that Shaun was being taken to an Acute Mental Health unit at a local Hospital. Shaun was detained under the Mental Health Act 1983 Section 136 for his own safety.

3.0.13 Shaun then underwent a psychiatric assessment at the Acute Mental Health Unit at a local Hospital. (The S136 process for assessment comprises of staff employed by BCUHB and staff employed by Gwynedd Council Adult Social Care.) In this case Adult D – Approved Mental Health Professional was employed by Gwynedd Council. The assessment was jointly undertaken by BCUHB and Gwynedd Council. Shaun is assessed as safe for discharge to the

Bed and Breakfast he had been living in since his arrest, his plan appears to be to return to Ireland. He had been found walking along the tracks in the direction of the Ferry port. This assessment was not shared with the GP.

3.0.14 Whilst on the railway track Shaun rang Louise and Tina asking them to retract their statements breaching his non-contact bail conditions. Louise and Tina duly contacted the Police and retracted their statements. Tina then decides to withdraw her support for the prosecution of the assault allegations. It is believed that it was this event that led to Tina deciding to retract her statement about the assault by Shaun. Efforts are made to support her to continue with the prosecution. A DAO then contacts Tina and informs her that despite her retraction, the case would still go to court due to NWP Domestic Abuse Policy. The DAO believed that Tina understood this and that the bail conditions given to Shaun would stay in place. However, Louise felt that NWP had not sufficiently explained the reasons for obtaining witness statements, i.e., that the statements could be used as evidence for prosecuting Shaun in Court.

3.0.15 The Police Protection of Vulnerable People Unit (PVPU) IDVA phones Tina the next day about her retraction of her statement asking explicitly if it was due to pressure on her. Tina stated, "it was her decision alone to retract, she also states that she was declining further support but was pleased that agencies were so helpful." Two days later Tina contacts IDVA leaving a phone message querying whether bail conditions would prevent her daughter Louise accompanying Shaun to Alcoholics Anonymous (AA). Records show that IDVA admin returned the call and advised that it would be a breach of bail conditions. A further call between Tina and the IDVA does not manage to reverse Tina's decision to retract her statement, the IDVA offers ongoing support regardless of the prosecution.

3.0.16 The day before the planned Court Hearing, the IDVA tries to contact Tina to offer support and the option of seeking a restraining order but cannot be contacted. After some consideration, the Crown Prosecution Service dropped the charges against Shaun the day before the hearing, and he was not required to attend court. This was on the basis that Tina and Louise had retracted their statements and that the Police view was that it was inappropriate to compel the victim and her daughter to attend against their wishes.

3.0.17 Louise questioned whether her mother had been provided with appropriate advice and information following the domestic assault incident in March 2016.

3.0.18 Whilst still living away from the family home in B&B accommodation, Shaun gave up drinking alcohol and became a regular attendee of Alcoholics Anonymous. Louise stated that he refrained from alcohol consumption for around 18 months. During this period Gorwel records indicate in May 2016 Tina and Shaun resuming living together.

3.0.19 There are no further allegations made or concerns raised by others to agencies related to Domestic Abuse during 2016. However, in March 2017 when Tina saw her GP for issues related to family bereavements, she spoke of the breakup of her marriage, but no disclosures related to domestic abuse were recorded. Tina shared with her GP that she did feel low sometimes and had a family history of depression. The GP suggested the Parabl service which provides talking therapies to promote recovery and empowerment to individuals with mild to moderate mental health concerns. The GP at the time was unaware that her husband had been arrested for an assault against her a year earlier as he had not been notified of the Section 136 assessment after Shaun's arrest and suicide attempt.

3.0.20 Between May 2017 to July 2017, Shaun attended his GP Medical Practice on seven occasions. Shaun engaged consistently with the GPs, attending appointments, being prescribed medication, having regular reviews and assessments, and ultimately showing improved health status. These are listed in detail as Shaun discloses significant information related to his feelings about Tina and state of mind related to their relationship. At the first appointment in May 2017 Shaun is prescribed sleeping tablets as he cannot sleep due experiencing paranoia and having intrusive thoughts that his wife is having an affair. The records acknowledged that Shaun is a recovering alcoholic (in a programme) and that he has ongoing support from a mentor and group meetings and has been alcohol free for over 12 months. The record notes that Shaun has a supportive wife and family. At a follow up appointment, a week later, he discloses that he is still having trouble sleeping. Discussions take place about Shaun's employment and how he enjoys his work and the routine and significantly around Shaun's intrusive thoughts concerning his belief that his wife is having an affair and how he is prepared to leave home and rent a house. The GP discussed the possibility of Shaun accessing Relate counselling. There are no records of Shaun pursuing this option.

3.0.21 At a third consultation two weeks later Shaun is accompanied by a friend who he states accompanies him to Alcoholics Anonymous. Shaun discloses ongoing paranoia noting that he has accused Tina of spiking his food and drink. He is still unable to sleep and catastrophises at night and gets paranoid thoughts, worried that wife will accuse him of abusing her and he builds this up and up in his head. Shaun is still not drinking but is smoking heavily and has lost weight. The notes also record that Shaun has been experiencing frontal headaches for two weeks which can wake him in the night, something he has not had before and a Neurological referral to Specialist Hospital is made in respect of this. The GP records Shaun as being a little on edge but having good rapport. The records also reference Shaun having just returned from Ireland with his wife. The Doctor notes no acute psychosis but obviously anxious and

some paranoia and no morbid thoughts. A short course of anti-anxiety medication is prescribed.

3.0.22 A week later in June 2017 a follow-up review takes place and Shaun is assessed by GP Dr 2. The Doctor's note states "Seems like a different gentleman! Came in very relaxed and smiling, not at all on edge like he was one week ago. States that he has made decision last week to split up with his wife. He has left the family home and is looking for temporary accommodation. He strongly feels this is the correct decision. He has slept every night and had no headaches." As Shaun's headaches had resolved he decided to cancel the proposed neurological appointment. The Doctor noted that her initial concern was his change in personality with headaches, but this no longer seemed to be the case and was likely a stress reaction.

3.0.23 At the fifth GP appointment a week later in mid-June 2017 Shaun is seen to be maintaining improved health albeit he is signed off work for a further week to provide time for Shaun to move to a new house. Shaun does not attend his Neurological appointment. At the sixth GP appointment in mid-June 2017 Shaun is assessed by GP Dr 2. Shaun is described as 'Doing well, looked relaxed, smiling, good rapport. Hopes to return to work, feels ready.' Shaun reports that his move has gone smoothly and that he plans to meet with wife to go through a few things at the weekend and maintains that it was the correct thing to do. Shaun agrees to trying a phased return to work over one week. Shaun does not attend a planned sixth appointment at the beginning of July a letter was sent with an appointment for the next day which again he does not keep. Around that time Shaun also cannot be contacted for concerns over an unrelated blood test.

3.0.24 In mid-July 2017 Shaun accompanied by Tina was assessed by Dr 2. The record states "Seen with wife Tina, they are speaking now. Continues to feel well and is looking back on how bad he was last month. Realises that his thoughts were out of control. He firmly believed his wife was having affairs, someone was medicating him, and he was creating plots and subplots about people. Realises now that his paranoia was probably out of control. No further headaches, functioning well at work. Discussed with patient and Tina – will refer to CMHT in case of future relapse.", Dr 2 makes a referral on that same day to BCUHB CMHT citing as the reason an Acute Stress Reaction.

3.0.25 The background information provided states "I saw Patient (Shaun) around two months ago when he presented in a bit of a crisis. He works as a trainer in Customer Support, enjoys his job and it gives him routine. He had to take a week off work at the time as he was feeling several things were playing on his mind, he is an alcoholic in recovery. Dry for over a year now and has ongoing support from the AA. He developed a strong feeling that his wife was having an affair, she strongly denied this. He felt someone was medicating him, but

he was not able to sleep and has catastrophic thoughts. On one occasion I saw him with a supportive friend from the AA who was
rather concerned he was going through some sort of breakdown. He became paranoid that his wife would accuse him of abusing her and that built up in his head. He was not eating and smoking heavily, complained of getting frontal headaches. He took time off work and made the decision to leave the family home, I saw him a week later and he seemed a different person, headaches had gone, I had referred him for a brain scan due to the acuteness of the headaches associated with personality change, but he cancelled as he got better. He is now back in work and functioning well. He came in with his wife today (now on speaking terms again) and she is quite concerned about how paranoid he became. Shaun is anxious it may happen again. Luckily throughout this time he did not resort to drinking alcohol."

3.0.26 On the same day in mid-July 2017 there is a corresponding BCUHB Hospital Mental Health record that states, "Referral from GP – noted as alcoholic in recovery with support from AA. Has developed strong feelings that his wife was having an affair (strongly denies) and felt that someone was medicating him, but not able to sleep and catastrophising. Became paranoid that wife would accuse him of abusing her. He took time off work and made decision to leave family home. S/B GP a week later – now back in work and functioning well. Came in with wife, now on speaking terms, she is quite concerned about how paranoid he became. Shaun anxious that it may happen again – throughout this time did not start drinking." Shaun's case was reviewed in a SPOA meeting on the four days later in July 2017. The decision was made that Shaun was not an appropriate referral and that Shaun may like to consider accessing the services of Parabl and continue to see his GP. The view was that the GPs referral to the CMHT was made when the feelings of paranoia had passed therefore the eligibility for CMHT input/ support would not have been reached. The GP surgery are informed of this decision immediately and they in turn left a message on Shaun's mobile phone and sent a letter to Shaun requesting him to contact the GP to discuss.

