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Domestic Homicide Review
Overview Report
DHR 0213

Report into the death of a woman

Report produced by Malcolm Ross
Independent Chair and Author

June 2016

List of Abbreviations

ARC	Assisted Recovery in the Community
ABMUHB	Abertawe Bro Morgannwng University Health Board
BCSP	Bridgend Community Safety Partnership
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DHR	Domestic Homicide Review
GP	General Practitioner
GUM	Genito – Unary Medicine
HMC	Her Majesty's Coroner
HMP	Her Majesty's Prison
IMR	Individual Management Review
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
NSPCC	National Society for the Prevention of Cruelty to Children
OASys	Offender Management System
PPD1	South Wales referral form for Public Protection issues notification
WASPI	Wales Accord for Sharing Personal Information
WCADA	Welsh Centre for Action on Dependency and Addiction

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INTRODUCTION AND BACKGROUND

Introduction

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 44 year old Bridgend woman, (the Victim) on 14th July 2013. Her husband (the alleged perpetrator) was arrested and charged with her murder. He has since been convicted of her murder and has been sentenced to life imprisonment with a recommendation of 18 years before he can apply for parole.

Purpose of a Domestic Homicide Review

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

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

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

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

1.5 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[2], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

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

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

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

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what the those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working,

Process of the Review

1.7 South Wales Police notified Bridgend Community Safety Partnership of the homicide and Bridgend Community Safety Partnership Executive Group reviewed the circumstances of this case against the criteria set out in Government Guidance and recommended to the Chair that a Domestic Homicide Review should be undertaken. The Chair ratified the decision.

1.8 The Home Office was notified of the intention to conduct a DHR on 30th August 2013 An independent person was appointed to be chair and author of the DHR Panel. At the first review panel meeting terms of reference were drafted.

1.9 Home Office Guidance[3] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review. The Overview report was presented to the Bridgend Safety Partnership Executive Group and accepted on 30th July 2014. Since that date a 'Learning Event' was held for all practitioners where Mental Health requested some amendments to the mental health issues within the report which took some months to be completed, hence the delay in submission of this report.

Independent Chair and Author

1.10 Home Office Guidance[4] requires that;

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

[3] Home Office Guidance 2013 page 15
[4] Home Office Guidance 2013 page 11

1.11 The Independent Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing over 80 Serious Case Reviews and Chairing that process and, more recently, performing both functions in relation to Domestic Homicide Reviews. Prior to this Review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

DHR Panel Members

1.12 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Mr Ross chaired the Panel and also attended as the author of the Overview Report. Other members of the panel and their professional responsibilities were:

- Head of Risk Reduction South Wales Fire and Rescue Service
- Detective Chief Inspector South Wales Police Public Protection Unit
- Senior Probation Officer, National Probation Service
- Head of Treatment Services WCADA
- Adult Safeguarding Officer Well Being Directorate Adult Services
- Inspector South Wales Police Community Safety Department
- Manager Bridgend County Borough Council Community Safety Partnership
- Acting Head Safeguarding Adults ABMU
- Mental Health Forensic Lead
- Independent Chair and Author of Review Report

1.13 The administration for the process was conducted by Business Support Officer, Bridgend County Borough Council

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

1.15 The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

Parallel proceedings

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

- BCSP advised HM Coroner on 16th September 2013 that a DHR was being undertaken. HM Coroner opened the inquest and adjourned it to a date to be fixed.
- The review was commenced in advance of criminal proceedings having been concluded and therefore it proceeded with awareness of issues of disclosure that may arise.

Scoping the Review

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

1.18 It was decided that the review should focus on the period from 1st January 1996 until the time of death of the victim, 14th July 2013, unless it became apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended.

1.19 The review also considered any relevant information relating to agencies contact with the victim and alleged perpetrator outside the time frame as it impacts on the assessment in relation to this case.

Individual Management Reviews

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

- Abertawe Bro Morgannwg University Health Board – Mental Health
- Bridgend County Borough Council Adult Well Being Directorate
- South Wales Police
- Wales Probation Service
- Bridgend County Borough Council Education Department (information sheet)
- Bridgend County Borough Council Safeguarding and Family Support
- South Wales Fire and Rescue Service
- Abertawe Bro Morgannwg University Health Board – GP and Emergency Department.

1.21 Guidance[5] was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

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

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

[5] Home Office Guidance 2013 Page 18

The area

1.24 The town where this Family resided at the time of the homicide is situated in the M4 corridor of South Wales. It is a small town with just over 10,000 residents, the majority being aged between25 years to 64 years. There are very few residents aged between 16 and 24 years (only 9%)

1.25 The main employment of the residents is classed as professional occupations followed by those within the skilled trades and Administrative and secretarial worlds. Unemployment is low, around 5%. The majority of people are in full time employment (30%) or retired (20%). 40% of residents have no formal qualifications while those with GCSEs, BCSE A level or degrees constitute around 55% of the population.

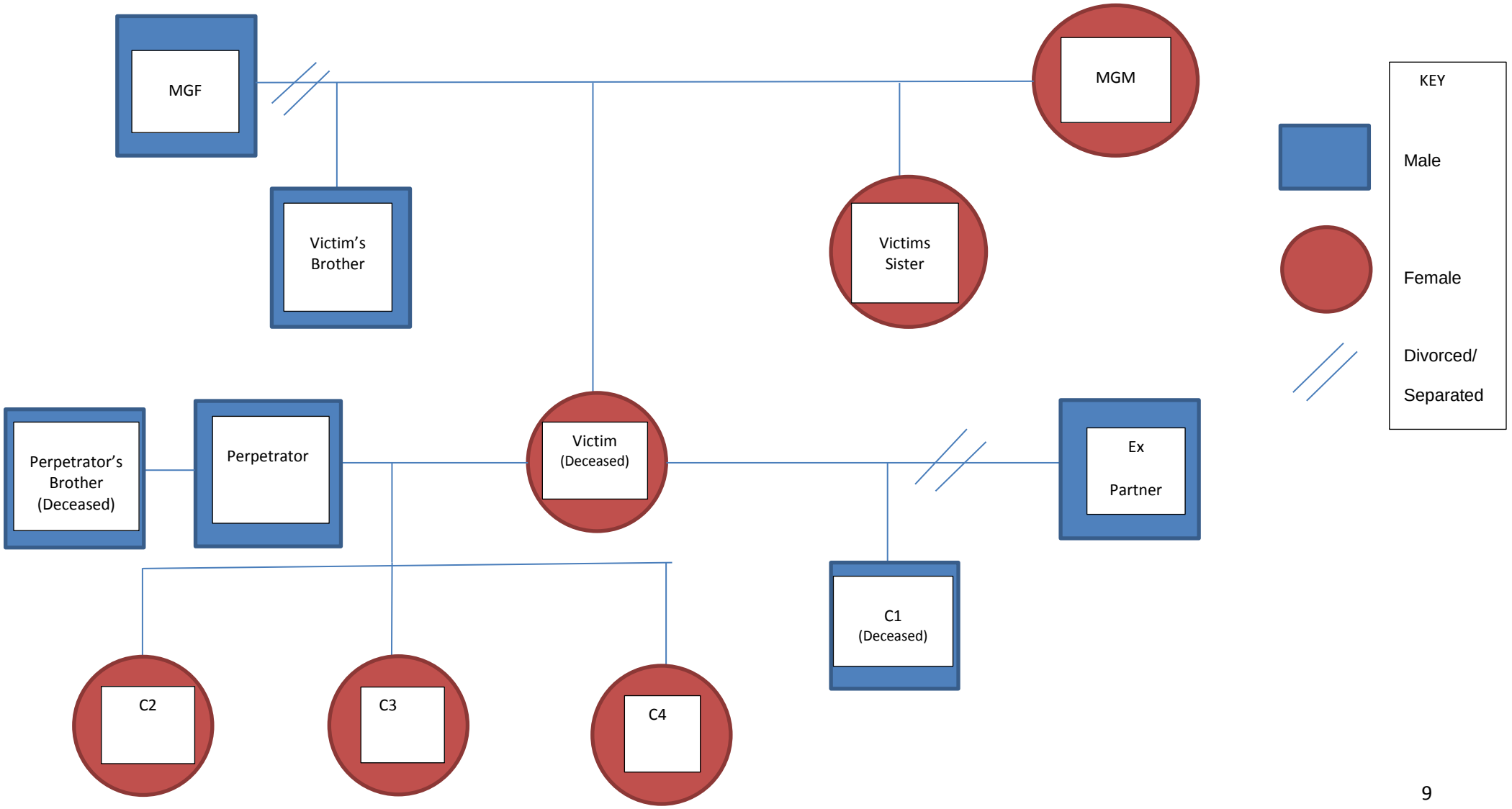
1.26 The majority of the households (38%) consist of one family with no dependent children, followed by 34% of household which are single occupancy.

