Domestic Homicide Review

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

Safer Pembrokeshire – Pembrokeshire Community Safety Partnership

In respect of the death of a woman

Pembrokeshire/DHR/2016-17/1

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(Independent Chairs and Authors)

Presented to Pembrokeshire Community Safety Partnership

20th October 2017

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Appendices

1. Introduction

1.1 At 02.49 on Monday 22nd February 2016 the perpetrator dialled 999 and requested an ambulance. The paramedics attending were concerned that the injuries to an unconscious female might have resulted from a violent struggle; they relayed their concerns to their control room. At 02:58 on Monday 22nd February Dyfed Powys Police control room received a call from Ambulance Control stating that paramedics had attended a call where a 27-year-old female was found in an unresponsive state in her own living room. There were signs of a struggle such as broken glass on the floor. Officers attended, and paramedics informed them of the female's serious condition. They informed officers of their suspicion that the male at the scene had committed the attack (he had blood on his hands). Paramedics carried out advanced life support and CPR on the victim over an extended period, but she was not responsive. Recognition of Life Extinct was called at 03.50. A Home Office pathologist concluded that the victim died as a result of a severe beating.

1.2 The perpetrator was arrested that night on suspicion of assault as the extent of the victim's injuries were unknown. Later at Haverfordwest Police Station he was re-arrested on suspicion of murder. In subsequent interviews he consistently denied the allegation. On 9th September 2016 he was convicted of her murder. He was sentenced to life in prison.

1.3 On 13th April 2016 the Chair of the Pembrokeshire Community Safety Partnership (CSP) was notified of the death of the victim and the case was referred to a multi-agency meeting comprising members of the CSP. The group met on 22nd April 2016 to consider the circumstances of the incident resulting in the death, against the criteria set out in the *Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews 2013 and 2016.* The meeting decided to initiate a Domestic Homicide Review (DHR), but its commencement would be delayed until a week after the end of the perpetrator's trial. A report confirming this decision was sent to the Home Office on the 11th May 2016. On the 22nd July, the full CSP approved the draft terms of reference as drafted by the Review Panel. Following this meeting the Community Safety, Poverty and Regeneration Manager for Pembrokeshire County Council contacted the joint Domestic Homicide Review Chairs to inform them of the case and the decision taken to undertake a Domestic Homicide Review (DHR).

1.4 In the preparation of this report, agencies have collated sensitive and personal information under conditions of confidentiality. The relationship between the perpetrator and victim and their family, medical and other relevant histories were reviewed going back twelve years. Throughout discussions the Panel and all agencies involved balanced the need to respect the privacy and dignity of the family, and respect for the criminal justice process, with the need for all agencies to learn lessons and so improve safety for the future.

2. Purpose, Scope and Terms of Reference

2.1 A DHR enables professionals to understand what happened and what needs to change to reduce the risk of such incidents reoccurring. It is not intended to inquire into how the victim died or who is responsible for the death. Nor are DHRs part of any disciplinary process; if errors are uncovered it is for others to find out whether any individual or organisation is to blame. Members of the Panel recognised that this was its remit.

2.2 The purpose of a DHR is outlined in Section 2 of the *Multi Agency Statutory Guidance 2016*:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

2.3 The Panel decided it would be appropriate to go back as far as necessary in reviewing the victim and the perpetrator's contact with the statutory and voluntary sectors. The Panel felt that an arbitrary cut off point could lead to important information being missed. The DHR covered the period from 2005, the date of the victim leaving school, to the time of her death in 2016.

2.4 The chronology of events show that the victim had more contact with statutory agencies and voluntary bodies than the perpetrator. Very little information was available regarding the perpetrator. His contact with agencies was sporadic. The victim had significant contact with several agencies. In reviewing the information provided in the Individual Management Review (IMR) and other reports, the Panel agreed the following terms of reference:

- The methods and effectiveness of communication between the agencies and the victim
- The extent to which information was shared appropriately;
  - Within individual agencies
  - Between agencies
- The effectiveness of risk assessment and risk management within the agencies involved
- The effectiveness of communication between statutory bodies and third sector bodies
- Were any signs or indications of domestic abuse missed by those agencies having contact with the victim?
- Other matters as considered appropriate by the Panel

The Panel also identified some general issues relating to the awareness of and the conduct of DHRs. These are noted in the recommendations below.