3.0.27 The seventh and final GP contact with Shaun is on that day in mid-July 2017 and states "Telephone consultation Dr 2 - CMHT called and left a message that they are triaging patient to Parabl. Not clear if they are giving him this information as when I called duty team back, they were not available. I will send patient this information as his mobile is not connecting asking him to contact me to discuss. Letter sent to patient."

3.0.28 Two days before the murder Tina and Shaun attended a horse racing event. At this event Shaun was seen shouting and gesturing at Tina in the belief she was having an affair and that she had arranged for a work colleague with whom she was having the affair to be at the races.

3.0.29 There was no further contact by Tina or Shaun with any agency from this point until Tina's tragic murder two days later. When the Chair and author met with Louise, she had expressed a wish to have a clearer understanding of Shaun's interaction with his GP, CMHT and the Neurological Team. The above text provides the necessary detail.

4.0 OVERVIEW

4.0.1 Louise and David describe growing up in a home where rows about money and jealousy between their parents could lead to abusive and sometimes violent behaviour perpetrated by their father towards their mother was a part of their childhood. They witnessed verbal arguments escalated by their father Shaun maybe twice a year punching to the stomach and ribs, poking, pushing and on one occasion dragging Tina to the ground by her hair. They also describe happier family times when they perceived the relationship between Shaun and Tina was loving and happy. Shaun's behaviour impacted on the children with David attempting to intervene as he grew up. This abuse and violence were kept a secret by the family with David acknowledging that his father could be stopped by the possibility of their community finding out. Tina did not confide in others, with her close friend from work describing Tina as not sharing anything about her relationship with Shaun.

4.0.2 The first recorded time that agencies have any knowledge of Domestic Abuse is in October 2002 when Shaun discloses to the CMHT that his binge drinking of alcohol causes a pattern of behaviour which repeats itself and impacts on his relationship with Tina. The CMHT recording notes "The control factor is a major factor in their relationship." This concern although noted did not result in any further exploration or action such as a referral to a specialist service which at the time in North Wales would have been Women's Aid for female victims.

4.0.3 There is then no record of Domestic Abuse concerns being identified by or reported to any agencies until late March 2016 when the alleged assault by Shaun of Tina is reported by Louise to NWP. We know that records of police call outs are not always a good indicator of risk or harm perpetrated in domestic assaults as a woman is likely to have experienced 35 physical assaults before contacting the police. Considering the time frame this may be over a number of years and may have become accepted in the home. On that day, the Police interview Tina and Louise and then in the early hours of the next morning interview Shaun. Shaun is released on Police Bail with conditions but later threatens to take his own life. Shaun speaks to his son who is at the time is not in the locality and David informs Greater Manchester Police who alert NWP of this. Shaun is apprehended by British Transport Police (BTP) supported

by NWP and detained on a Section 136 of the Mental Health Act for his own safety. He is assessed as safe to release into the Bed and Breakfast he has been staying since the break-up of his marriage. This behaviour by Shaun did lead to Tina deciding to retract her allegations of abuse. There is no record of coercive and controlling behaviour on Shaun's behalf being considered during this assessment. However, that does not mean it was not taking place regularly and undocumented. Shaun's wish to return to his native Ireland was noted and may have provided some reassurance that he no longer posed a threat to Tina, a woman he had allegedly assaulted less than 24 hours before.

4.0.4 The NWP response to the March 2016 report by Louise of alleged Domestic Abuse to Tina where that a DASH was completed and a referral made to a Specialist Service for Domestic Abuse and the arrest, questioning and subsequent management of Shaun appear timely and thorough. The Panel reflected on NWP involvement and interaction with Shaun and concluded that their actions were consistent with the level of service that would be expected. The Panel found no significant departures from policy or process and there were no identified learning points.

4.0.5 The Panel reflected on BTP involvement and interaction with Shaun and concluded that their actions were consistent with the level of service that would be expected. The Panel found no significant departures from policy or process and there were no identified learning points.

4.0.6 Following the Domestic Abuse incident in March 2016 the Police notify Gorwel the Specialist Domestic Abuse Service who make immediate contact and offer Tina support and other options such as a Restraining Order. Following Tina's decision to retract her support for the Prosecution (which the Panel believe was due to Shaun's call from the railway lines on the night they believe he attempted to take his life) Tina is contacted on two occasions by the IDVA but then not again until a month later the day before the planned Magistrates Court appearance. Regarding this lack of IDVA contact with Tina between the end of March and the 4-week period leading to the scheduled court case, Gorwel accepted that this was not what would have been expected in terms of IDVA practice. Since the events of 2016 the service is now a commissioned service and working towards Leading Lights accreditation. Current practice would be that only those assessed as high-risk victims of Domestic Abuse would be referred to the IDVA service and weekly contact is expected to be maintained throughout their support from the service. An IDVA Team leader is now in post providing supervision to all IDVAs and a robust case management policy introduced setting out clear expectations regarding contact, case recordings and file audit processes. It is also noted that should Tina's case happen now this would not have met the high-risk criteria for an IDVA service and would be referred to the Community based Floating Support team where there is also an expectation of weekly contact. The Panel accepted this view

and noted that the lack of contact was unlikely to be common practice at that time but more likely an anomaly.

4.0.7 The Panel reflected on Gorwel involvement and interaction with Tina and concluded that, with the exception of a lack of IDVA contact during a 4-week period, the actions were consistent with the level of service that would be expected. The Panel found no significant departures from policy or process.

4.0.8 Whilst still living away from the family home in B&B accommodation, Shaun gave up drinking alcohol and became a regular attendee of Alcoholics Anonymous. Louise stated that he refrained from alcohol consumption for around 18 months. In May 2016 Tina and Shaun resumed living together.

4.0.9 In May 2017 Shaun is seen by the GP he states that despite a long-standing issue with the misuse of alcohol he has been abstaining from drinking and attending AA with the support of a mentor. This mentor accompanies him to the GPs surgery and expresses concerns that Shaun is having a breakdown. One of the symptoms described to the GP by Shaun are intrusive thoughts which by their very nature he cannot manage, these thoughts are about him believing that Tina was having an affair these were jealous and paranoid thoughts and a history of separation.

4.0.10 The GP Practice stated that they had not been provided with a copy of the March 2016 CMHT Assessment following the detainment under section 136 of the Mental Health Act. The practice was unaware of Shaun's previous arrest for a domestic assault and further for walking on a railway track with potential suicidal intentions. During interview with the Chair and the Author, Dr 1 and Dr 2 stated that it may have been helpful to have had the information, and it could have been included within the referral to CMHT. There was no suggestion that having had the information would have altered the actions taken by the GPs. During interview for this review with Dr 1 and Dr 2 they described Shaun as having good insight throughout the 10-week assessment period and that Shaun did not present as a risk to himself and had not made any comments to suggest he intended to harm anyone else.

4.0.11 In mid-July 2017 Tina attended the GP appointment with Shaun who describes he no longer feels paranoid about Tina having an affair and realises "he was out of control" at that time but is feeling much better. The GP is concerned enough about it happening again to make CMHT Referral for Acute Stress. This referral was not accepted as it was felt that Shaun did not meet the threshold for CMHT intervention at that time.

4.0.12 The Panel reflected on the GP Medical Practice involvement and interaction with Shaun and concluded that their actions were consistent with the level of service that would be expected. The Panel found no significant departures

from policy or process but did identify some learning points which are discussed later in the report. Information provided by an Assistant Medical Director for Primary Care confirmed that the GP Medical Practice had complied with current health guidance regarding issues of paranoia. (NICE Medical guidance – Psychosis and schizophrenia in adults: prevention and management Clinical guideline [CG178] Published date: 12 February 2014.)

4.0.13 Shaun's employer (a major telecommunications company) were contacted but declined to engage in the DHR process. The Panel had hoped to establish whether Shaun's sickness records was affected by his alcohol use and whether the employer had any concerns or knowledge of Shaun's alcohol use. It was hoped that the employer could have demonstrated whether any support systems were in place for employees affected by alcohol use.

5.0 ANALYSIS

5.1 SHAUNS BEHAVIOUR WAS NOT IDENTIFIED AS DOMESTIC ABUSE BY AGENCIES OR THE FAMILY BEFORE 2016

5.1.1 In this case, there were several clear indicators that the relationship was controlling, abusive and violent for many years throughout their children's childhoods. The family had hidden the domestic abuse with Shaun's friend and work colleagues believing them to be a normal family. Therefore, the only witnesses to this controlling abusive and violent behaviour were their children. There is significant evidence that growing up in this environment children normalise these behaviours as a coping mechanism.[2] This is not unusual and agencies like Women's Aid will be able to provide plenty of evidence that domestic abuse is hidden to the outside world in many victim cases with children being part of the secret. In addition to the normalised behaviour, it is likely that not only was it normalised but children living in such an environment will be fearful to tell anyone and children are often conflicted and loyal to both parents. Domestic abuse is a largely hidden crime, occurring primarily at home. Women often don't report or disclose domestic abuse to the police (HMIC, 2014) and may underreport domestic abuse in surveys, particularly during face-to-face interviews.[3]

5.1.2 Both siblings recall childhood memories involving significant violence and abuse against their mother. Whilst both recall use of violence on both sides, the idea that Shaun regularly punched, kicked, and pulled Tina's hair (including to the ground), identifies a consistent pattern of physically abusive behaviour. It is worth considering what it tells us about a father who is prepared to commit that behaviour in front of his own children and what may have taken place when the children were not present.