Subjects of the Review

1.27 The following genogram identifies the family members in this case, as represented by the following key:

- Victim - a 45 year old woman - mother of 4 children
- Perpetrator - . a 45 year old man – estranged husband to the victim
- C1 – first child of Victim – deceased
- C2 – second child of Victim and Perpetrator
- C3 – third child of Victim and Perpetrator
- C4 – fourth child of Victim and Perpetrator
- MGM – Mother of Victim and grandmother of C1 - 4

GENOGRAM


MGF
MGM
Victim's Brother
Victims Sister
Perpetrator's Brother (Deceased)
Perpetrator
Victim (Deceased)
Ex Partner
C1 (Deceased)
C2
C3
C4
KEY
Male
Female
Divorced/ Separated

2 Summary

2.1 The Victim and the Perpetrator married in the mid '90's but separated in 2011. The Victim already had her first child, but she went on to have another three with the Perpetrator. The eldest child died in tragic circumstances in 2008. She was described as a slight woman with a loving nature, and very much smaller in build than the Perpetrator.

2.2 The Perpetrator was a man with a long history of offending behaviour between 1981 and 2005. He had eleven convictions for fourteen offences which included one offence against the person, three offences against property, five theft and kindred offences, one public order, one assault on a police officer, one offence of dangerous driving, failing to provide a specimen of breath, affray and possession of an offensive weapon. He served three short custodial sentences. He was a large, well-built man, very powerful and dominating.

2.3 He had an extensive history of hazardous drinking. He received treatment from mental health services over an 18 year period for depression and had a history of taking overdoses of prescribed medicine. The focus of the Perpetrator's mental health treatment was not to curb or cure his drinking but to manage symptoms of depression and unstable mood. He was also diagnosed with personality disorder which would have been a treatment obstacle but was not a treatment target. He discharged himself from services in 2011 when he stopped taking his mood stabilizing medication.

2.4.1 He was also known to be violent and his behaviour was very unpredictable. Domestic Violence against the Victim was not unusual and episodes of serious threats to the Victim's life were also known. Attempting to strangle her and attempting to drown her in a bath of water was the description of some of the attacks he made on the victim.

2.3 Agencies had years of contact with the Perpetrator, the Victim and the children, especially during the 1990 and early 2000's. At the time there was not thought to be a high risk of harm and few interventions were put in place to protect the Victim or the children. The severity of the domestic abuse from the Perpetrator may have been underestimated.

2.4 The full extent of the abuse was not understood nor was the emotional impact of the abuse on the victim or the children.

2.5 Although the Victim and Perpetrator separated in 2011, the Perpetrator would visit the Victim's home every day and other family members describe how he controlled her movements whilst he was with her. There was some suggestion that during his time with the Victim, he may have pressured her to continue their intimate relationship.

2.6 In 2013 the Victim, her mother and one of her children went abroad for a holiday. She returned to the resort on her own within a short time and on returning to the UK disclosed that she again intended to return to the resort.

2.7 The Perpetrator was informed of her intention which unexpectedly, initially did not cause any friction between them. The children assumed that the Perpetrator would be angry, but he did not appear to be so. The Victim had booked flights to return to the resort on 17th July 2013.

2.8 On 13th July 2013, the Perpetrator went to the Victim's house as usual. They took the dogs for a walk and later went for a meal at a local restaurant. He then went to his sister's house where he was living at that time.

2.9 The following day, the Perpetrator again went to the Victim's house at 9.00am. He took C3 to work at 1.30pm and arranged to collect C3 at the end of her shift at work at 10.00pm. He indicated that he was going to see a friend and go drinking. At 10.00pm he failed to collect C3 from work. C3 rang the Victim and the Perpetrator but there was no reply from either. C3 then rang C2 and both went to the Victim's house. They found they couldn't get the key in the lock of the front door. The house was secure.

2.10 Being concerned about the welfare of their mother and knowing that their father had spoken of committing suicide in the past, they called the police.

2.11 Officers attended and found the body of the Victim in an upstairs room apparently having been strangled. The family car was missing and police circulated observation for the vehicle.

2.12 The Perpetrator was very quickly traced at his place of work and arrested. He was found to have cuts to his wrists and apparently had taken tablets. He was taken to a nearby hospital where he was admitted for 4 days. He was taken into custody and interviewed about the death of the Victim. He made no comment to all questions. He was charged with her murder.

2.13 The Perpetrator later appeared before the Crown Court and was convicted of Murder. He was sentenced to life imprisonment with a recommendation that he serves 18 years.

Terms of Reference for the Review

Aim

2.14 The aim of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what the those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and

- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working,

Process

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

Individual Needs

2.16 Home Office Guidance[6] requires consideration of individual needs and specifically:

> "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?"

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

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

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

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

2.20 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act.

Family Involvement

2.21 Home Office Guidance[7] requires that:

> "Members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",
> and:
>
> "Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

2.22 The 2013 Guidance states[8]:

[6] Home Office Guidance page 25
[7] Home Office Guidance page 15
[8] Home Office Guidance 2013 page 16

> "The Review Panel should recognise that the quality and accuracy of the review is likely to be significantly enhanced by family, friends and community involvement. The panel should therefore make every effort to include these parties and, to ensure that when approaching and interacting with these parties, the Review Panel follows best practice".

2.23 In this case the Overview Report Author made contact with the Senior Investigating Officer (SIO) from South Wales Police at an early stage. Contact with the children of the Victim and alleged perpetrator was initially made by a letter sent, via the Police Family Liaison Officer, to the victim's eldest child, the Victim's mother and the Victim's sister, explaining the review process and inviting them to contribute to the review should they wish to do so.

2.24 The Victim's children were seen by the Author at the eldest child's home on 26th September 2013 in the company of the two other children and her grandmother. They indicated that they wished to be part of the review process and after a lengthy conversation, they were left to consider in what way they wished to contribute. Later that day the Author visited the Victim's mother and sister at her mother's family home and a similar conversation took place.

2.25 The Author has kept the family informed of the process throughout.

2.26 Comments made by the family members have been included and referred to in this report.

2.27 A letter inviting the Perpetrator to contribute to this review was sent to him and his solicitor whilst the Perpetrator was in HM Prison in remand. He has not acknowledged the letter or indicated that he wishes to be seen as part of the review.

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

2.29 The family are content with the terms Victim and Perpetrator and would not wish the use of pseudomyns.

3 SUMMARY OF KEY EVENTS AND ANALYSIS OF AGENCY INTERVENTIONS

3.1 Whilst the time scales for this review have been determined to be between 1st January 1996 and 14th July 2013, agencies were asked to consider any pertinent points before those dates that would be of interest to the review process. At the Victim's first appointment with Mental Health Services she described physical violence from the Perpetrator in the context of alcohol intoxication. The Victim described him trying to drown her in the bath on one occasion and attempting to strangle her on another. At the time, he was facing criminal charges for assault towards the Victim. The Victim dropped the charges on condition that he sought help. A referral was sent for Community Psychiatric involvement. He received Community Psychiatric Nurse input and bereavement counselling. He was discharged in October 1995 having maintained stability.