3. Process

3.1 General

3.1.1 Notification of the DHR was sent to agencies (statutory and voluntary) who were asked to identify whether organisations had involvement with either the victim or perpetrator. If there was contact, they were asked to undertake an Individual Management Review (IMR) of that contact. The organisations were asked to look critically and openly at

individual and organisational practice to find out whether changes could and should be made and, if so, how this should be achieved. Each agency was asked to ensure a senior member of staff who had no prior involvement with the case would complete the IMR. Each agency was referred to *Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews 2013* on how to prepare an IMR and for information concerning each aspect of the DHR. Where agencies had no contact, they completed a nil return.

3.1.2 The Panel ensured that all relevant information obtained was analysed. Joint independent Chairs from the School of Law at Aberystwyth University were appointed prior to the commencement of the Review and they, along with the CSP, appointed the other members of the Panel ensuring membership from relevant agencies. The Panel appointed a former General Practitioner to act as an independent consultant.

3.1.3 At the first meeting of the Panel the terms of reference (drafted by those who attended the meeting and amended by the Chairs of the Panel) were reviewed and agreed. The terms of reference specifically required agencies to consider risk assessment and risk management in their IMRs. The IMRs identified a number of risks and vulnerabilities as noted in the sequence of events (Section 7). These underpinned the analysis and recommendations.

3.1.4 It was clear that there was involvement by agencies and practitioners with the victim and the perpetrator, though none regarding domestic abuse between the perpetrator and victim. Eighteen IMRs were received. The final IMRs received were mostly produced in a timely manner. The authors were either Panel members of briefed by members of the Panel. Two IMRs recorded no contact with either the victim or the perpetrator. Ten recorded no contact with the perpetrator.

3.1.5 Upon receipt of the IMRs a chronology of events was produced. The IMRs and chronology were discussed by the Panel and points of clarification and further information requested and received. The IMR authors discussed their reports with their respective agency Panel member, who then fed back to the Panel meetings. The Panel requested more information from some agencies. Overall this was not an issue, but there were initial difficulties getting information from some statutory organisations. Whilst the Panel had a full IMR from Hywel Dda University Health Board

some problems were encountered in getting detailed information from the victim's General Practitioner, although these were resolved. This is discussed below.

3.1.6 Contact with family members was made by an independent from Advocacy After Fatal Domestic Abuse (AAFDA) signposted through Safer Pembrokeshire CSP to support the family.

3.1.7 The Panel met on three occasions, two of which were to consider the IMRs, information reports and to progress this Overview Report.

3.2 Timeliness of the Review

3.2.1 The initial Review Panel agreed that any legal proceedings had to take precedence and were conscious of the need not to compromise the criminal investigation. Criminal proceedings were completed when the DHR Panel first met. The perpetrator was convicted of the victim's murder on 9th September 2016 at Swansea Crown Court.

3.2.2 This review has exceeded the six month timeframe specified for a DHR. Although momentum was maintained, there were delays. Firstly, the Panel awaited the outcome of the criminal proceedings and secondly, the Panel experienced initial difficulties in accessing information from the victim's General Practitioner.

3.2.3 The Overview Report and Action Plan were presented to the Safer Pembrokeshire CSP on 20th October 2017.

4. Domestic Homicide Review Panel

4.1 The Review Chairs are Professors John Williams and Kate Williams. Both Chairs are members of the Department of Law and Criminology at Aberystwyth University and have legal training. John Williams is a barrister and has experience of Serious Case Reviews. Kate Williams has legal training, has lectured in law and in criminology and has practical (as a trustee for a domestic abuse service working with victims of domestic abuse) and research experience of domestic abuse.

4.2 The members of the Panel were senior managers from the key statutory agencies. Some of the members were the authors of the IMRs. IMR authors had no direct contact or management involvement with the case. Panel membership was as follows;

- Chairs
- Dyfed Powys Police
- Hywel Dda University Health Board
- Pembrokeshire County Council (PCC)
- Drug Aid Cymru
- National Probation Service (NPS)
- Safer Pembrokeshire CSP
- General Practitioner Consultant

At the time, no specialist domestic abuse service was operating in Pembrokeshire. The Panel decided not to include representation from that sector. Two more general services were offering support to victims of domestic abuse at the time and both were invited and attended the first meeting. They were satisfied with the composition of the panel and did not believe they needed to be included in any further deliberations.