[2] Rhoades, KA (2008) Children's responses to interparental conflict: A meta-analysis of their associations with child adjustment. Child Development, 79(6) [3] How common is domestic abuse? - Women's Aid - hiips://www.womensaid.org.uk › information support ONS 2015

5.1.3 The panel considered that that if the children had been able to share with their network i.e., teachers etc that these events happened at home then there may have been an earlier opportunity for agencies to support this family. The panel acknowledged that currently there is a greater understanding and awareness of domestic violence amongst children and adults compared with when Louise and David were children.

5.1.4 The panel further reflected that it is highly possible that both siblings grew up in an environment where hypervigilance was the norm, as they may have always been anticipating when the next argument might start between their parents.

5.1.5 Whilst the siblings cite both mum and dad being violent, due to gender differentials, it is unlikely that Tina could have realistically assaulted Shaun with the same force i.e., pulling him by the hair to the ground as he did to her. In domestic abuse and violence incidents hair pulling and similar violence of punching to the ribs and stomach is commonplace by male perpetrators against women and often does not lead to visible injuries, so potentially less likely to be detected by friends or work colleagues.

Statistics on Male Victims of Domestic Abuse. There are important differences between male violence against women and female violence against men, namely the amount, severity, and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt[1] or killed than male victims of domestic abuse.[2]

5.1.6 Thinking about children who find themselves in this position, the challenge remains how best to support children and young people growing up in homes where domestic abuse is prevalent.

5.1.7 As children spend most of their childhood in school, it is worth considering what can be put in place in the education setting. It is important to consider that children may not think themselves victims like David and Louise and don't think it necessary to disclose to anyone outside the family.

5.1.8 Awareness raising around domestic abuse is already attached to many schools' curriculum through PSE type of delivery, but professionals need to reflect that

[1] Walby & Towers, 2017

[2] Walby & Allen, 2004 (ONS, 2020A; ONS, 2020B)

a child victim of domestic abuse may not feel able to disclose and if so, does the school have the skills set to respond.

5.1.9 There may be some useful discussions to be had with education and to consider if not already happening whether to employ a specialist who supports schools. Best practice warrants considering when and where a child would feel safest to disclose, bearing in mind that they may return home after disclosing

sensitive information will and not know what impact that will have on their mum as the likely target for blame.

5.1.10 One in seven (14.2%) children and young people under the age of 18 will have lived with domestic violence at some point in their childhood. They may be in the same room or in another room and are able to hear the abuse.[3]

5.1.11 The fact that Shaun persisted in alleging that Tina was having an affair is likely to be more indicative of his own behaviour and again is very common in domestic abuse behaviour where the perpetrator judges their female victim by their own behaviour, not by the victim's behaviour.[4]

5.1.12 Agencies offering support were available and advertised at this time in North Wales but this information either did not reach Tina or she felt unable or afraid to seek advice. In March 2016 Tina allowed her daughter to report the assault to the Police and provided a statement. The Panel do not know why she had this change of heart. Tina did not share her concerns or fears with her friends which again is not uncommon for victims for fear of shame, humiliation or greater threats and retribution from the perpetrator. Again, it is not uncommon for victims of domestic abuse to change their minds in line with the changing behaviour that is perpetrated against them as power and control behaviours are psychologically challenging for the victim. It is also important to acknowledge that Tina and Shaun had shared good times as well, which make it hard for a victim to separate out the behaviour from the person.[5]

5.1.13 In 2002 the CMHT records indicate that the professionals were aware the relationship between Shaun and Tina was marked by 'control'. At that time in 2002 CMHT did not have a Domestic Abuse Policy and professionals did not have the training required to identify and act on Domestic abuse and may not have seen control as an indicator of Domestic Abuse. Having guidelines or checklists may help professionals identify concerns presented under mental health for example. A simple checklist might include a question that considers

[3] hiips://www.womensaid.org.uk/information -support/what-is-domestic-abuse/impact-on-children-andyoung-people

[4] hiips://www.womensaid.org.uk/information -support/what-is-domestic-abuse/recognising-domestic-abuse/

[5] hiips://www.womensaid.org.uk/information -support/what-is-domestic-abuse/recognising-domestic-abuse/

whether the issues are related to relationships and does that flag concerns that could be triaged elsewhere as a cause for concern.

5.2 BREACH OF BAIL CONDITIONS

5.2.1 The first recorded police incident of domestic abuse came in 2016. Consequently, no service involved with either Tina or Shaun had identified domestic abuse as a concern. Research indicates that a female victim of domestic abuse is likely to have been physically assaulted at least 35 times

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before reporting an incident in addition to any other abusive behaviours. As it was Louise who made the report on her mother's behalf it is not known how many physical assaults Tina had experienced up to this point. Tina and Louise retracted their statements and decided not to pursue the case. It is likely that Shaun's threat of suicide was a contributing factor to that decision, although the Panel also recognise that both Tina and Shaun were at that time committed to staying together. The phone calls made in March 2016 by Shaun to Tina and also to Louise whilst on the railway lines were not known to services until June 2018 when Louise disclosed the information to the Author and Chair. Tina was approached by Gorwel about her retracting her statement, but Louise was not spoken to by any agency.

5.2.2 Shaun successfully persuaded Tina, his victim and daughter Louise to retract their statements which was a breach of bail conditions. With hindsight the panoramic view was not available to agencies at the time. Had the IDVA known Tina's history of abuse and assaults, they may have been able to offer a more intensive intervention. IDVAs are likely to be better informed as to the conflict a victim experiences at such a critical point prior to potential court appearances.

5.3 COERCIVE AND CONTROLLING BEHAVIOUR

5.3.1 In September 2012 the Government published guidance on coercive and controlling behaviours and then in 2015 became law by virtue of Section 76 of the Serious Crime Act 2015 – 'Controlling and Coercive Behaviour in an Intimate or Family Relationship'. The Cross-Government definition of domestic violence and abuse outlines controlling, or coercive behaviour as follows:

- Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

- Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.[6]

5.3.2 coercive and controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

5.3.3[7] In a study of domestic abuse survivors 95 out of 100 reported experiencing coercive control. Data from the Crime Survey for England and Wales suggest that women are overwhelmingly the victims of coercive controlling behaviour. [10]

5.3.4 Crime survey data found that women are far more likely than men to be the victims of coercive and controlling behaviour abuse that involves ongoing degradation and frightening threats –two key elements of coercive control. [8]

5.3.5 In a separate review by Myhill, coercive control was highly gendered, with women overwhelmingly the victims. coercive control was associated with more frequent and severe forms of abuse, greater physical and mental injury, greater disruption to victims' lives in terms 73 of time taken off work, and greater propensity for external agencies to become involved. [9]

5.3.6 Although friends of Tina and Shaun did not suspect domestic abuse, they were aware that 'something' had occurred in the year prior to Tina's murder, from the 2016 incident onwards. They believed their relationship was ending and that this had an impact on Shaun's mental health. Tina's friend knew of the 2016 event, but it was not shared by Tina in any detail, just a comment that 'things had got heated' and that they were splitting up. Shaun's friends were more aware that there was a significant issue with the relationship breaking down, however, this was not identified as Domestic Abuse. Friends and colleagues also spoke of a couple equally jealous of each other.

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

[7] Kelly, L; Sharp, N and Klein, R, Finding the Costs of Freedom How women and children rebuild their lives after domestic violence [London: Child and Woman Abuse Studies Unit, 2014], p.19

[8] Myhill, A, Measuring coercive control: what can we learn from national population surveys? [Violence Against Women 21[3], 2015, pp. 355-375]

[9] The police response to domestic violence: Risk, discretion, and the context of Andy Myhill PhD Thesis City, University of London Department of Sociology March 2018

5.3.7 It is poignant that Tina did not share her situation with friends and colleagues. What the panel learnt about Tina was that she was a woman who had remained with her husband despite times when they fought. Louise noted that her mum did not have the quick temper like Shaun, David and Louise and would remain calmer.

5.3.8 It is indicated that Tina was liked by her friends and family. There was little information shared about Tina's hobbies and interests as she did no go out much. There is mention of Tina going to Bingo and the pub with friends. What the panel have discovered is that when she did go out, she was persistently accused of being unfaithful, accused of using her phone in the pursuit of affairs and had her finances scrutinised by Shaun.

5.3.9 The panel considered that Tina was likely to opt to stay at home because whenever she did go out, there was likelihood of things escalating into an argument.

5.3.10 The panel further considered that this is the type of jeopardy victims of domestic abuse may experience regularly, that is, to go out with friends led to rows and put Tina at risk of further emotional and physical abuse. It would seem Tina chose to keep this part of her life private. Therefore, there was little opportunity for friends to offer support, or for Tina to seek help or comfort outside of the home as no one knew the extent of Shaun's behaviour.