3.2 Mental health services became involved again with the Perpetrator in 1997 until 2011. The Perpetrator was briefly admitted to psychiatric hospital following

overdoses on two occasions between 1997 and 2001 but was otherwise treated on an outpatient basis.

3.3 The Perpetrator had a criminal record prior to 1993 having served two prison sentences and had convictions for being drunk and disorderly, for assaults, including assault on a police officer, and criminal damage. He was arrested and convicted of using threatening behaviour in 1997 following a domestic violence incident in 1996. He had a nine month prison sentence in 1999 for dangerous driving and a community order in 2005 for affray and possession of an offensive weapon.

3.4 It was also noted during this period that on one occasion charges were brought but the Victim dropped the charges provided the Perpetrator sought treatment. The notes show that he received Community Psychiatric Nurse input and bereavement counselling. He maintained stability so was discharged and did not present again for two years. He was finally discharged from Mental Health Services in 2011. It should be noted that the Victim was also in contact with Mental Health Services on this occasion and was last seen in July 2013.

3.5 The Perpetrator was treated for a mood disorder. As part of that treatment, he was offered anger management.

1996

C1 aged 9 years this year

C2 aged 6 years this year

C3 aged 1 year this year

C4 Born this year

3.6 Both the Perpetrator and the Victim had separate GPs therefore their records were not joined. However, it would not have been possible to join up the healthcare records of the Perpetrator and the Victim due to confidentiality, information governance and consent to share information. There is very limited information[9] that can be shared about people's healthcare.

3.7 On 10th November 1996, the Victim reported to Police that she and the Perpetrator had argued after he had consumed alcohol. He had damaged the bathroom door and had thrown paint down the stairs. He had then driven off in his car with C3. Officers attended at the family home by which time the Perpetrator had returned with the child. He threatened the officers whilst in possession of an axe and refused to come out of the house. With the safety of the children in mind the Duty Inspector decided not to take any further action at that time but summoned the Perpetrator at a later date for the offence of threatening behaviour. He subsequently appeared before Magistrates and was fined. It can be argued that in 1996, such action by the police was reasonable, but it is noted that there was no reference to sharing information with Social Services, which in 1996 would have been expected.

[9] Sharing of information would have legitimately occurred only through child safeguarding, MARAC or criminal investigations.

3.8 In November 1996, he attended at his GP stating that he had a long time problem of losing his temper and drinking resulting in him not being able handle his life. It was causing problems at home. He had two periods in hospital following overdoses of prescribed medication.

1997

C1 aged 10 years this year

C2 aged 7 years this year

C3 aged 2 years this year

C4 aged 1 this year

3.9 During January 1997, GP records indicate that the Victim was seen for anxiety state and for stress related issues at home but no further information is available about these presentations. The Victim's early medical records were transferred from 'Lloyd George folders' onto computer and details have been abbreviated for the computer systems. Therefore details of illnesses and treatments are very brief.

3.10 On 10th November 1997, the perpetrator was admitted to hospital having overdosed on Paracetamol and Ibuprofen tables. He had a disagreement with nursing staff over smoking and self-discharged before being seen by a Consultant. He had stated that he had family problems due to binge drinking - up to 17 pints of beer over a weekend. He was re-referred to Mental Health Services.

3.11 On 15th December 1997, the Perpetrator attended at a psychiatric outpatient clinic where he disclosed the circumstances of his overdose and also admitted pouring petrol around the house with the intention of burning the house down. He reported having problems sleeping, problems controlling his anger and having suicidal ideations.

1998

C1 aged 11 years this year

C2 aged 8 years this year

C3 aged 3 years this year

C4 aged 2 years this year

3.12 On 16th February 1998, at a psychiatric outpatient appointment, the Perpetrator disclosed that he was having trouble sleeping, he was not eating and had not worked since November 1997 due to his illness. He said that he had stopped drinking since October 1997, however he had disclosed in November 1997 that he was drinking some 17 pints over a weekend. It is not known if this was a deliberate lie or if he had got his dates wrong. He put his illness down to his brother's suicide. His medication was amended.

3.13 A week later, on 23rd February 1998, the Perpetrator reported to his psychiatric outpatient clinic that he felt better, he was staying away from alcohol and his sleep and appetite had improved.

3.14 On 25th February 1998, the Victim called the Perpetrator's mental health Doctors asking if the appointment that had been made for him at the clinic on 9th March could be brought forward as the situation at home was beginning to deteriorate. An appointment was made for 2nd March 1998 but he failed to attend due to him being physically unwell.

3.15 Two days later on 27th February 1998, the Victim presented to her GP with low moods.

3.16 On 9th March 1998, the Perpetrator was seen again at the psychiatric outpatient clinic. He was feeling better and stated that he had not been drinking alcohol.

3.17 On 6th April 1998, he stated that he was still not drinking but he was still getting angry over 'little things'. He failed to attend his psychiatric outpatient appointment on 27th April 1998.

3.18 On 8th June 1998, the Perpetrator disclosed at a psychiatric outpatient clinic appointment, that he had overdosed a month before by taking Diazepam and Venlafaxine tablets and now felt 'stupid' about it. There is no other record of this overdose episode perhaps indicating that he did not attend at the Emergency Department.

3.19 His condition improved somewhat during July and August 1998, but in September the Perpetrator disclosed that he had been unable to concentrate at work, resulting in him breaking his arm in an accident. He was having trouble sleeping and his relationship with his wife was poor. His medication was increased.

3.20 On 9th September 1998, the Perpetrator's GP referred him to the CMHT. He was subject to an initial assessment by the CMHT which noted a history of violence towards his wife that was usually induced by drink.

3.21 On 14th September 1998, the Perpetrator again attended at the psychiatric outpatient clinic where he stated that he had had a bad weekend, lacking motivation and stated that he would kill himself if he could be sure his family would be cared for. He expressed having no interest in his family. Two days later the CMHT file indicates that his relationship with his wife continued to be poor.

3.22 By 28th September 1998, he was feeling better. He had no thoughts of self-harm and his interest in his family had improved. On 29th September 1998, the Perpetrator's Nurse Therapist wrote to the psychiatric health care clinic informing the clinic that he had missed his last two appointments so he had been 'off-listed'.

3.23 Four days later on 3rd October 1998, his CPN visited him at home and recorded that the Perpetrator's depressive symptoms continued to fluctuate. This comment was repeated following another home visit on 11th November 1998. On 12th November 1998, the CMHT record the fact that his depressive moods were causing concerns despite a change of medication. The Perpetrator's tolerance was low, his sleep disturbed and he was experiencing ideas of self-harm. It should be noted that there were four young children in the household during this period.

3.24 On 23rd November 1998, he disclosed to the psychiatric outpatient clinic that he had impulsively overdosed on Effexor and Diazepam some three weeks before this appointment and he had thought about hurting himself with a chain saw, but had considered that it would be too painful. He denied thoughts of self-harm at that moment.

3.25 He had stopped taking his medication. His medication was again changed, and again no evidence of any thoughts given to the family circumstances or risk.

3.26 He failed to attend a psychiatric outpatient appointment on 7th December 1998 and by the 21st December 1998, he reported feeling much better and he was back in work.

1999

C1 aged 12 years this year

C2 aged 9 years this year

C3 aged 4 years this year

C4 aged 3 years this year

3.27 On 1st January 1999, the Victim attended at her GP with reactive depression.

3.28 Later during January 1999, the Perpetrator continued to report fluctuating depression and he failed to attend a psychiatric outpatient appointment on 1st February 1999. On 22nd March 1999, his psychiatric outpatient records shows that he appeared to have recovered from his depressive illness and had stopped taking his medication. He was advised to continue.

