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

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

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Executive Summary

Presented to Ceredigion Community Safety Partnership on 27th July 2015

Background to the Domestic Homicide Review

The DHR was established following the killing of a woman by her male partner in March 2014. The perpetrator contacted the emergency services who attended the scene and discovered that the victim had been stabbed several times. The perpetrator also had a number of non-fatal and self-inflicted stab wounds. He was taken to hospital and initially refused treatment. He was later treated for his wounds. He claimed he was mentally unwell and was transferred to a mental health facility.

The couple had lived together since 2004 during which time that had lived in three different counties – one in England and the other two in Wales. During that time both victim and perpetrator had contact with both general practitioners and hospitals. The perpetrator had a history of mental illness and had in 2002 been detained under s.2 Mental Health Act 1983.

Terms of reference and membership of the panel

In May 2014 the decision was taken to undertake a DHR. The Home Office was notified immediately. Joint chairs were appointed in June 2014. In setting up the DHR, the *Multi Agency Statutory Guidance and* the *Ceredigion Domestic Homicide Review Protocol* was followed.

The following terms of reference of the Panel were agreed:

1.1. Terms of Reference as:

- The effectiveness of communication between the different agencies and individuals involved.
- The extent to which information was shared appropriately:
    - Within individual agencies.
    - Between agencies.
    - Across geographical boundaries.
- The effectiveness of risk assessment and risk management within the agencies involved.
- The effectiveness of communication between statutory bodies and third sector bodies.
- Could more have been done to raise awareness of services available to victims of domestic violence and abuse?
- Other matters as considered appropriate by the panel.

The DHR Panel had joint independent Chairs. Membership of the Panel was designed to ensure that there were representatives from a range of agencies relevant to this case. In addition, a former General Practitioner was appointed as a

panel member to act as a consultant to advise in particular on sharing of information from one GP surgery to another about the mental health of the perpetrator. Contact between the DHR panel and the Dyfed Powys Police was through the Senior Investigating Officer who was a member of the panel. The Chairs made contact with members of the families.
Individual Management Reviews were provided by the Local Health Board and Ceredigion County Council. Reviews were also received from a number of other agencies who reported that they did not have any contact with the victim or the perpetrator. These were the Dyfed Powys Police, the Ceredigion Domestic Abuse Forum and the National Probation Service. A number of other agencies and Third Sector bodies were approached; all reported that they had no contact with either victim or perpetrator.

Recommendations

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

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

3. The training of all staff to a level appropriate to their need, in identifying, recording and sharing concerns should be a key priority within Health

Boards and Hospitals. Joint training with General Practitioners and primary care contractors will promote a greater understanding on how to share concerns. The training programme should be reviewed regularly and an overview of both the training programme review and the monitoring of uptake.

4. For local authorities:
   a. procedures should be introduced that reinforce the duty of all front line staff across all departments in local authorities to record and share information within and outside of the authority relating to concerns about the suspicion or disclosure of domestic violence;
   b. Local Authority Domestic Abuse policies should be widely disseminated to all staff and management as a matter of urgency.

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

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

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

8. In order to encourage open discussions at DHR meetings, minutes should not normally be discoverable. This will facilitate open discussion in the

DHR meetings. Only in the case of a public interest to disclose being established should they be made available.

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

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