5.3.11 Tina remained with Shaun despite periods of abusive behaviour, the seriousness and frequency of which is not known or documented.

5.3.12 In Louise's DHR interview statement she said that her mum and dad both argued with an equal veracity at times. Thinking about the decision to withdraw from the Court process it is possible to empathise with the emotional pressure both Tina and Louise felt. Tina would not have wanted to have the threat of Shaun killing himself on her conscience and Louise has stated throughout that she loved both parents so may have felt conflicted that she put her dad in that position before the Court.

5.3.13 The panel reflected that this may have represented a missed opportunity for professionals to offer Tina any type of support. It is likely that Tina would likely have been grappling with the assault being public for the first time. It must be acknowledged that the IDVA's expertise is critical here to get the balance right between respecting the victim's decision not to engage with services, but also ensuring they have the correct information to be able to ask for help when they can feel ready and safe to do so and utilise something like the support of

Women's Aid and the Freedom Programme specifically designed for victims of domestic abuse.

5.3.14 The Panel acknowledges that this coercive and controlling behaviour was continually reinforced by the physical violence and threats she endured during her marriage. The extent to which this impacted on Tina not knowing where to seek help or feeling unable to seek help could not be established. Tina's decision to withdraw her statement could also have been influenced by the years of coercive and controlling behaviour, but again the extent to which this was the case could not be established.

5.3.15 Although both Tina and Louise were later to retract their statements, Louise's decision to report her father to the police suggests a new level of concern for her mother's welfare on this occasion, bearing in mind the alleged assault took place two days prior to Louise finding out about it.

5.3.16 Both children recalled heated arguments between their parents and occasional physical violence by both Shaun and Tina, which continued into their adolescent and adult years.

5.3.17 There is much written about the reasons why women don't report domestic abuse or violence. Research indicates that a woman in this situation needs to consider what the consequences might be, potentially threats and more abuse and violence.[10] It is feasible that Tina did not feel empowered or safe to ask for help. The best predictor of future behaviour is often past behaviour and Tina would have a wealth of abusive experiences to draw upon in making her decision to seek or not seek help.

5.3.18 There are some of examples which imply that Shaun displayed coercive and controlling behaviour towards Tina. Examples would include: -

- Shaun physically assaulting Tina by punching in the belly and ribs, pulling hair
- CMHT 2002 assessment that 'their relationship was focussed on control'
- Shaun's frequent accusations that Tina was having affairs (noting that the only report of any affair was that of Shaun at a time when David was a young child)
- Shaun's comments and arguments regarding finances, inheritance, alleged hidden savings.
- Shaun's negative comments towards Tina at times when she was going out socially with her friends.

[10] Myth 2: If it was that bad, she'd leave hiips://www.womensaid.org.uk/information -support/what-isdomestic-abuse/myths/

- Shaun's threat to end his life unless Tina and Louise withdrew their statements.
- Shaun's continual checking of Tina's phone believing her to be using it against him in her alleged affair.

5.3.19 coercive and controlling behaviour impacts on the whole family. Callaghan in 2015 noted "They are immediately involved and affected by coercive and controlling behaviour that does not simply target the adult victim but affects the entire family."[11] As examples, Women's Aid and perpetrator programmes generally identify the 'control wheel' of abusive behaviours, whilst the Freedom Programme offer women an alternative form of relationship based on equality as does the equality wheel in perpetrator programmes.[12]

5.4 SHAUN'S MISUSE OF ALCOHOL

5.4.1 Shaun's misuse of alcohol is a significant feature in this Review. Shaun consumed alcohol on a routine basis and that the extent of alcohol intake warranted at least two attempts to detoxify and attendance at Alcoholics Anonymous with its abstinence 12 steps recovery programme. Early on the morning of the murder Shaun purchased alcohol.

5.4.2 According to Louise and David, Shaun drank alcohol generally in the evenings and bank holidays as he was in regular employment. It was noted by his employer in a Police statement that Shaun occasionally smelt of alcohol. The Panel considered that his misuse of alcohol may increase the likelihood of Shaun starting an argument and physical exchange with Tina as alcohol served as a 'disinhibitor' giving him permission to be more confrontational. Louise stated Shaun's behaviour was quite different when he had not consumed alcohol, i.e., being generally calmer and not prone to arguments and physical exchanges. Specialists in domestic abuse would challenge the notion of alcohol as the main factor. Domestic abuse relies on the perpetrator's intention to maintain control over victims. With the information shared by Louise and David through their childhood experiences it is likely alcohol was not always present during the abuse but was likely to be an aggravating feature on occasion. Research

[11] Callaghan J, et al. (2015) Beyond "witnessing": children's experiences of coercive control in domestic violence and abuse. Journal of Interpersonal Violence

[12] hiips://www.theduluthmodel.org and hiips://www.freedomprogramme.co.uk

tells us that alcohol is not responsible for domestic abuse but can be a contributory factor.[13]

5.4.3 In thinking about Shaun's behaviour on the railway line there are some observations to consider. Arguably it could be said that alcohol was not clouding his judgement as Shaun was of sound mind to be coherent enough to phone and ask Tina and Louise to retract their statements and discontinue the prosecution. By contacting Tina and Louise Shaun placed himself in breach of his bail condition 'not to contact Tina or Louise directly or indirectly for any reason' but was not charged with breach of bail or arrested. Had Shaun been arrested a further court sanction may have increased the seriousness of the bail conditions to reflect his disregard for those already imposed.

5.4.4 There is a lot of evidence that breach of bail conditions and restraining orders feature in increasing the risk of serious harm to victims of domestic abuse as the disregard for sanctions demonstrates a wilfulness to persist with the abusive behaviour despite constraints being in place.

5.4.5 The type of behaviour displayed by Shaun of threatening to take his life and therefore impose emotional pressure on Tina and Louise is not uncommon as a form of controlling behaviour. In this situation it appears to have had the desired effect of changing Tina and Louise's mind and them retracting their statements.

5.5 ACUTE MENTAL HEALTH UNIT NOT SHARING INFORMATION WITH GP MARCH 2016

5.5.1 Having been found on the railway track in March 2016, Shaun was detained under section 136 MHA and taken to the Acute Mental Health Unit at a local Hospital. At 21.40 Shaun was assessed by Dr 3 - Locum Consultant Psychiatrist (BCUHB) and Adult D - Approved Mental Health Professional (Gwynedd Adult Services). There is a detailed written record of the assessment which concludes that Shaun was safe for discharge, stating – 'Return to Bed and Breakfast – then Ireland'. The outcome of the Section 136 assessment states 'Shaun was discharged, as there was no evidence of mental disorder but an 'acute stress reaction due to detention by police and excess alcohol use'.

5.5.2 The Chair, Panel Member and the author met with Manager 1, Adult Services Manager for BCUHB who is based at the CMHT Unit where Shaun was assessed. Manager 1 was able to review information relating to Shaun's 2016 assessment and

[13] Myth number 1 Alcohol and drugs make men more violent, hiips://www.womensaid.org.uk/information support/what-is-domestic-abuse/myths/

advised that normal practice is for the assessment report to be shared with the patient's GP and that this had been done by faxing a copy to the GP. Manager 1 stated that there was no fax on Shaun's file and on the basis that the GPs stated that they did not know about the assessment, it seems likely that the report was never shared.

5.5.3 As previously stated, the Panel have established that it has been routine practice for the Acute Mental Health Unit to share the medical assessment reports with the patients GP. The Panel have considered the findings of this review and whilst it cannot be stated as a certainty, it appears probable that in this instance, the Acute Mental Health Unit did not share the medical assessment undertaken in March 2016 with the GP.

5.5.4 Shaun's GP was questioned as to whether decisions or referrals may have been managed differently if the GP had received a copy of the Acute Mental Health Unit report at the time it was undertaken. The GP responded that the information would probably have been included in the 2017 referral to the CMHT. The GP went on to state that her own assessment of Shaun was based on his presentation at the time of the consultation, later adding that Shaun had much improved and was showing good insight into what had previously occurred.

5.5.5 Shaun had told the GP that his wife was being unfaithful on multiple occasions. The Panel considered whether the GP identified that 'control' was a significant factor and could have responded to this information differently.

5.5.6 Had the GP consulted a specialist domestic abuse organisation like 'Respect' an organisation that supports men to change their behaviour, Shaun may have been offered a voluntary programme, such as Choose to Change.

5.5.7 In response to the above, the Panel have recommended that the Acute Mental Health Unit implement processes which ensure that Section 136 Assessments are shared with the patient's GP. The Panel also recommend that Acute Mental Health Unit's cease using fax machines as a primary means of relaying sensitive and confidential information and instead utilise secure email systems. Such systems can password protect confidential information, which can provide a clear audit trail, and which can utilise a send receipt option as a means of confirming that the intended recipient has received the assessment.

5.5.8 A Single Point of Access (SPOA) may be helpful for running questions, concerns, and thoughts if there is the suggestion that an incident they are assessing is domestic abuse related. The Panel recognise that within the Review it appears agencies are looking at this as a single agency and not discussing within a community multi agency framework that has a panoramic view of events and incidents.

5.6 FOLLOW-UP CONTACT AFTER DISCHARGE IN MARCH 2016

5.6.1 During the interview Manager 1 stated that the information system showed up a referral to Dr 4 back in March 2016 albeit there was no evidence of Shaun having been being seen by Dr 4.