3.29 He was now working full time after being off sick for 6 months.

3.30 Just over a month later, 29th April 1999, he was admitted to psychiatric hospital following an overdose of Diazepam and after stating he had not taken alcohol for 18 months, but that he had consumed some 10 pints that day. He claimed to have been at a funeral of a friend's father which had upset him and brought memories back to him of his own brother's death. He stated that he wished the tablets had killed him but claimed that he would not do that again. He admitted that he was having a difficult time in his marriage.

3.31 He was discharged against medical advice into the care of his sister, with outpatient appointments arranged for him to attend.

3.32 On 4th May 1999, the Perpetrator reported that his wife was threatening to leave him. He had not been in work for 5 weeks. There had been deterioration in his moods. He stated that his employers were being very supportive. His Prozac was increased to 40mgs per day.

3.33 On 9th July 1999, the Perpetrator was stopped by the Police whilst driving his car. He reversed into the Police car causing damage and injuring an officer. He was described as being very drunk. He was taken into custody and attempted to tear up his clothing and tie the pieces around his neck before being restrained by officers. The Victim subsequently contacted the Police and informed them that the Perpetrator had not taken his medication for about a month. The Perpetrator was charged and subsequently appeared before the Crown Court in October of 1999. He pleaded guilty to dangerous driving and other associated matters and was sentenced to 9 months imprisonment and disqualified from driving for 2 years.

3.34 On 20th July 1999, the Perpetrator failed to attend at his psychiatric outpatient appointment as he had just returned from holiday. The following week he attended at the clinic again but left without telling staff why he was leaving.

3.35 On 3rd August 1999, the Perpetrator attended at the psychiatric outpatient clinic stating he left the previous appointment because of tooth ache. He had stopped taking his Prozac tablets. He was showing poor motivation, irritability and loss of temper which he had had for a number of years. He reported that he was now a house husband looking after the children as his wife was working at a night time job. The Author's meetings with the family indicate that this was untrue. He disclosed that he was being seen by a CPN and it is recorded that there were no symptoms of depression. He agreed to be referred to a day hospital for counselling.

3.36 Two days later, on 5th August 1999, a note on his file with the CMHT, indicates that a Consultant Psychiatrist considered that his angry outburst were part of his premorbid personality.

3.37 After discussing the matter with the Perpetrator the Consultant thought it an appropriate time for the CPN to withdraw the services. There was no more involvement with the CPN service.

3.38 On 22nd December 1999, the Victim attended her GP with depression.

2000

C1 aged 13 years this year

C2 aged 10 years this year

C3 aged 5 years this year

C4 aged 4 years this year

3.39 The Perpetrator was released from Prison in January 2000.

3.40 In April and May 2000, the Victim reported to her GP that she was depressed and tired all of the time. By September 2000, her condition had improved somewhat.

3.41 The Perpetrator was seen again by a Consultant Psychiatrist in July 2000. He stated that he was feeling depressed and felt lethargic about doing anything. On 18th September 2000, a Consultant Psychiatrist had an urgent consultation with the Perpetrator following another overdose. He did not attend the Emergency Department of the hospital and he declared that he felt no adverse effects of the overdose. He promised that he would not make more attempts to overdose and that his wife, the Victim, had removed all tablets from the house to prevent a repeat event.

3.42 On 9th October 2000, the Perpetrator was seen at the psychiatric outpatient clinic where his mood was slightly more stable but he was still having panic attacks. He stated that he had no thoughts of self-harm. There were no specific biological symptoms of depression detected. It was suggested that he attended for anger control sessions.

3.43 On 23rd October 2000, a letter from the psychiatric outpatient clinic to the Perpetrator's GP indicated that a blood test had shown an increase use of alcohol and a depletion of vitamin B.

3.44 On 4th December 2000 he was again seen at the psychiatric outpatient clinic where the Perpetrator described how he had low confidence, he was having angry outbursts over minor issues and he had not been working since his release from prison. He had not been drinking and had used no illicit drugs.

2001

C1 aged 14 years this year

C2 aged 11 years this year

C3 aged 6 years this year

C4 aged 5 years this year

3.45 On 19th January 2001, the Victim reported to her GP that she was depressed.

3.46 By mid-January 2001, the Perpetrator described at the psychiatric outpatient clinic that he felt better, he was less angry and at this time he had a better relationship with his wife. A review was arranged in six months-time.

3.47 On 6th February 2001, the Victim called the psychiatric outpatient clinic stating that the Perpetrator had taken a serious overdose of his prescribed medication and he had been admitted to a medical ward at a local hospital. She described how he regrets the overdose but still wishes that he was dead. It was decided that he was still at risk of deliberate self-harm and if he attempted to discharge himself he would be assessed and possibly detained under Section 5(2) assessment under the Mental Health Act 1983.

3.48 On 8th February 2001, the Perpetrator was transferred to psychiatric ward and treated for a depressive illness. It transpired that he had had an argument with his wife on 5th February 2001, and had taken the tablets impulsively. He had been found unconscious in his garage by a neighbour while his wife was in the house. He was taken to intensive care where he stated that he had not written a note but had intentionally overdosed in a place where he thought he would not be found. He had not considered his family at the time of doing so, but had intended to kill himself. He stated that he was glad he didn't die and said he had no plans to self-harm again in the future. He had recently received a claim for insurance from the police for damage he had caused to a vehicle. He also stated that his marriage had been under strain recently. He was measured on the BECK[10] Suicidal Intent Scale with a result of being a medium risk with a score of 16. Following his admission he reported that he felt better and wanted to settle down with his family.

3.49 On 16th February 2001, the Perpetrator was discharged from the psychiatric ward and referred to the Community Mental Health Team (CMHT).

3.50 On 26th February 2001, just 10 days after his discharge, a member of the public made an anonymous referral to Children's Safeguarding about the perpetrator's family, giving information to the effect that the father suffered from depression and had previous doused the house with petrol, there were domestic violence disturbances that spilled over into the street between the Perpetrator and the Victim

[10] BECK Suicidal Intent Scale is a self- report measure of suicidal thinking

and the son was so upset regarding the father's overdosing that he went to a neighbour's house and wet himself. The information went on to suggest that the mother locked the children out of the house and only allowed them back in at meal times. The caller was concerned that if a social worker should contact the family then the Perpetrator would 'go off it again'. Family members refute that this was the case.

3.51 From the records it appears that with respect to this information enquiries were made with other agencies, but concerns are raised in this report that telephone contact with the Health Visitor did not take place until 14th March 2001. There were no concerns expressed by the Health Visitor, who, apparently, had known the family for some 14 years, although the Health Visitor had 'heard rumours about the father'. There are no further details about the rumours, or what had been done about them.

3.52 On 15th March 2001, the local Comprehensive School was approached for information and although C1's behaviour had been deteriorating over the last 10 months in that C1 had been tearful and disruptive, there were no concerns. It is recorded that the Victim was supportive of the children's education but the father was not known to the school.

3.53 Still following on from the anonymous referral, on 16th March 2001 the local primary school was contacted for information and there were no concerns expressed about C2, C3 and C4.

3.54 On 19th March 2001, the CPN was contacted in connection with the referral. It was stated that the Perpetrator was known to have a depressive disorder but had been prescribed Lithium and despite overdosing in February 2001, he was responding well and there were no immediate concerns.

3.55 The result of the anonymous referral and the protracted checks with other agencies the referral is signed off as;

> "No further action was deemed necessary by the Team Manager as there were no concerns expressed by agencies".

3.56 Records from the CMHT indicate that during March, April and up until 11th May 2001, the Perpetrator progressed well.

3.57 On 11th May 2001, he attended at the psychiatric outpatient clinic where he reported hearing noise calling his name. It was deemed to be a result some of his medication which was stopped.