5. Individual Management Reviews

5.1 IMRs / reports were received from the following agencies involved with the victim and/or the perpetrator;

Hywel Dda University Health Board
Pembrokeshire County Council, Children's Services
Pembrokeshire County Council, Adult Services
Pembrokeshire County Council, Youth Services
Pembrokeshire County Council, Education
Pembrokeshire County Council, Housing
Dyfed Powys Police
Mid and West Wales Fire and Rescue Service
Milford Youth Matters
National Probation Service
Gwalia
The Community Rehabilitation Company (CRC)
Welsh Ambulance Service NHS Trust
Drug Aid Cymru
Citizen's Advice Bureau

Hafan Cymru
Advocacy West Wales

5.2 Each IMR report noted contact they had with either the victim or the perpetrator and reviewed the nature of that contact. In the case of Hafan Cymru and Advocacy West Wales confirmation was received that there had been no contact with either party.

5.3 The Panel scrutinised and quality assured each IMR. Specific issues were raised and discussed at Panel meetings and the IMRs and chronologies updated accordingly.

6. Family Relationship Background

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

	Relation	**Comment**
Victim	Mother	
	Father	
	Sister	
	Brother	
	Child	Cared for by maternal grandparents since 2008
Perpetrator	Relatives	Possible child from previous relationship

7. Chronological Sequence of Events (including criminal proceedings)

Date(s)	**Event**	**Comment**
09/1982	Perpetrator born.	
01/1989	Victim born.	
2005	Victim identified as having emotional behavioural difficulties and moderate learning difficulties.	Special Educational Needs status at time of leaving school – identified moderate learning and emotional difficulties. No data was available to follow this up because Pupil Level Annual Schools Census (PLASC) data only commenced in 2004.
06/2005	Victim first known offending.	Case dismissed.

Date(s)	Event	Comment
07/2007	Victim gave birth to a baby.	
05/2008	20-05-2008 victim advised Health Visitor during a home visit of an incident that had occurred on the 15-05-2008 – perpetrator reported to be male ex-partner.	This shows a willingness to report domestic abuse and a knowledge of who such information should be shared with.
05/2008	Victim's child.	Assessed by Social Services. Child staying with maternal grandparents. Assessment closed by Child Care Assessment Team.
06/2008	Health visitor receives 'high risk' domestic incident notification report from Police, perpetrator was male ex-partner.	Shows a willingness to report domestic abuse and a knowledge of who such information should be shared with.
01/2009	Perpetrator arrested for possession of controlled substances, charged and bailed.	
09/2009	Health Visitor receives 'high risk' domestic incident notification from Dyfed Powys Police. Victim identified as assaulting ex-partner.	
01/2010	Health Visitor receives 'high risk' domestic incident report, perpetrator was male ex-partner, not current perpetrator.	Shows willingness to report domestic abuse and a knowledge of who such information should be shared with.
07/2010	Victim referred to Mental Health Team. She was assessed and found to be	She did not follow up on the signposting.

Date(s)	Event	Comment
	feeling very low but not to be suffering from a mental health problem. A decision was taken to monitor her mental health over the short term and refer her to other agencies by signposting.	
09/2010	Victim's child living permanently with maternal grandparents as per private arrangement.	
09/2010	Perpetrator attacked at a party. He suffered a collapsed lung and possible skull fracture. He was reluctant to make a statement because he feared reprisals.	
11/2010	Perpetrator arrested for assault (believed to be connected to his having been assaulted in 09/2010).	
02/2011	Perpetrator arrested on suspicion of having kicked in the glass in his then girlfriend's front door. He claimed the door broke when he closed it too hard. No further action was taken due to absence of witnesses.	A child, possibly his, was present during the event.
06/2011	Perpetrator reported as having kicked his dog.	