5.6.2 Manager 1 subsequently confirmed that there was no follow-up action requested from the Acute Mental Health Unit after the end of March assessment and that the case should have been closed at that point.

5.6.3 Manager 1 explained that Shaun's case was allocated against Dr 4 for administrative purposes as it was Dr 4 that covered the geographical area in which Shaun lived.

5.6.4 The Panel considered the information contained in the IMR's and the comments of Manager 1 and were in agreement that Shaun was never under the care of Dr 4 but that Dr 4's name only appeared as a result of an administrative process.

5.6.5 In response to the above the Panel have recommended that Acute Mental Health Units review the way in which the electronic database is used regarding assigning a patient to a consultant and regarding ensuring that a patient's details are properly closed on the system in a timely manner.

5.7 THE 2017 GP REFERRAL TO CMHT AND THE OUTCOME DECISION

5.7.1 At the time of the referral to CMHT (July 2017), Shaun's health was improved and the main driver for the referral was Shaun's fear that he could relapse into a poor state of mental health in the future.

5.7.2 Manager 1, Adult Services Manager for BCUHB, advised that Shaun's referral was given due consideration by the SPOA team and that it was a correct decision not to accept Shaun as a patient.

5.7.3 Manager 1 confirmed that the SPOA discussions were based on the information contained in the GPs referral and that no other past records would have been reviewed as part of the assessment. Manager 1 also noted that even if the 2016 assessment report had been available during the SPOA meeting, the 2016 report stated that Shaun did not have a mental disorder at that time. This may have represented a missed opportunity for Shaun to link into a male support group or voluntary domestic abuse programme. Of course, Shaun would need to have accepted that his behaviour was unacceptable, but with no alternative intervention offered, the medical model of assessment shut down signposting

opportunities. Consultation with domestic abuse groups or online provision may have offered alternatives to keep Shaun engaged in the dialogue of his unacceptable behaviour that may have offered him thinking time to what he may do differently.

5.7.4 Manager 1 explained that some records were paper based, and some records were electronic. The implication was that it was not easy to access full patient information at short notice.

5.7.5 The Adult Services IMR entry in mid-July 2017 states, under Expected Standards/Practice, 'The GPs referral to the CMHT was made when the feelings of paranoia had passed therefore the eligibility for CMHT input/ support would not have been reached. It was appropriate that a follow up by the Consultant Psychiatrist was requested.'

5.7.6 The Adult Services IMR states 'SPOA decision that this was an inappropriate referral and was forwarded to Dr 4, Consultant Psychiatrist as Shaun was under his care. Decision shared with the GP.'

5.7.7 The Panel were subsequently advised that the phrase 'It was appropriate that a follow up by the Consultant Psychiatrist was requested' was inserted at the IMR stage and was not stated on Shaun's medical records. On this basis the Panel accepted that there was no requirement or intention for Shaun to be subject to any 'follow up by the Consultant Psychiatrist.'

5.7.8 The Panel have established that Shaun was NOT under the care of Dr 4, Consultant Psychiatrist and that a follow up assessment was not required or requested.

5.7.9 The Panel discussed the GP referral and agreed that Shaun was not in need of urgent Acute Mental Health intervention given that his presentation was much improved and that the catalyst for the referral was Shaun's fear that he may relapse into a poor state of mental health in the future. On this basis the Panel questioned whether a referral to CMHT was necessary.

5.7.10 The author met with an Assistant Medical Director for Primary Care West who clarified that the actions of the GP Medical Practice were correct in making a referral to CMHT and that the GPs actions were in line with NICE Medical guidance – Psychosis and schizophrenia in adults: prevention and management Clinical guideline [CG178] Published date: 12 February 2014. It was also stated that the medical practice (Primary Care) had an expectation that Shaun would receive some level of CMHT input despite the fact that his symptoms had diminished. Conversely – as already stated, CMHT rejected the referral and maintain the view that they would take the same action if the same situation arose again.

5.7.11 The two differing professional viewpoints have resulted in recommendations being made regarding BCUHB reviewing existing protocols on referrals in consultation with GPs.

5.7.12 Whichever view is accepted; it does appear that the domestic abuse as a form of controlling behaviour has not been considered in-depth and how it might have influenced Shaun's presentation and emotional well-being. When reflecting on the information available to the GP at any one time, it seems there was a missed opportunity to pool all the information that was mounting which was held in different places.

5.7.13 It is worth exploring if GP practices locally have any network of support for themselves to signpost, seek specialist advice and recognise the potential links to domestic abuse and violence in the presentation of relationship distress and paranoia. It is noticeable throughout that Shaun did not self-disclose his abuse, just his own distress. It also seems that there were no red flags raised between Tina's GP appointments and Shaun's in terms of Shaun's paranoia directed at Tina and Tina presenting with low mood.

5.8 APPROPRIATENESS OF SIGNPOSTING TO PARABL

5.8.1 Both Tina and Shaun were advised individually by their GP to consider engaging with services offered by Parabl.

5.8.2 At the end of March 2017 Tina met with the GP and records state 'discussion re family bereavements last year also break up of marriage, does get low sometimes, family history depression, advised re Parabl service.'

5.8.3 The outcome of the SPOA meeting in considering the GP referral for Shaun was 'Above referral was reviewed but noted as an inappropriate referral although CPN had noted consider Parabl?'

5.8.4 Comments from GPs implied that they were uncertain whether Parabl was an appropriate option for Shaun.

5.8.5 The Panel discussed the appropriateness of signposting Tina and Shaun to Parabl and concluded that the services offered through Parabl would not have been appropriate for domestic abuse related issues. Shaun needed to attend a dedicated programme looking at changing behaviour.

5.8.6 Parabl have confirmed that Tina and Shaun did not make contact with the service. The Panel did not make any recommendations regarding the above.

5.9 GORWEL – ACCURATE RECORDING OF INFORMATION

5.9.1 The Gorwel IMR identified that a brief telephone conversation took place between PVPU IDVA and Tina at end of March 2016 albeit the content of the discussion is not recorded. Gorwel noted this and confirmed to the Panel that training has now taken place and a case management policy has been introduced addressing case recordings, frequency of contact and case management processes.

5.9.2 This is a significant learning point for all agencies when looking at a chronology following such a tragic murder. The shared view of significant concerns may assess and support a victim sooner in their given situation. Record keeping is crucial to that shared knowledge of events and incidents and increasing concerns as they are documented, but also what is done with the recorded information. Unless someone acts on concerning information it remains just an inactive record.

5.9.3 Gorwel also advised the Panel that regarding the IDVA service provided, they have already identified the need to make sure all updates are placed on the Discovery system - and not, as in this case, the RMS only (RMS being a Police only recording system) - this internal recommendation has already been implemented by Gorwel. The Panel have also been advised that Gorwel have upgraded their case management system which is now specific for IDVA services and have also increased capacity in the team.

5.9.4 In response to the above the Panel accepted Gorwel's own findings and reiterate the recommendations that: -

5.9.5 Staff receive additional training regarding keeping detailed and accurate notes as regards contacts with clients. All staff are informed of the need to update both electronic databases, i.e., Discovery System and RMS.

5.9.6 The panel reflected that in addition to the staff training, learning regularly from DHRs, or alike as part of good practice, would assist in understanding and appreciating the joined-up nature of work and appreciate how significant recording is when all agencies add their notes together.

5.10 GORWEL – REVIEW OF PRACTICE RELATING TO VICTIMS WHO NO LONGER SUPPORT A PROSECUTION.

5.10.1 Following a phone call from Shaun on the railway lines in March 2016 Tina and Louise decided not to support a prosecution. The IDVA from Gorwel contacted Tina immediately but then did not do so during the intervening weeks before the Magistrates Court Hearing date. Gorwel acknowledged that current practice would have generated additional IDVA contact. Louise has since stated that her mother did not fully understand the Criminal Justice process and further contact could potentially have focussed her awareness of risk such as coercive controlling behaviour and threats to allow her to make an informed decision. The Panel are mindful that during the final IDVA contact in early May

2016 (during which the IDVA completed proforma questions) Tina stated that her husband was back home and felt she had to give him another chance as they had been married for over 30 years but would definitely call the Police if another incident took place. This returning to the abusive relationship is understandable and must be acknowledged difficult to understand, empathise with and 'police' by any agency as a victim wants to believe it won't happen again.

5.11 THE LACK OF AWARENESS OF DOMESTIC ABUSE AND VIOLENCE IN THE CONTEXT OF THE MEDICAL PRACTICE

5.11.1 The May to July 2017 appointments with the GP that Shaun attended demonstrated the GPs ability to engage with Shaun. Shaun disclosed significant Domestic Abuse risks to the GP such as separation, alcohol, mental health issues and jealousy. He described intrusive thoughts and paranoia which he struggled to control. There is no evidence that Shaun's behaviour and symptoms were seen through the Domestic Abuse lens or that consideration was given to the safety of his ex-partner.