3.58 At a home visit on 18th May 2001, the CPN made an entry which is illegible, to the effect that the Victim stated the Perpetrator 'was ???? at times'. Nothing more was recorded.

3.59 On 18th June 2001, she described him to the CPN as being, 'difficult to live with'.

3.60 On 6th July 2001, the Perpetrator described himself to the Psychiatrist as being in a reasonable mood and having a good time with his children.

3.61 On 7th September 2001, the Perpetrator was seen at home during a hand over session with a new CPN. He was in a low mood and under considerable stress. He had smashed the living room up the previous week and the Victim thought that he was on the downward spiral again. He was working illegally and giving another man a large part of his earnings. The possibility of antidepressants was discussed. On 27th September 2001, following a referrals meeting in the Community Mental Health Team, a Locum Consultant Psychiatrist prescribed the Perpetrator antidepressants

without seeing him and without being able to assess his mental state at that time. A comment in the IMR states that although this practice may be within GMC guidelines it was another month before the Perpetrator was seen again after the antidepressants were prescribed.

3.62 On 5th October 2001, the Perpetrator was seen again by the CMHT. He had had a calm week but he was continuing to work illegally. Three days later, on 8th October 2001, the Victim reported to the CMHT that the Perpetrator had stopped taking his medication and had spent the day in bed.

3.63 On 12th October 2001, the Perpetrator complained that he was suffering side effects from the antidepressants and had stopped taking them. He was feeling better as a result.

3.64 On 16th October 2001, the Locum Consultant Psychiatrist completed a Disability Living Allowance form for the Perpetrator declaring him unfit for work, albeit the Perpetrator was working illegally and this matter was known and recorded on the Perpetrator's case notes.

3.65 On 9th November 2001, the CPN attempted to see the Perpetrator at home. He walked out of the meeting. The Victim stated that she was concerned about his 'snapping' at the oldest child and how she felt trapped and she wanted to leave him. She was concerned however that whatever she would do, he would attempt to commit suicide. An appointment was made for him to attend the psychiatric outpatient clinic and the Victim was notified of this appointment.

3.66 On 16th November 2001, the Victim reported to the CPN and the Psychiatrist that the Perpetrator was depressed, would lose his temper over trivial matters and was nasty towards the oldest child. The CPN arranged to see the Perpetrator weekly and the Psychiatrist arranged to see him every 6- 8 weeks. His medication was changed because he claimed he had a needle phobia and therefore did not want the regular blood tests that were needed for his original mood stabilizer.

3.67 On 6th December 2001, the Victim contacted the CPN stating that the Perpetrator had taken a higher dose of his medication by mistake. There were no adverse effects.

2002

C1 aged 15 years this year

C2 aged 12 years this year

C3 aged 7 years this year

C4 aged 6 years this year

3.68 During January 2002, the Perpetrator appeared to be progressing well with the medication he was prescribed. On 11th January 2002, CPN supported him in his application for Disability Living Allowance.

3.69 In February 2002, the Perpetrator passed a driving test which followed his disqualification, thereby re-instating him as a licensed driver.

3.70 On 1st March 2002 he was seen at home by the CPN. He had remained stable apart from one episode when he had 'over reacted' to a letter from school about his step-sons behaviour

3.71 In April 2002, the Perpetrator went to France coaching his son's rugby team. He told the CPN that he was working on the occasional days but finding he couldn't cope and had had two accidents. The CPN records that he would ask the Welfare Benefits agency to call the Perpetrator to reassess his benefits.[11]

3.72 An entry in the CMHT IMR dated 26th April 2002, indicates that the CPN supported the Perpetrator in his application for Disability Living Allowance, at the same time knowing that he had been coaching boys in rugby and that he had been working illegally only a matter of months before.

3.73 However during the same month, April 2002, the Victim reported to her GP that she was suffering from anxiety and depression. Her depression continued during the following months until October 2002 when her condition improved slightly, with her attending at her GPs at some time during most months.

3.74 On 17th May 2002, the Perpetrator was seen at the psychiatric outpatient appointment where he disclosed that he had tried to hold down a job on a building site but he had cut his thumb. He undertook to take a less difficult job. He also attempted to claim compensation from the Criminal Injuries Compensation Board, but that failed.

3.75 On 28th June 2002, he was seen again at home by the CPN. His wife, the Victim, was present. He reported feeling depressed and requested an increase of his medication, which was approved by his Psychiatrist on 1st July 2002. The Victim was informed of this and arrangements made for her to be responsible for the collection of his medication.

3.76 On 12th July 2002, the Perpetrator again mistakenly, took an increased amount of his medication without suffering any effects.

3.77 The 23rd August 2002, was the 10 year anniversary of the death of the Perpetrator's brother, which caused some depression but it appears that he had 'worked his way through it'.

3.78 On 11th October 2002, there was a minor upset in the family home when the eldest child was involved in a criminal damage incident. This annoyed the Perpetrator, but the Victim took control and calmed the situation down. The police were not involved.

3.79 On 29th November 2002, the Perpetrator fell from his horse resulting in him attending the Emergency Department of hospital. Due to his pain he smashed a door but otherwise he was uninjured.

[11] Whilst it is appreciated that Mental Health Services would not have been responsible for any issues around vetting and that would have been for the rugby club, there is concern that given his antecedents and involvement with the Police a Criminal Records Bureau (CRB) enquiry would have raised some concern about his history and the Rugby Football Union guidance in 2002, would have required a CRB, (now called Disclosure and Baring Service - DBS) check to be completed for all coaches for their suitability and for insurance purposes.

3.80 On 18th December 2002, records show that he was assaulted, but there are no further details recorded. He was going through a stressful time.

2003

C1 aged 16 years this year

C2 aged 13 years this year

C3 aged 8 years this year

C4 aged 7 years this year

3.81 On 28th February 2003, the Perpetrator told the CPN during a home visit that he had had one violent episode where he had thrown hammers after working 8 days consecutively.

3.82 The Perpetrator remained well during the summer of 2003, until 4th September 2003, when at a psychiatric outpatient appointment he reported he was low in mood, having a loss of energy and crying more often. He stated that he had not taken alcohol or drugs for 5 years and that he gets on well with his children and wife. An increase of medication was prescribed with the caveat that if he felt too sedated that he could choose to decrease it.

3.83 On 9th September 2003, at another psychiatric outpatient appointment, the Perpetrator disclosed that he had been irritable with his son but they had since made up and now he was getting on well with his wife and all four children.

3.84 On 17th September 2003 the Perpetrator reported to CPN that he had suffered a neck injury falling off a horse and had needed a collar for three weeks. On 17th November he said he had fully recovered from the neck injury. He then returned to some casual manual work

2004

C1 aged 17 years this year

C2 aged 14 years this year

C3 aged 9 years this year

C4 aged 8 years this year

3.85 On 11th March 2004, the Perpetrator was seen at the psychiatric outpatient clinic. He was described as being ‘mildly anxious’ and It was suggested that he be referred to a voluntary Mental Health charity run day centre.

3.86 On 15th March 2004, he attended an outpatient appointment with his CPN and Consultant Psychiatrist. They discussed attending a voluntary sector day centre and the perpetrator was advised to contact the CPN to arrange to visit the day centre.

3.87 On 14th June 2004, an entry in the CPN's file stated that the Perpetrator had been seen driving a lorry around the area despite him previously stating that he was too anxious to work. The note goes on to say that it was clear that the Perpetrator no longer wished to engage with the CPN and he was 'hobbling', doing manual labour jobs. It was decided to refer him to psychiatric outpatient. He did not attend a Psychiatric Outpatient appointment on 8th July 2004.