Date(s)	Event	Comment
07/2011	Health Visitor receives 'high risk' domestic incident report from Police, incident occurred 20-06-2011, perpetrator was male ex-partner, not current perpetrator.	Shows willingness to report domestic abuse and a knowledge of who such information should be shared with.
09/2011	Victim referred to Mental Health Team. The assessment found that she was not suffering from a mental illness. Decided to signpost to appropriate services with some short-term monitoring of her mental health.	The victim did not follow up on signposting.
10/2011	Perpetrator charged with shoplifting.	
12/2011	'Medium risk' domestic incident notification.	Shows willingness to report domestic abuse and a knowledge of who such information should be referred to.
12/2011	Perpetrator arrested for drunk and disorderly behaviour – he was verbally abusive and aggressive towards Police Officers. Pelargonic and vanillylamide (PAVA) spray used.	
03/2012	Perpetrator involved in road traffic collision in London where he suffered fractures of both clavicles and the right lamina.	

Date(s)	Event	Comment
05/2013	Victim arrested for assault on male; not the perpetrator.	
05/2013	After arrest victim had a Mental Health Assessment. No serious mental health problems but needed a change in medication and agreed to contact Prism and make an appointment for herself – this after admitting that she was unable to remember appointments. She refused more support from outpatient mental health.	Victim did not follow up self-referral to Prism.
07/2013	Victim convicted of assaults and sentenced to an eighteen month Criminal Justice Act Community Order with requirements.	Worked with Wales Probation Trust, National Probation Service, The Community Rehabilitation Company and Gwalia (ex-offender floating support programme) over the 18-month period.
11/2013	Victim suffers slashed wrists. Admitted to being self-inflicted, though she did not remember doing it. Mental health assessed again and referred to General Practitioner for alteration of medication. This was done in 12/2013.	Scored 0 on Women Abuse Screening Tool (domestic abuse).
07/2014	Perpetrator claimed to have been assaulted in the face at a nightclub by a named male. Welsh Ambulance	Crown Prosecution Service pre-charge advice was submitted. Outcome was no further action due to evidential difficulties.

Date(s)	Event	Comment
	Service and Dyfed Powys Police attended and he was taken to hospital.	
07/2014	Perpetrator visits General Practitioner due to depression.	
08/2014	Perpetrator assessed by Mental Health Team. Recommended low level intervention and medication.	
01/2015	Police received report of arguing at victim's address. They then received another report about a fire. They arrested both victim and perpetrator. Victim set fire to her home. Charged with arson. Perpetrator charged with possession of cocaine.	
02/2015	Victim convicted of arson and imprisoned for 24 months and four licence conditions attached.	
02/2015	Child Care Assessment Team contacted by National Probation Service to undertake assessments for the victim and her child.	Checks completed and forwarded to National Probation Service.
10/2015	Victim released from custody. Working primarily with National Probation Service, Mid and West Wales Fire and Rescue Service and Gwalia.	Upon release the victim was drug free and had trained as a nail technician whilst in prison. Records indicate she was positive and had ambitions. Whilst initially support was positive, much of the third sector support was

Date(s)	Event	Comment
		via electronic means rather than face to face.
02/2016	Perpetrator called 999 at 02.49 and asked for an ambulance. Paramedics find victim unconscious at home, she is pronounced dead at 03.50.	Paramedics were suspicious of the circumstances and called the police.
02/2016	Perpetrator arrested on suspicion of murder of victim	
02/2016	Perpetrator charged with victim's murder	Detained at Swansea Prison until the trial on 09/2016.
09/2016	Perpetrator convicted of murder on 9th September 2016 and sentenced to life in prison	

8. Family Involvement

8.1 The victim had contact with her parents and they were the principal carers for her child.

8.2 The IMRs revealed that the victim had been in relationships in the past and there is evidence of domestic abuse by previous partners in 2008 and 2011. Three 'High Risk' domestic incident notices were issued by Dyfed Powys Police and evidenced in Health Visitor records. This suggests that she was aware of how to report such incidents. There is no record of her reporting any domestic violence incidents involving the perpetrator.