5.11.2 Dr 1 stated that she had reviewed how the medical practice educates people about domestic abuse and had taken steps to raise awareness in the practice. The Panel discussed the potential for GPs to identify, and place 'markers' on at-risk families and individuals. The Panel had varying viewpoints as to the appropriateness and practicality of GPs being able to place 'markers' on at-risk families and individuals and being able to safely use and manage such information. The Panel noted that holding information about Domestic Abuse incidents presented challenges in terms of complying with GDPR and in ensuring that any person identified as presenting risk was not subsequently put-off from seeking GP intervention. It must be noted that other models of the management of Domestic Abuse such as the IRIS model[14] allow referral to specialist services to occur in a GDPR compliant manner.

5.11.3 Professionals working in the domestic abuse field would place victim safety ahead of confidentiality as in any safeguarding concern. Multi-agency forums have proven successful for many years in ensuring agencies have all the information pertinent to any risk to victims by sharing significant concerns for example through MARACs. Where these multi-agency forums don't operate or the concerns do not meet thresholds, information can go undetected.

5.11.4 The Panel did agree that GPs would need to give practical consideration as to how they use and manage data regarding individuals identified as being linked to Domestic Abuse albeit the Panel did not consider that it was appropriate to issue a recommendation regarding this point.

[14] hiips://irisi.org/

5.11.5 In response to the above, the Panel made the following recommendations – that all GP Medical Practices to provide frontline staff with appropriate information and training to be able to identify signs of domestic abuse and be able to signpost individuals to an appropriate support/advisory service. In addition, all GP Medical Practices should display appropriate domestic abuse information within the practice to raise awareness and to provide key information to patients.

5.11.6 Awareness raising is important but having expert advice available may be far more helpful to busy GP Practices. The Panel acknowledged that all GP practices have had and continue to have access to the BCUHB Safeguarding Team should they wish to obtain advice or support concerning potential issues of domestic abuse. The Panel are also aware that GPs could access and use information from the 'Bright Sky' App. Bright Sky is a safe, easy to use app and website that provides practical support and information on how to respond to domestic abuse. It is for anyone experiencing domestic abuse, or who is worried about someone else. Bright Sky helps the user to spot the signs of abuse, know how to respond, and help someone find a safe route to support.

5.11.7 The Panel felt that it would also be beneficial if GPs had access to other external agencies who have specialist trained staff available for discussions, for example Live Fear Free or Women's Aid. In response to the recommendations within this report BCUHB will review practice to ensure GP's can be easily signposted to appropriate specialist agencies.

5.11.8 The Panel discussed the potential for GPs to utilise the HITS screening tool. HITS is an easy-to-use screening tool and scale that stands for Hurt, Insult, Threaten and Scream. The tool includes four questions that physicians can provide to women via a questionnaire to assess risk for Intimate Partner
Violence (IPV). The questions can also be asked verbally. A series of questions

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are asked about how often the individual's partner hurts, insults, threatens or screams at them. Individuals have five different answers they can selecting, including never, rarely, sometimes, fairly often and frequently. The answer for each question is given a point value, with 1 point for never, up to 5 points for frequently. The score on the tool can range between 4-20 points. Any score that is above a 10 shows doctors that the individual is suffering from abuse. The Panel are advised that that if one of the HITS is answered yes this would instigate a DASH Risk Indicator Checklist assessment and if relevant a MARAC Referral. BCUHB intend to explore the potential for this to be used more widely within GP surgeries.

5.11.9 At the time of presenting this report, BCUHB have advised that all GPs in North Wales must participate in safeguarding training in the same manner as all other Health Board employees in line with the BCUHB Statutory and Mandatory Training Policy and Procedure. Domestic Abuse is one themed topic which would be covered at the standard level in Level 2 sessions. The minimum GMC requirements for GPs are to participate in Level 3 safeguarding at least once every five years. There have been discussions and meetings in relation to piloting IRIS in North Wales, this is dependent on the Ministry of Justice funding. In anticipation of the pilot being evaluated and successful, there is the expectation that this will then be implemented across the remainder of North Wales. In the interim period as part of the recommendations of this review, every GP Practice (circa 100) across North Wales have received copy of the Domestic Abuse Virtual Training alongside assessments and workbooks to support the training material. Training Dates have been shared with each of the practices in addition to receiving monthly Safeguarding Bulletins from the Corporate Safeguarding Team, which provides link to the Safeguarding website and contact details to their all-Designated Safeguarding Persons / Safeguarding Specialist.

ANALYSIS - RESPONSE TO TERMS OF REFERENCE

5.12 ANALYSE THE COMMUNICATION, PROCEDURES, AND DISCUSSIONS, WHICH TOOK PLACE BETWEEN AGENCIES, INCLUDING CONSIDERATION OF POTENTIAL CONFUSION IN TERMINOLOGY.

5.12.1 The analysis has highlighted communication/procedural issues encountered regarding Acute Mental Health Unit not sharing information with GP March 2016.

5.12.2 The analysis has highlighted procedural issues encountered regarding the Acute Mental Health Unit's use of the electronic database when assigning a patient to a consultant and ensuring that a patient's details are properly closed on the system in a timely manner.

5.12.3 The analysis has highlighted communication/procedural issues regarding the 2017 GP referral to CMHT and the outcome decision.

5.12.4 The analysis has highlighted procedural issues regarding the appropriateness of signposting Tina and Shaun to Parabl.

5.12.5 The analysis has highlighted procedural issues regarding Gorwel's recording of information.

5.13 ANALYSE THE CO-OPERATION BETWEEN DIFFERENT AGENCIES INVOLVED WITH THE VICTIM, ALLEGED PERPETRATOR, AND WIDER FAMILY

5.13.1 The Panel were of the view that agencies involved with Shaun and Tina cooperated appropriately and professionally. Whilst there were some areas of improvement noted in terms of sharing information, this was based around administrative processes and not a failure or unwillingness to cooperate.

5.13.2 It is important to engender a culture of curiosity for professionals approaching the topic of domestic abuse. This is an ongoing challenge for professionals who may tend to focus on their own field of specialism. Sharing of information is important and a community approach to domestic abuse needs to be encouraged to protect more victims.

5.14 ANALYSE THE OPPORTUNITY FOR AGENCIES TO IDENTIFY AND ASSESS DOMESTIC ABUSE RISK

5.14.1 The GP medical practice were one such agency who had the potential to identify and assess domestic abuse risk. This has already been discussed above in item 5.11.

5.14.2 Gorwel and North Wales Police were also involved in identifying and assessing domestic abuse risk. As stated earlier in the report, the Panel were satisfied that the actions of both agencies had been consistent with the level of service that would be expected. The Panel found no significant departures from policy or process and there were no identified learning points.

5.15 ANALYSE AGENCY RESPONSES TO ANY IDENTIFICATION OF DOMESTIC ABUSE ISSUES.

5.15.1 The agencies directly involved in responding to domestic abuse issues were North Wales Police and Gorwel.

5.15.2 At the time that Tina accessed the service of Gorwel all IDVA's were Safe Lives accredited as a condition of their funding. In addition, Gwynedd had an IDVA based in the Police PVPU which allowed for the immediate sharing of information and discussions relating to victims. This is recognised as best practice. IDVA's are often the key agency in sharing information on victims.

5.15.3 The Panel reflected on Gorwel involvement and interaction with Tina and concluded that, with the exception of a lack of IDVA contact during a 4-week period, the actions were consistent with the level of service that would be expected. The Panel found no significant departures from policy or process. The only learning points were in relation to the recording and storing of information which is discussed later in the report. Having a reluctant victim of domestic abuse is not uncommon for factors already highlighted such as shame, humiliation, and fear

of retribution. The volume of domestic abuse nationally presents a challenge for how IDVA's work with each separate victim. Resourcing and funding such work should be a priority so that victims like Tina can maintain regular contact to access a different 'dialogue' to the one they may be hearing daily from their perpetrator. It takes time to build trust and rapport with a worker and in this instance, the IDVA likely needed more time to allow Tina opportunity to reflect and make different decisions.

5.16 ANALYSE ORGANISATIONS ACCESS TO SPECIALIST DOMESTIC ABUSE AGENCIES

5.16.1 The violence against Women, Domestic Abuse and Sexual Violence VAWDASV (Wales) Act 2015 requires the devolved partners in Wales (local authorities, health boards and fire and rescue services), working with non-devolved partners, such as the police, OPCC and third sector organisations, to develop a VAWDASV Board to prepare a needs assessment and strategy for tackling VAWDASV.

5.16.2 In North Wales this has been developed on a regional basis rather than on an individual local authority basis. There are joint commissioning arrangements in place, and the specialist services for DA and sexual violence are commissioned collectively, using a number of different funding avenues to ensure there are services available across the region, all comparable quality and ability to work across county borders. The needs assessment work identifies gaps in provision and works to develop services where required and as funding allows. This includes voluntary and court mandated perpetrator programme development.

5.16.3 All partners are part of this network, all participate in the MARAC process, are aligned to the Police PVPU workforce, and understand the referral processes.

5.17 ANALYSE THE TRAINING AVAILABLE TO THE AGENCIES INVOLVED ON DOMESTIC ABUSE ISSUES

5.17.1 In addition to the bespoke and individual training that each public sector organisation undertakes as part of general staff development, the Wales Act requires that all (devolved) public service organisations, and specialist third sector organisations undertake training as required by the Act. This is called the National Training Framework for Wales and enshrines awareness raising and training/interventions across the sectors. This is being rolled out across Wales. Ultimately, all public sector workers will have received training at an appropriate level. There are 6 levels within the framework. The aspect that has been reflected on in this review as regards training is relevant to general practitioners and is addressed in the relevant sections of the report.