3.88 On 29th September 2004, the Perpetrator was seen at the Psychiatric Outpatient clinic by a locum Specialist Registrar where he stated that over the previous six weeks he had been aggressive and damaging furniture. The Victim confirmed this and stated that he had also been shouting. She disclosed that she was taking anti-depressants and she was having panic attacks. The note on file reflects that there had been a long history of a volatile marriage which was 'therefore accepted by his wife'.

3.89 The Specialist Registrar said that he asked the Victim to buy a safe so she can keep his tablets there and then administer them to him, putting some responsibility on her to monitor his medication. His mood stabilizing medication was increased

3.90 The note goes on the say that the Perpetrator mentioned that he had not seen his CPN for some time and at another psychiatric outpatient appointment in October 2004, he stated that he actually disliked the CPN. It was decided that there was no requirement for any intervention from CMHT. He also stated that he became anxious and tense after a few days at work when he has flashes of anger.

3.91 On 21st October 2004, the Perpetrator attended a psychiatric outpatient appointment. A referral to the Community Mental Health day care centre was completed asking for help to get out of the house and take part in activities. It included a record of the Victims views saying "wife would also appreciate help"

3.92 On 2nd December 2004, the Perpetrator was seen again at the Psychiatric Outpatient Clinic where he stated that he had been 'pretty good' and that he had not been aggressive for 3 months, even though he felt like being aggressive sometimes.

3.93 The Specialist Registrar wrote that the Perpetrator could control his aggressive feelings and channel his aggression constructively more than before.

3.94 Whilst the Perpetrator was receiving Disability Allowance benefit, there is evidence of him:

- coaching a rugby team on a trip to France,
- going to Florida with his family on holiday,
- working on building sites, driving lorries and trucks, and,
- on one occasion he was injured falling from a horse.

3.95 To recap, during 2004, continued to see aggressive behaviour from the Perpetrator, and no referrals regarding domestic violence or child protection concerns by any agency. By now there were robust mandatory referral processes in place for both of these issues, which will be referred to later in this report. He was by now living with his sister, of whom there was information prior to this date to the effect that she too was the subject of his aggression. It is not known what her domestic circumstances were at that time and whether there was any risk to anyone as a result of his behaviour.

3.96 During 2004, the Victim attended at her GP in May, June, August and December with depression and anxiety related complaints.

2005

C1 aged 18 years this year

C2 aged 15 years this year

C3 aged 10 years this year

C4 aged 9 year this year

3.97 On January 14th 2005, the Perpetrator visited the mental health day care centre but subsequently did not attend or reply to a letter or phone call. His wife spoke to the day care worker who said that he was experiencing some difficulties. Psychiatric Consultant

3.98 On 3rd March 2005, the Perpetrator was seen in the psychiatric outpatient clinic. He reported that he was feeling slightly upset and down in his mood. His father had been diagnosed with a heart condition. He reported that he had not had any aggressive outbursts. He had a brain scan in January 2005 with nothing abnormal detected.

3.99 In April 2005, the Victim attended at her GP complaining of anxiety and depression. In more detailed notes from her GP, she stated that her son had been in trouble with the police and the Perpetrator was gambling. She felt unable to cope and having an increasing number of panic attacks. Her records show that by 4th May she was feeling better.

3.100 During the late evening of 12th May 2005, the police and fire and rescue services were called by the Victim to the home address, where the Perpetrator had deliberately set fire to items in the front room of the house. The Victim and children ran to a neighbour's house fearing for their own safety. When the Police arrived they were faced with the Perpetrator brandishing an axe threatening to kill them and to burn the house down. A police negotiator was summoned and the Perpetrator was arrested. He was charged with offences of affray and arson. He was released the following day on conditional bail. He appeared before the Crown Court in October 2005, where he was given a suspended prison sentence. This was later revoked and varied to a 2 year conditional discharge.

3.101 As a result of this incident, a Domestic Violence referral was made, together with a child protection referral and a Multi-Agency Risk Assessment Conference (MARAC) was convened for the 25th May 2005.

3.102 During his time in Police custody for these offences, he was examined by a Forensic Medical Examiner, who recorded that the Perpetrator had chronic psychiatric problems and was on mood stabilisers.

3.103 The following day, 13th May 2005, a referral was made to Children's Safeguarding regarding this incident. This resulted in an initial assessment being conducted, but there is a note in the Mental Health Chronology to the effect that it was decided that there was no role for Social Services Department as there was no information to suggest that the children were present at the time of the fire and both the Victim and the children were at the neighbour's house. It appears that Social Services were informed in any event and informed the Victim of the concerns should the Perpetrator return to the family home.

3.104 The same day, 13th May 2005, the Victim went to her GP informing the Doctor about the events of the 12th May. She told the GP that she and the children had been

moved into a temporary safe house. She was reported to be very upset but not suicidal.

3.105 On 17th May 2005, the Perpetrator was seen at a Psychiatric Outpatient appointment as an emergency. The notes record,

> "long history of difficulties. Doesn't talk about his difficulties and has been lying all throughout. Wants one to one sessions for his difficulties and ready to talk".

The note says that his wife had decided to leave and as soon as she got ready the Perpetrator got aggressive and 'couldn't handle it. He smashed the property and set newspapers alight on the settee. He locked him-self in an after a few minutes poured water to make the fire die."

3.106 A psychiatric history was taken and a diagnosis of personality disorder with poor impulse control and aggressive tendencies recorded. Risk of damage to property was recorded. Long standing marital problems, past problems with substance misuse were noted and the current incident was noted to have been influenced by alcohol.

3.107 He was referred for anger management to the day hospital.

3.108 On 25th May 2005, the Perpetrator was sent a letter by a CPN, telling him that he was now on the waiting list for Anger Management treatment. There does not appear to have been a re-assessment of the risk he posed to his family.

3.109 On the same day, 25th May 2005, the Victim saw her GP. She reported that the Perpetrator was not allowed near the family home and things were calmer.

3.110 On 27th May 2005, Police and Social Services informed the Victim that the Perpetrator was going to be allowed contact with her and the children but only after a re-assessment of his risk had been completed.

3.111 On 31st May 2005, bail conditions were lifted allowing him to return to the family. The Social Services Team Manager recommended a risk assessment be conducted but there is no reference or copy of such an assessment to be found on any file papers.

3.112 On 1st June 2005, a Safeguarding Support Worker visited the family home and raised numerous points for consideration as to whether the Perpetrator should be living at home with the Victim and the children. Those points included:

- Social Services concerns for the safety of the children
- Cannabis cultivation in the garden
- The Perpetrator drinking heavily on the day of the offence which included the use of an axe.
- Ongoing depression and medication
- The Perpetrator awaiting Anger Management appointment
- The Perpetrator witnessing domestic violence as a child

3.113 In view of these concerns, the Perpetrator signed a written agreement to live with his sister until a full risk assessment had been completed.

3.114 The Perpetrator attended a psychiatric outpatient appointment on 2nd June 2005. He said his relationship with his wife was getting better and that he was now allowed to stay at the family home in the day time. He denied drinking for seven years.

3.115 On 8th June 2005, a MARAC meeting was held. Feed back to Safeguarding on the following day indicated that there were concerns that the Perpetrator was back in the family setting and the Police were concerned that the Victim did not fully appreciate the risk posed by having the Perpetrator back in the family.

3.116 It was decided that a joint visit be made to the Victim. Two Social Workers and a Police Inspector visited the Victim that same day and explained the risk the Perpetrator posed to the whole family. The Victim acknowledged the risks and stated that the Perpetrator was living at his sister's house and that he was awaiting anger management appointments. The Victim expressed a wish that she would like her children to undergo counselling so they didn't turn out like their father. They received counselling from CAMHS 3 or 4 times.

3.117 On 30th June 2005, at a Psychiatric Outpatient appointment the Perpetrator said that he was back living with the family with no injunctions from the Court. Social services were not willing for him to stay and wanted a further assessment of his risks. The Perpetrator was prescribed 400gms of Lithium as his medication. It was noted that he was still awaiting Anger management appointments.