9. Overview

9.1 The couple were both born in the Dyfed Powys Police area. Both parties were British Caucasian, and neither were registered as disabled. Their general health status and their engagement with health services are noted in Section 7. At the time of the incident they each lived in Pembrokeshire. The victim and perpetrator had a relationship of at least three years. There is no evidence that the relationship was abusive even though

reports of domestic abuse against previous partners had been noted. The victim had been referred for support from a mental health team and in this respect she might have been classed as being a vulnerable adult. Whilst this might have compromised her ability to seek help, the Panel concluded this did not appear to be the case. When, in a previous relationship, she was the victim of domestic abuse there is clear evidence that she asked for help from the police (see Section 7, Chronological Sequence of Events entries dated: 06/2008; 01/2010; 07/2011; and 12/2011).

9.2 The victim had a child from a previous relationship. This child had been residing with the maternal grandparents for many years prior to the homicide. It is believed that the perpetrator has one child from a previous relationship, although this is not clear from the evidence. The perpetrator had contact with some statutory agencies, largely for physical health problems, though from 2014 onwards there were a few low-level mental health issues. There is no suggestion in any of the mental health records that the perpetrator posed a risk to self or others. At the time of the homicide he was not on the Severe Mental Illness Register and his General Practitioner was not actively monitoring his mental health.

9.3 The victim had considerable involvement with statutory agencies and the third sector. She had prolonged contact with the National Probation Service and The Community Rehabilitation Company as well as health issues linked to mental health. After the victim and perpetrator became a couple there was no intervention by any agency or practitioner associated with domestic abuse within the relationship.

10 Detailed Analysis

10.1 General Practitioner

10.1.1 The General Practitioner consultant on the Panel reviewed the victim's medical records at the surgery. There are several entries in correspondence that indicate violence and abuse by her previous partner. However, the records disclosed no reference to domestic abuse between her and the perpetrator. Her General Practitioner had referred her to mental health services in relation to suicidal thoughts in 2010.

10.1.2 The perpetrator had limited contact with his General Practitioner about feeling 'low'.

10.2 Health Board and Hospital Services

10.2.1 At the initial booking visit by the midwife in 2007, there is evidence that a 'Routine Enquiry in relation to domestic abuse' was completed, but no domestic violence was disclosed.

10.2.2 'High Risk' Domestic Incident Notifications were received by Health Visitors from the police in 2008 and 2010 identifying previous partners as the perpetrators. A similar notification was received in 2009, where the victim was named as the perpetrator against a previous partner.

10.3 Local Authority

10.3.1 The victim and perpetrator had limited contact with the local authority. There was contact about domestic abuse relating to the safety of her child due to actions of a previous partner.

10.3.2 The victim was in contact with the local authority relating to the following: child protection; adult protection, youth services, and housing.

10.3.3 Child protection: Referrals were made to child protection services concerning the victim's child. The result of the enquiries did not identify any cause for concern relating to the care of the child by the maternal grandparents.

10.3.4 Adult protection: A referral to adult safeguarding was made in 2015 by the National Probation Service prior to sentencing. The outcome of this referral was communicated to the National Probation Service. This contact found her not to be an adult at risk, as she did not meet 'vulnerable adult' criteria as she was not considered to be at risk of significant harm. Under the new Social Services and Well-being (Wales) 2014 she would not be classed as an 'adult at risk', although she might be classed as someone in need of a 'watching brief'.

10.3.5 Housing: the victim was a Pembrokeshire County Council tenant from 2007-2015.

Following her conviction for arson in her final Pembrokeshire County Council property, her tenancy was revoked and upon her release from prison accommodation was identified within the private sector.

10.3.6 For almost a four-month period in 2014 the victim engaged with Pembrokeshire County Council youth services and was signposted to Milford Youth Matters and the 'Get It' engagement programme. The 'Get It' programme was designed to develop soft skills to move young people under 25 years closer to employment. The victim engaged with this programme more than with Wales Probation Trust or other third sector activity. For a time after being in the programme the victim appeared to have improved her life. The effects appeared to be short-lived and not followed up by other agencies.

10.4 Police

10.4.1 The Police were not involved in the domestic relationship between the victim and the perpetrator, but rather in relation to their individual behaviour, albeit on occasions involving both.

10.4.2 On several occasions the Police had contact with the victim. The reasons for this ranged from suspected drug possession to her being charged with arson in 2015. Some contacts with the Police involved the victim and the perpetrator. However, these did not suggest an abusive relationship. The relationship was volatile, but the victim did not raise any allegations of domestic abuse.