5.18 CONSIDER IF MORE COULD BE DONE IN THE LOCAL AREA TO RAISE AWARENESS OF SERVICES AVAILABLE TO VICTIMS OF DOMESTIC ABUSE

5.18.1 All relevant partners in North Wales are dedicated to promoting the Welsh Government Live Fear Free Helpline and associated campaigns on a consistent and continuing basis. Individual organisations promote DA awareness on a regular basis and often in a collective and collaborative way.

5.18.2 As stated above, this review highlighted the need for all GP Medical Practices to provide frontline staff with appropriate information and training to be able to identify signs of domestic abuse and be able to signpost individuals to an appropriate support/advisory service. In addition, all GP Medical Practices display appropriate domestic abuse information within the practice to raise awareness and to provide key information to patients.

5.18.3 The Panel are mindful of the complexity of domestic abuse and recognise that scoping out good practice examples from other areas could support local community initiatives to improve practice and knowledge.

5.18.4 One such resource is Respect UK, and Respect Phoneline UK - a domestic abuse organisation that focuses on working with male perpetrators and can offer support and advice.

6.0 CONCLUSIONS

6.0.1 In the 30 years that Tina and Shaun lived in North Wales they had very little contact with the agencies that feature in the DHR process. They were, according to David and Louise, a close-knit family who led private lives and maintained regular employment. It was only in the two years leading up to the murder of Tina that both parties had notable interactions with the agencies.

6.0.2 Tina's only involvement with Adult Social Care, Gwynedd Council was by virtue of being employed by them at a local Council owned residential home. Her contact with the local GP was limited in nature, the IMR indicating that she rarely visited the Medical Practice.

6.0.3 Tina's interactions with NWP were brief and the report acknowledges that their actions were consistent with the level of service expected.

6.0.4 Tina's experience with Gorwel could have been improved there were lessons to be learned regarding recording and storage of information and the

importance of engaging with victims who decide to withdraw from the Criminal Justice process to ensure they are making an informed decision based on an understanding of risk.

6.0.5 Tina had very limited interactions with the agencies who overall discharged their duties correctly.

6.0.6 Prior to Tina's murder, Shaun's only interactions with the NWP and BTP related to his arrest and detainment following the March 2016 domestic abuse incident, again with both agencies discharging their duties correctly.

6.0.7 The main bulk of Shaun's agency interactions were with BCUHB and Adult Social Care, Gwynedd Council – either by virtue of visiting his GP or by being assessed by, or referred to, the CMHT unit. It was through these agency interactions that most recommendations arise.

6.0.8 The Panel concluded that there are lessons to be learned regarding the processes involved in the sharing of information between Acute Mental Health Unit and the GP and that protocols on CMHT referrals need to be reviewed in consultation with GPs. Agencies have well-established practices suitable to their own agency needs, but agencies need to be curious to learn and think differently and promote sharing concerns as part of the closure of cases.

6.0.9 It is also concluded that there are improvements that can be made regarding the way in which the Acute Mental Health Unit utilise the electronic database when managing patient information.

6.0.10 The Panel also concluded that there are improvements that can be made in the way in which Gorwel record and store information and engagement with victims who have retracted statements.

6.0.11 The events that unfold in this review reinforce the importance of educating people about domestic abuse and raising awareness of the associated key indicators. The Panel concluded that GP Practices in Wales can help raise awareness by ensuring that staff are sufficiently informed about the domestic abuse and risk and that steps are taken to raise awareness of domestic abuse to patients.

7.0 LESSONS TO BE LEARNT

LESSON 1

7.1.1 Shaun's most intensive period of Medical Assessment was during the lead-up to the fatal stabbing of Tina, i.e., May 2017 to July 2017. Shaun saw the GP on 7 occasions during this period. The two GPs who undertook the assessments were unaware that approximately one-year prior Shaun had been: -

- Arrested for Common Assault of Tina
- Released on Bail to appear in court
- Had been re-arrested for trespass on the railway suspected of being suicidal
- Had been admitted to the CMHT Hospital unit where he was assessed and discharged

7.1.2 All of this information could have been available to the GP if the Hospital had correctly shared the 2016 Consultants Assessment. Research tells us that two of the most risky times for victims of domestic abuse are when the relationship is ending or if the victim is pregnant. This is well documented in research and national data.

7.1.3 The Panel acknowledged the enormity of scale of patient data held by the Health Boards across Wales in both written and electronic format and the complexity of trying to accurately retain, maintain and share appropriate patient information with key stakeholders.

7.1.4 In this case the Panel felt that the GPs would have benefited from having prior knowledge of Shaun's previous March 2016 Mental Health Assessment during the time that they were seeking to address Shaun's sleep issues, Paranoia and Anxiety and understanding where that paranoia originated, i.e., mistrust in his relationship and where that stemmed from. It may have fallen outside of the GPs remit but with hindsight can consider what may have helped during those 7 GP visits.

7.1.5 The Panel accepted that the CMHT Hospital unit in question does routinely share assessments with GPs but at the same time raised questions about the appropriateness of using fax machine technology as the means of sharing such patient information. It is possible to hypothesise that professionals could pick up the phone if they are concerned – discharge the case by sharing concerns and sounding out other professionals as part of an exit strategy from working with an individual.

7.1.6 The Panel were unable to speculate as to whether the GP practice could have provided potential ongoing support services/interventions had they received a copy of the CMHT Consultant's assessment in March 2016. Both CMHT and the GP practice would have benefitted from a specialist service (e.g., Women's Aid) to check out concerns and options of available interventions if they had picked up on concerns.

LESSON 2

7.1.7 The records retained by the CMHT suggested that Shaun's case was left open after his March 2016 assessment and that a referral to Consultant Dr. 4 was to take place. However, the findings of the review found that Shaun's case should have been formally closed at that time and that no referral to Dr. 4 was ever intended to take place.

7.1.8 There are no records to suggest that any follow up action was to take place with Shaun following the CMHT assessment of March 2016.

7.1.9 As already stated, the GPs were unaware of Shaun's CMHT Assessment.

7.1.10 In response to the above the Panel have recommended that CMHT's review the way in which the electronic database is used when assigning a patient to a consultant and ensuring that a patient's details are properly closed on the system in a timely manner.

LESSON 3

7.1.11 Themes arose from reviewing Shaun's interaction with the GP Medical Practice regarding differing views as to when a referral to CMHT was deemed appropriate. The key issue was that the GP Medical Practice made a referral to CMHT for Shaun in mid-July 2017 at a point when Shaun had shown signs of health improvement, albeit it was still considered by the GP to be in line with National Guidance. On this basis there was an element of presumption that CMHT would accept the referral. However, the SPOA team at CMHT considered the referral was not appropriate and instead of accepting Shaun as a patient, they recommended that Shaun was signposted to Parabl. However, the GP did not have all the information about the domestic abuse when making their referral. Thinking about missed opportunities, information sharing is the running thread through this review. The GP may have considered other specialist support had they thought more about the behaviour element of Shaun's presentation.

7.1.12 In effect this issue demonstrated that there was some difference in professional opinion between the GP and the CMHT. BCUHB have given the matter due consideration and have agreed to the review's recommendations.

7.1.13 The Panel agreed that BCUHB need to review protocols around CMHT referrals in consultation with GPs and CMHT to address the differing professional opinions

and to review what information is considered at the SPOA referral review stage.

LESSON 4

7.1.14 The GPs notes of the end of March 2017 record that discussions took place with Tina about accessing the services of Parabl in order to help Tina with some of the problems she was experiencing with her relationship breakdown, recent family bereavements and her low mood. This is a significant event because the GP is not able to link Tina's needs and concerns necessarily to that of Shaun's as they may have been seen by two different GPs and there was no flag on the system to direct a GP to look at Shaun's notes to see what has been going on. Parabl may not have been the preferred option for Tina at this stage. Women's Aid would certainly have had more experience in dealing with the nuances of mood and concerns than Parabl, but a GP would need to be able to know this was about abusive behaviour rather than focusing on the low mood and depression.

7.1.15 The GPs notes in mid-May 2017 record that discussions took place with Shaun about RELATE and counselling. It is generally accepted by specialists in the field of domestic abuse that neither Relate nor counselling is a good intervention for Domestic abuse victims for fear of revictimising the victim through the perpetrator being given a platform to discuss his concerns with a victim 'held hostage' in the room. The preference is always to refer to the likes of Women's Aid and use their expertise to take a victim centred approach with victims. Perpetrators need support too, but it must be evidenced based programmes to unpick the behaviours and beliefs around entitlement with a separate time and place for the perpetrator.

7.1.16 Shaun attended his final GP assessment in mid-July 2017 accompanied by Tina. At this stage Shaun had notably improved in his state of health. During the assessment, the GP agreed to make a referral to CMHT due to Shaun's concerns that he may relapse in the future. In simple terms the GP made a referral to the CMHT at a time when Shaun was in a much-improved state of health. Understandably, CMHT did not accept the referral and advised that Shaun should be referred to Parabl but better still would have been a suitable group for men who have perpetrated these behaviours.