3.118 His prescription of Lithium was increased as a result of monitoring from 400 mgs on 30th June 2005, to 600 mgs on 26th July 2005, to 800 mgs on 1st August 2005.

3.119 On 15th August 2005, the Wales Probation conducted an OASys[12] risk assessment. OASys is the tool used by the Prison Service and Wales Probation to assess the likelihood of the risk of reoffending and the risk of serious harm. It is a comprehensive assessment tool that applies to all offenders aged 18 and over, using static and dynamic indicators.

3.120 The result of this assessment was that the Perpetrator was deemed to be a 'medium risk' of harm to the public, known adults (family members) and staff (Police Officers). The risk factors were linked to the use of alcohol, conflict when the Perpetrator was feeling angry, upset or threatened. There is nothing to indicate that any enquiries were made with the Children Services or the Police Domestic Violence Unit in coming to that risk assessment score.

3.121 On 13th September 2005, his lithium medication was increased to 1000mgs.

3.122 As a result of a request from the Crown Court for a psychiatric report, on 29th September 2005, the Perpetrator was seen by his Consultant Psychiatrist who recorded that the Perpetrator was feeling better with the increased medication and was working occasionally as a manual labourer. He was still waiting for Anger Management. He reported that the Perpetrator had not consumed any alcohol since May 2005. He described the Perpetrator as having a personality disorder. Marital problems were identified as being a risk factor for future violence and his violence was linked with his personality disorder and alcohol misuse. The report recommended a Community Supervision Order with psychiatric treatment as a condition, an offending behaviour programme through the Probation Service and anger management through mental health services. There is no note regarding any risks to the victim or children.

3.123 Just before his Crown Court appearance, the Perpetrator was subject of a psychiatric report. In that report, the Perpetrator was described as having a personality disorder. Marital problems were identified as being a risk factor for future violence and his

[12] MAPPA Guidance Version 3 National MAPPA Team National Offender Management Service as amended by MAPPA Guidance 2012 Version 4 Ministry of Justice 2012.

violence was linked with his personality disorder and also alcohol misuse. The report recommended the court should impose a Community Supervision Order with psychiatric treatment as a condition, offending behaviour programme and anger management. The Perpetrator had been on the list for Anger Management treatment some 5 months.

3.124 At Crown Court the Perpetrator was sentenced to 8 months imprisonment suspended for 2 years with the suggested requirements as outlined in the report being additionally imposed.

3.125 The day after the court hearing, Social Services considered the risk to the children and found that there was no risk to C3 and C4 adding that the family had recently been on holiday to Florida.

3.126 Complying with National Standards, the Probation Service conducted another OASys assessment within the specified 15 days after sentence.

3.127 The result of this was very similar to the previous assessment save in this assessment a Sentence Plan was created that focused on Thinking Skills and Alcohol Relapse Prevention.

3.128 On 4th November 2005, Consultant Psychiatrist was asked for a copy of his report by someone who was going to conduct a Core assessment on the family. The Consultant Psychiatrist replied that he had written a report but it was not a risk assessment. He was happy for the report to be released once the court had granted permission.

3.129 On 11th November 2005, a Social Worker from Children Services, made a home visit to conduct a Core Assessment on the family. Present were the Perpetrator, the Victim, C2, C3 and C4. The Victim would not allow the children to be spoken to alone as the Social Worker was a stranger. The Perpetrator explained that the family was an open family, which was very loving and close to each other and they had no secrets from each other.

3.130 The result of the visit was that no concerns were recorded.

3.131 The first psychiatric outpatient appointment following his Crown Court appearance took place on 14th November 2005 with the Consultant Psychiatrist who spoke with the Victim who told him that he Perpetrator was feeling and behaving much better since taking the Lithium medication. His relationship with his wife was much better as was the relationship with his children. Domestic Violence was discussed. The Victim was spoken to separately and said that he occasionally disliked his wife having an opinion separate from his, that he used to be violent if she disagreed, she occasionally concedes to avoid argument. She said she was previously scared of him after alcohol or if his temper rose but had not lost his temper except once recently but that did not cause problems. The possibility of both the Perpetrator and the Victim attending RELATE, (a counselling service) was positively met by both. The Victim said he was not drinking now and confirmed the seven year gap in drinking.

3.132 On 1st December 2005, the Perpetrator and the Victim were seen at home by Social Services as part of the Core Assessment process. The Perpetrator explained that part of the reason for his aggression in the past had been as a result of the consequences of the death of his brother. He had mentioned this before to other professionals, and had attended bereavement counselling between 1993 and 1996 apparently to good effect.

3.133 On 5th December 2005, the Perpetrator was accompanied by the Victim at a Psychiatric Outpatient appointment. Both were very worried saying that Social Workers had informed them that there was an investigation on going into an incident in 2001 when the Perpetrator was alleged to have doused the children's beds with petrol. He strongly denied the incident as did the Victim. The children were present when they were told this by the social workers and they too stated that the allegation was false. There was no record at that time of who was investigating this incident and an actual investigation did not materialise, but it later transpired that Children Services were suggesting an investigation.

3.134 On that same day, it is recorded by Wales Probation that the Perpetrator had attended WGCADA now renamed WCADA (Welsh Centre for Action on Dependency and Addiction) for an assessment and the outcome was that there was no requirement for further intervention. Wales Probation chronology indicates that the Perpetrator was angry at the suggestion that the 2001 incident was only now being investigated.

3.135 At a meeting with Probation on 20th December 2005, the Perpetrator mentioned that he had instructed a solicitor regarding the investigation and was happy that this was being dealt with. In any event he had been told by Social Services that the investigation had now been closed, but without giving a reason.

2006

C1 aged 19 years this year

C2 aged 16 years this year

C3 aged 11 years this year

C4 aged 10 years this year

3.136 On 13th January 2006, the Perpetrator attended at a Psychiatric Outpatient appointment where he stated that things were good at home and he was getting on well with his wife. He was taking his medication as directed. He was still unable to attend the Probation led Enhanced Thinking Skills Course due to insufficient numbers of people attending.

3.137 On 25th January 2006, for some reason that is not known, a telephone call was made from Children's Safeguarding to the Rapid Response Team stating that the Perpetrator had undergone an assessment in November 2005 and there was no need for any further action. The IMR Author does not understand why this call was made involving the Rapid Response Team and the assessment mentioned cannot be found on file.

3.138 On 30th January 2006, the Anger Management Course was cancelled until June 2006. There was no reason given for the cancellation. Further it was decided by Probation that the Enhanced Thinking Skills Course could not be started until the Perpetrator had completed the Anger Management Course. The Perpetrator had been waiting since June 2005 for such courses.

3.139 On 1st February 2006, the Perpetrator's place on the 14th February 2006 Anger Management Course was confirmed. He was also told of a change of Consultant.

3.140 On 6th February 2006, the Perpetrator attended for his Anger Management Course assessment, during which he stated that he had never hit his wife and the fire at the house was as a result of an argument with his wife and he had extinguished the fire himself. He admitted drinking to excess and looking for fights. The Mental Health IMR Author thought that he appeared to be minimising the domestic violence within the household during the assessment process. Screening assessments revealed no significant depression or anxiety symptoms and moderate levels of anger. His history showed domestic abuse incidents such as him attempting to strangle his wife and drown her in a bath of water.

3.141 On 7th February 2006, during an appointment with his Offender Manager from Probation, his risk was assessed as being Medium Risk of Harm to Public, Known Adult being family member, and staff namely police officers. These risk factors were linked to alcohol use and conflict when he was feeling upset angry or threatened. The Probation IMR Author noted that there did not seem to be any relevant updates or reviews to this risk assessment as required every 16 weeks.

3.142 On 14th February 2006, the Perpetrator attended his Anger Management Course. Of the 10 sessions available to him, he failed to attend on 2 occasions. The course finished on 18th April 2006.