10.4.3 The Police had contact with the perpetrator. This contact related to drunkenness, drugs, driving, theft, and acts of violence and criminal damage. He was the victim of a serious attack in 2010, when he suffered a collapsed lung and possible skull fracture. He was reluctant to make a statement because he feared reprisals (for details see 09/2010 of the chronology in Section 7 above). This incident is not related to the matters under consideration as part of this Review.

10.5 Wales Probation Trust, National Probation Service and The Community Rehabilitation Company

10.5.1 There is no evidence that either the victim or perpetrator had contact with Wales Probation Trust, National Probation Service or The Community Rehabilitation Company in relation to domestic abuse. Following conviction and release from prison the victim worked with both the National Probation Service and The Community Rehabilitation Company. There was an opportunity for constructive engagement as the victim was not using any substances and wanted to stay out of trouble and retrain. Whilst work with the victim met the requirements of the order, the engagement appeared to be rather formulaic.

10.5.2 In their work with the victim in 2014 it was noted, particularly by the National Probation Service, that on several occasions the victim failed to attend appointments. YHowever, in 2015-16 her attendance with the National Probation Service had improved and she appeared more willing to engage. Contact with Gwalia was sporadic. Had such support been continued it may have encouraged her to distance herself from the perpetrator. This support could have been followed up by the National Probation Service. In October 2015 the victim appeared to be in a better frame of mind and had expressed the desire to make changes. This was a missed opportunity to support her to improve her life and well-being. It would not have prevented the attack that caused her death, however, it might have supported her to enhance her capabilities and improve her life chances. This is something she appeared to want to do, but she needed help to achieve. It may have helped her to move away from the dangerous and precarious life she was leading.

10.5.3 The Panel had some difficulty obtaining all the information from the National Probation Service. Information was brief and there was a need to make follow up requests for additional information, which was provided. The Panel recognised the need to take into account the restructuring occurring during the time that Wales Probation Trust, National Probation Service and the Community Rehabilitation Company were working with the victim. There is nothing to suggest that this restructuring negatively impacted upon the service delivered to the victim.

10.6 Third Sector

10.6.1 There is no evidence that either the victim or perpetrator had contact with a third sector organisation working in domestic abuse. However, the victim had contact with the third sector through other means. Firstly, Milford Youth Matters via the 'Get It' programme. Secondly, she was signposted to Prism, a third sector organisation, to support her in overcoming her use of illegal substances, but to participate in and benefit from this service she was required to self-refer, which she opted not to do. Thirdly, she was involved with Gwalia in 2013 and upon her release from prison in 2015. During the 2015 face to face contact, engagement with the third sector appeared positive. Over-reliance on telephone, text and other means of communication seemed less effective. For a period of time following her release from prison a large amount of the contact with Gwalia involved using electronic communication when she appeared to most need support. Whilst this clearly played no part in her homicide, support may have enabled her to continue to distance herself from the perpetrator as she had stated they were not a couple when she came out of prison. Finally, she engaged with the Dyfed Drug and Alcohol Service on a single occasion in 2015; at this time she believed regular appointments were not needed and she was signposted to a local art support group.

10.6.2 There appears to have been missed opportunities to build on the victim's successes, particularly in October 2015 when she appeared to be in the right frame of mind, not using drugs, and seemed to want to change her life. In carrying out this type of support work, agencies should ensure that when they engage people, particularly potentially vulnerable people, they seek regular face to face contact. Furthermore, organisations providing such important support should have effective mechanisms to cover sickness and holiday periods. Vulnerable clients should not be left without essential support during staff absence. Commissioners might build in more effective management and monitoring of these types of arrangements.

10.7 Procedural Matters

10.7.1 The Panel felt that there is a need to raise awareness of the function of Domestic Homicide Reviews amongst agencies and practitioners. The initial reluctance of the General Practitioner to provide information to the Panel was based on a legitimate

concern over the issue of confidentiality. Advice was obtained by the General Practitioner from the Medical Defence Union who advised caution in sharing any information despite the most recent Home Office Guidance. The General Practitioner records did not disclose any reason for concern in relation to the victim and perpetrator. However, it was essential that the Panel were reassured that this was the case. General Practitioners may play a crucial role in the work of Panels. It is essential that they and their advisors are made aware of the need to cooperate. The involvement of the General Practitioner Consultant on the Panel was crucial in obtaining eventual agreement to provide information and should be recognised as good practice for other reviews.