7.1.17 The findings of this review confirm that neither Shaun or Tina engaged in talking therapies with RELATE or Parabl which may have been a good thing as outlined above to avoid revictimisation.

7.1.18 Both talking therapies and Relate are excellent organisations, but in this instance the Panel recognise that Shaun would have benefitted from a specialist intervention that focused on changing his abusive behaviour, rather than interventions that focus on relationship problems, stress and anxiety.

7.1.19 The Panel note that the referral to CMHT in July 2017 resulted in the CMHT recommending Shaun access Parabl. Shaun could have accessed Parabl earlier in May 2017 when he was first advised by the GP about RELATE and counselling services.

7.1.20 In line with recommendations, BCUHB will be reviewing arrangements between CMHT and GP surgeries to ensure that there are clearly defined processes in terms of who takes on responsibility for issuing advice about services such as Parabl. This includes how patients are referred to Parabl, i.e., whether this is by means of verbal advice or on a more formal basis involving some form of written referral (Either from CMHT or the GP Practice).

LESSON 5

7.1.21 GPs stated that on reflection they had sought to raise awareness of Domestic Abuse within the Medical Practice amongst staff and to patients. They aimed to achieve this through ensuring staff were sufficiently informed about Domestic Abuse and by displaying appropriate posters/information on the walls of the Medical Practice. It needs to be acknowledged that Tina was unlikely to have disclosed at this stage. Any anecdotal evidence from staff should be shared with the GP or Practice Manager if concerning, but there is no evidence to say that receptionists for example had conversations with Shaun or Tina alerting them that anything was amiss.

7.1.22 Louise talked about the longstanding occurrences of Domestic Abuse within the household during her growing up and into adulthood. The Panel were of the view that Domestic Abuse within the household had become normalised. Children raised in an environment where domestic abuse is frequent are themselves victims and will undoubtedly shape their thinking as to not telling, keeping it in the home, keeping it hidden protecting mum and dad.

7.1.23 Whilst the public profile and awareness of Domestic Abuse has increased significantly over recent years, the Panel are supportive of any measures that can be implemented to further raise awareness and educate. In this review it is noted that GPs recognised the need to raise the profile of Domestic Abuse within the Medical Practice.

LESSON 6

7.1.24 The Gorwel IMR identified that a brief telephone conversation took place between PVPU IDVA and Tina at the end of March 2016 albeit the content of the discussion is not recorded. Gorwel noted this and confirmed to the Panel that they are discussing further training for staff on keeping detailed and accurate notes as regards contacts with clients.

7.1.25 Gorwel also advised the Panel that regarding the IDVA service provided, they have already identified the need to make sure all updates are placed on the Discovery system – and not, as in this case, the RMS only – this internal recommendation has already been implemented by Gorwel

7.1.26 In response to the above the Panel accepted Gorwel's own findings and reiterate the recommendations that staff receive additional training regarding keeping detailed and accurate notes as regards contacts with clients and that staff are informed of the need to update both electronic databases, i.e., Discovery System and RMS. The Panel noted that training has now taken place and a case management policy has been introduced addressing case recordings, frequency of contact and case management processes.

7.1.27 The Panel reflected on Gorwel involvement and interaction with Tina and concluded that, with the exception of a lack of IDVA contact during a 4-week period, which the panel accepted as an anomaly, the actions were consistent with the level of service that would be expected. The Panel found no significant departures from policy or process.

LESSON 7

7.1.28 The Panel were disappointed at the refusal of the employer to engage in the process and consider that this raises wider implications about DHR reviews being unable to access potentially relevant information and therefore being unable to make associated recommendations.

8.0 RECOMMENDATIONS

8.1.0 Acute Mental Health Unit /CMHT

8.1.1 A number of themes arose from reviewing Shaun's interaction with the Acute Mental Health Unit/CMHT.

8.1.2 Themes include: -

- The likelihood that the Acute Mental Health Unit did not share the end of March 2016 patient assessment with the GP despite it being routine practice.

- The appropriateness of using a fax machine as the main means of relaying patient information to GPs.

- Shaun having his case assigned on the electronic database to Dr 4 even though there was no intent to make further contact with Shaun.

- Shaun's case remaining 'open' on the CMHT electronic database when it should have been formally closed.

8.1.3 Based on the above, the Panel makes the following recommendations: -

RECOMMENDATION 1

8.1.4 That the Acute Mental Health Unit implement processes which ensure that patient assessments are shared with the patient's GP.

RECOMMENDATION 2

8.1.5 That the Acute Mental Health Unit cease using fax machines as a primary means of relaying sensitive and confidential information and instead utilise secure email systems which can password protect confidential information, which can provide a clear audit trail, and which can utilise a send receipt option as a means of confirming that the intended recipient has received the assessment.

RECOMMENDATION 3

8.1.6 That CMHT review the way in which the electronic database is used regarding assigning a patient to a consultant and regarding ensuring that a patient's details are properly closed on the system in a timely manner.

8.2.0 GP Medical Practice

8.2.1 Themes arose from reviewing Shaun's and Tina's interaction with the GP Medical Practice regarding awareness of Domestic Abuse.

8.2.2 Themes include ensuring staff are sufficiently informed about domestic abuse, and, raising awareness of domestic abuse to patients

8.2.3 Based on the above, the Panel makes the following recommendations: -

RECOMMENDATION 4

8.2.4 All GP Medical Practices to provide frontline staff with appropriate information and training to be able to identify signs of domestic abuse and be able to signpost individuals to an appropriate support/advisory service.

RECOMMENDATION 5

8.2.5 All GP Medical Practices to display appropriate domestic abuse information within the practice to raise awareness and to provide key information to patients.

8.3.0 CMHT and GP Medical Practice

8.3.1 Themes arose from reviewing Shaun's interaction with the GP Medical Practice regarding differing views as to when a referral to CMHT was deemed appropriate. The key issue was that the GP Medical Practice made a referral to CMHT for Shaun in mid-July 2017 at a point when Shaun had shown signs of health improvement, albeit it was still considered by the GP to be in line with National Guidance. On this basis there was an element of presumption that CMHT would accept the referral. However, the SPOA team at CMHT considered the referral was not appropriate and instead of accepting Shaun as a patient, they recommended that Shaun was signposted to Parabl.

8.3.2 In effect this issue demonstrated that there was some difference in professional opinion between the GP and the CMHT. BCUHB have given the matter due consideration and have agreed to implement the following recommendations: -

RECOMMENDATION 6

8.3.3 CMHT to take into consideration available information they may also hold on an individual that may or may not be known to general practice when considering GP referrals.

RECOMMENDATION 7

8.3.4 General Practice to understand the mechanisms used by CMHT to assess GP referrals to them in the knowledge of the protocol and key sections.

RECOMMENDATION 8

8.3.5 Future revisions to the protocol to include general practitioners as consultees / representation as a member of the working group.

8.4.0 Gorwel – Accurate Recording of Information /Data Input

8.4.1 The Gorwel IMR identified that a brief telephone conversation took place between PVPU IDVA and Tina at the end of March 2016 albeit the content of the discussion is not recorded. Gorwel noted this and confirmed to the Panel that they are discussing further training for staff on keeping detailed and accurate notes as regards contacts with clients.

8.4.2 Gorwel also advised the Panel that regarding the IDVA service provided, they have already identified the need to make sure all updates are placed on the Discovery system - and not, as in this case, the RMS only - this internal recommendation has already been implemented by Gorwel.

8.4.3 In response to the above the Panel accepted Gorwel's own findings and reiterate the recommendations that: -

RECOMMENDATION 9

8.4.4 Staff receive additional training regarding keeping detailed and accurate notes as regards contacts with clients.

RECOMMENDATION 10

8.4.5 Where appropriate that staff are informed of the need to update both electronic databases, i.e., Discovery System and RMS.

8.5 Lack of Engagement of Shaun's Employer

8.5.1 The refusal of the employer to engage in the process raises wider implications about DHR reviews being unable to access potentially relevant information and therefore being unable to make associated recommendations. Employers need support to understand what a valuable contribution they could make to a DHR review by being sensitive to their understanding and reluctance to do so. It is likely that awareness raising would be beneficial.

RECOMMENDATION 11

8.5.2 The Panel recommend that the Home Office give consideration to extending the scope of DHR's to include a statutory obligation on major UK employers to engage with the DHR process.

GLOSSARY OF TERMS

AAFDA	Advocacy after Fatal Domestic Abuse
BCUHB	Betsi Cadwaladr University Health Board
BTP	British Transport Police
CID 16	Public Protection Referral Form
CMHT	Community Mental Health Team
CP	Community Psychiatrist
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DAO	Domestic Abuse Officer
DASH	Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and Management Model (2009)
DHR	Domestic Homicide Review
FLO	Family Liaison Officer
Gorwel	Domestic Violence Support Services
GP	General Practitioner of Medicine (Doctor)
HAFAL	Voluntary, community based mental health support organisation
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Review
MHA	Mental Health Act
MAPPA	Multi-Agency Public Protection Arrangements
NICE	National Institute for Health and Care Excellence
NWP	North Wales Police
Parabl	Talking Therapies Partnership
PVPU	Protecting Vulnerable People Unit (Police)
RELATE	Relationship Support Charity
SPOA	Single Point of Access
WAST	Welsh Ambulance Services NHS Trust

End of Report