10.7.2 When completing Individual Management Reviews agencies should at the outset provide a full account of their engagement with the victim, perpetrator and any other relevant person. This will reduce the delays involved in filling gaps in the IMRs or having to request information that should have been disclosed on the original document. Whilst the Panel is aware that agencies have competing claims on their time and resources these should not prevent a timely and fulsome response to the request for an IMR.

10.7.3 Careful consideration should be given to the timing of contact with the family of the victim. Early involvement is desirable, although not always possible, and involvement remains the choice of the family.

11 Recommendations

11.1 The Panel believes the death of the victim was not predictable and that there was nothing any of the agencies involved could have done to prevent it from happening. The recommendations below must be read within that context. They are intended to identify issues that agencies may consider so that in other cases they could provide support for people to reduce the risk of a homicide or serious injury.

11.2 The Panel recommends that steps should be taken to ensure that all agencies and practitioners are fully aware of the role and purpose of a Domestic Homicide Review.

This relates to the expectation that information must be shared and, subject to data protection principles, does not compromise the duty of confidentiality. It is also important that agencies and practitioners are aware that the DHR process is not about apportioning blame or responsibility, but rather about identifying lessons that can be learnt.

11.3 Agencies working with people considered vulnerable should proactively engage with clients and monitor their level of engagement. Self-referrals should be used carefully.

11.4 Agency communications hard to reach clients who lead chaotic lives should predominantly be face to face. Electronic communication should be kept to a minimum.

11.5 Agencies should ensure contingency plans are in place to cover key workers' periods of sickness and/or holiday. Long breaks in face-to-face engagements with clients, particularly when there is ongoing intensive work, should be avoided.

11.6 When entering into contracts for the provision of support services, commissioners should ensure that successful bidders are fit for purpose. This includes having protocols describing how the provider will establish and maintain contact with clients, particularly those where it is difficult to engage or there is a risk of disengagement.

12. Conclusion

12.1 As noted above, the outcome of this case was not predictable, and the IMRs and deliberations of the Panel do not identify any contributory failings in the way in which different agencies responded to the needs of the victim and perpetrator that might have avoided her death.

12.2 The recommendations of the Panel focus on ways in which support for people might be improved for them to achieve greater well-being. It is significant that upon leaving prison, the victim had addressed her drug issue and had received training as a nail technician. Whilst generally the Panel had confidence in existing processes and

procedures, it identified areas requiring modification. These are highlighted in the Action Plan.

Appendix 1

Home Office

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5 November 2018

Dear Ms Richards,

Pembrokeshire/DHR/2016-17/1

Thank you for submitting a revised Domestic Homicide Review report following the Quality Assurance Panel's feedback.

The Panel was grateful to you for considering the issues they raised in their letter of 25 June 2018.

The Panel has carefully considered the revised report and is satisfied that all matters have now been addressed. The Panel is content for the revised report to be published and it would be helpful if you could provide us with the web link to the report when available by emailing us at: DHREnquiries@homeoffice.gov.uk.

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

Yours sincerely

Charlotte Hickman
Chair of the Home Office DHR Quality Assurance Panel

Domestic Homicide Review
Recommendations and Action Plan
In respect of the death of a woman

1. Recommendations

1.1 The Panel believes the death of the victim was not predictable and that there is nothing any of the agencies involved with the victim or the perpetrator could have done to prevent it from happening. The recommendations below must be read with that in mind. They are intended to identify issues that agencies may consider in the hope that in other cases they could provide support for people to reduce the risk of a homicide or serious injury.

1.2 The Panel recommends that steps should be taken to ensure that all agencies and practitioners processes are fully aware of the role and purpose of a DHR. This relates to the expectation that information must be shared and that this does not, subject to data protection principles, compromise the duty of confidentiality. It is also important that agencies and practitioners are aware that the DHR process is not about apportioning blame or responsibility, but rather about identifying lessons that can be learnt.

1.3 Agencies working with people considered vulnerable, particularly because of mental health issues, should proactively engage with clients and monitor their level of engagement. Self-referrals should be used carefully and only when assessed as being appropriate.

1.4 Agency communications with disengaged and chaotic clients should predominately be face to face. Electronic communication should be kept to a minimum, used only when considered appropriate.

1.5 Agencies should make contingency plans to cover key workers' periods of sickness or holiday. Long breaks in engagements with clients, particularly when there is ongoing intensive work, can have negative consequences and should be avoided.

1.6 Embedded within each milestone of the recommendations is that commissioners should ensure that successful bidders are fit for purpose. This includes having protocols describing how the provider will establish and maintain contact with clients, particularly those where there is unwillingness to engage, a risk of disengagement or a lack of engagement.

Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
What is the over-arching recommendation?	Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the Home Office Quality Assurance Panel, however the review panel can suggest recommendations for national level)	How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?	Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?	Have there been key steps that have allowed the recommendation to be enacted?	When should this recommendation be completed by?	When is the recommendation actually completed? What does outcome look like
It is important to ensure that all agencies and practitioners are fully aware of the role and purpose of a DHR. They need to understand that: i. information must be shared; ii. the DHR process is about identifying	1. Pembrokeshire Community Safety Partnership promote the role and remit of DHRs. 2. General Practitioners be made aware of the role and contribution of DHRs.	Dissemination, training and awareness raising. Responsible authorities to ensure DHR protocols are in place and up to date.	All relevant statutory agencies and third sector organisations who facilitate or provide pertinent services.	Agencies provide awareness training for existing staff.	Incorporated into relevant staff induction programme, from April 2019 with refresher training every 2 years. This should be overseen by Pembrokeshire	Ongoing.

lessons that can be learnt; and iii. the DHR process is not about apportioning blame or responsibility.					Community Safety Partnership through a system of bi-annual reporting.	
Agencies working with people considered vulnerable, particularly because of mental health issues, should proactively engage with clients and monitor their level of engagement. Self-referrals should be used carefully and only when assessed as being appropriate.	Organisations (local and regional) working with vulnerable people.	Agencies offering front-line services should review their self-referral procedures.	All relevant statutory agencies and third sector organisations who facilitate or provide pertinent services.	Agencies review self-referral procedures. From April 2019 Commissioners should include evidence of self-referral policies and procedures as part of all commissioning processes.	Review of self-referral procedures to be completed by September 2019. All agencies to report progress to the first meeting of Pembrokeshire Community Safety Partnership following that date.	Clear procedures to be in place by September 2019 From April 2019 and thereafter ongoing
Agency communications with disengaged and chaotic clients should predominately be face to face. Electronic communication should be kept to a minimum,	Organisations (local and regional) working with vulnerable people.	Agencies providing front-line services to vulnerable clients should review communication and engagement procedures.	All relevant statutory agencies and third sector organisations who facilitate or provide pertinent services.	Agencies review communication and engagement procedures. From April 2019 Commissioners should include	Review of communication and engagement procedures to be completed by April 2019.	Clear procedures to be in place September 2019

used only when considered appropriate.		Where gaps are identified new protocols developed and disseminated.		evidence of communication and engagement procedures as part of all commissioning processes.	All agencies to report progress to the first meeting of Pembrokeshire Community Safety Partnership following that date	From April 2019 and thereafter ongoing
Agencies should ensure contingency plans are in place to cover key workers' periods of sickness and/or holiday. Long breaks in face-to-face engagements with clients, particularly when there is ongoing intensive work, should be avoided.	Organisations (local and regional) working with vulnerable people.	Agencies providing front-line services to vulnerable clients should review staff business absence and continuity procedures. Where gaps are identified new protocols developed and disseminated	All relevant statutory agencies and third sector organisations who facilitate or provide pertinent services.	Agencies review staff business absence and continuity procedures. From April 2019 Commissioners should include evidence of regular reviews of staff business absence and continuity procedures as part of all commissioning processes.	Review of review staff business absence and continuity procedures to be completed by April 2019. All agencies to report progress to the first meeting of Pembrokeshire Community Safety Partnership following that date	Clear procedures to be in place September 2019. From April 2019 and thereafter ongoing