3.143 On 13th April 2006 the Perpetrator commenced a Pre Programme session for the Enhanced Thinking Skills Course. He attended the course between 26th April and 11th July 2006, missing only one session due to illness. There is no indication that the usual post programme report was written and the OaSys risk assessment was not updated to reflect the outcome of the programme.

3.144 In September 2006, the Perpetrator attended at another psychiatric outpatient appointment saying that he felt the communication with his family was excellent and the relationship with his wife was much better.

2007

C1 aged 20 years this year

C2 aged 17 years this year

C3 aged 12 years this year

C4 aged 11 years this year

3.145 During early February 2007, Wales Probation was preparing to apply to the Crown Court for a revocation of the Perpetrator's Probation Order. This would usually involve contact with the Police Domestic Violence Unit, Children's Services and any other agency who had information on the Perpetrator to ensure that the revocation application had the most up to date information to put before the Crown Court. There is nothing to suggest that this was done prior to the application being heard on 16th February 2007. It is the view of the Wales Probation IMR Author, that given the Perpetrator's apparent compliance with the order, his engagement and behaviour, this application was reasonable and appropriate.

3.146 Once the order had been terminated a review/ termination OASys risk assessment should be conducted, but there is no evidence that this was done.

3.147 Throughout 2007, up until the end of November, the Perpetrator attended psychiatric outpatient appointments and was recorded as being stable, abstinent from alcohol with no reported incidents of Domestic Violence. However, on 26th November 2007, attended at his GP for his routine blood tests and appeared tearful and distressed which concerned the phlebotomist who made an urgent referral to the psychiatric outpatient clinic. He was seen the same day.

3.148 The psychiatric assessment showed he was trembling, feeling low and had pins and needles sensations in the tips of his fingers. He stated that he had been 'nasty'' and had been having suicidal thoughts.

3.149 His current problems were described as low mood and anxiety symptoms. He was prescribed an antidepressant/anxiolytic and a blood test taken to check level of Lithium. A psychiatric outpatient appointment was made for 3 months hence.

2008

C1 aged 21 years this year

C2 aged 18 years this year

C3 aged 13 years this year

C4 aged 12 years this year

3.150 On 9th April 2008, the Police submitted a PPD1 referral form to Children's Safeguarding regarding C3 who was being bullied by a male person who was sending her messages to her mobile phone encouraging her to kill herself. This was dealt with by the police and Education and her mother. The Victim, the mother, was also engaged with the process.

3.151 On 15th April 2008, the Victim attended at her GP's surgery complaining that she wanted help. She was having difficulty coping. She explained the problem with C3 and also added that C1 had taken an overdose recently. The GP gave her antidepressants and offered to see C3 for a consideration for the referral to child and family guidance.

3.152 On 29th April the Victim was again seen by her GP. She reported that there had been arguments at home

3.153 In May 2008, the Victim's son (the Perpetrator's step son) was killed in a Road Traffic Collision at the age of 21 years. This had a significant effect on the family especially the Perpetrator.

3.154 On 6th June 2008, the Perpetrator attended at his GP following the loss of his step-son, complaining of being irritable, lack of sleep and having a poor appetite. He was prescribed Diazepam, but warned that is would only be a short term prescription as there was a chance of dependency.

3.155 On 12th June 2008, the Perpetrator attended at an outpatient psychiatric clinic. He was described as being extremely emotional, with outbursts of anger, and physically aggression towards his wife including holding her by the throat. His wife had told him he was splitting up the family. He was prescribed medication to help with his situation.

3.156 The following day, 13th June 2008, the Victim told her GP that the Perpetrator was behaving 'oddly', and that she had concerns about staying in the house. She stated that after school, both she and the children would go straight out. The GP advised her to talk to the police and the GP would contact the Perpetrator's GP and advice that GP of the information that had been disclosed. There was no documented liaison between the GP's

3.157 In July 2008, the Perpetrator failed to attend his next outpatient appointment. On 15th August 2008, the Victim attended at her GP with anxiety and depression for which she was prescribed medication.

3.158 On 21st August 2008, the Victim reported to her GP that the Perpetrator had a fragile mental state and was no support to her at all. Her attendance at CRUSE was discussed.

3.159 During September 2008, the Victim attended CRUSE which helped her condition but she was still depressed over her son's death

3.160 On 18th September 2008, the Perpetrator was feeling better and reported at a psychiatric outpatient appointment that his out bursts of anger were now under control.

2009

C2 aged 19 years this year

C3 aged 14 years this year

C4 aged 13 years this year

3.161 On 15th January 2009, the Victim's GP referred her to the Community Mental Health Team for an assessment of her depression and advice regarding suitable treatment. The referral letter states that the Victim had been having low moods and urges to self-harm.

3.162 On 12th February 2009, the Perpetrator attended at a psychiatric outpatient clinic where there were no concerns and arrangements were made to reduce his existing medication that he had been prescribed to help him cope with the loss of his son.

3.163 On the same day, the Victim had a Care Programme Approach assessment by the Community Mental Health Team. She reported having thoughts about suicide which may have been caused by her being very stressed following the death of her son.

She was attending CRUSE and it was not thought she needed CMHT input. A letter dealing with the assessment was sent to her GP on 19th February 2009

3.164 On 8th April 2009, the Victim told her GP that she was still depressed and there was stress in the family over her son's death. One daughter had left to live with friends. The Victim was having paranoid thoughts. She stated that she would try a low dose of antipsychotic medication.

3.165 On 2nd June 2009, the Perpetrator attended again at his GP with a depressive disorder. He was reviewed at the psychiatric outpatient clinic on 2nd July 2009 and was doing quite well with no evidence of mood symptoms and anti-psychotic drugs were discontinued.

3.166 It was discovered that his Lithium levels were low, so he was referred back to the psychiatrist by his GP for an adjustment of the medication for that problem.

3.167 On 8th September 2009, the Perpetrator's psychiatrist wrote to him asking him to attend for a repeat blood test. He had a blood test on 30 September 2009.

3.168 Throughout the rest of the year the Victim reported to her GP that she was still depressed and for the majority of that time indicated that she was having relationship problems at home.

2010

C2 aged 20 years this year

C3 aged 15 years this year

C4 aged 14 years this year

3.169 In January, June and July 2010, the Victim was treated for reactive depression.

3.170 On 21st January 2010, the Perpetrator telephoned his GP complaining of pain in his neck and shoulder. He stated that he had been seen by the physiotherapist at the local rugby club. He stated that he had been taking double the recommended dose of analgesics because he was in so much pain. He was advised accordingly.

3.171 The Perpetrator also failed to attend a psychiatric outpatient appointment on 4th February.

3.172 The Victim was seen for a CPA assessment on 12th February 2012, following which, the CPN wrote to the GP stating:

> "she currently denies suicidal ideation and feels much more in control and less depressed. She is continuing to see CRUSE on a fortnightly basis and is having some benefit from this. It is not felt that our team could offer more than this at this time. [The Victim] is happy to continue with CRUSE at present and if her symptoms deteriorate, do not hesitate to re-refer. I have also given her our team number if she has any concerns."

3.173 On 29th April 2010, the Perpetrator attended another psychiatric outpatient clinic where it is recorded that there were no concerns.

3.174 On 1st June 2010, the Perpetrator went to his GP following many months of problems including low moods, occasional suicidal thoughts, binge drinking most nights of the week, and tremors. He admitted being untruthful in the past regarding the amount of alcohol he was drinking and his general condition, which he justified by saying he would see someone different each time he attended.

3.175 On 3rd June 2010, the GP wrote to the Mental Health Team stating that the Perpetrator had been to the GP's surgery accompanied by his sister as he was in crisis. He admitted that he had been less than truthful about his mental condition in stating that everything was improving. He complained of deepening mood disturbances, increased irritability with outbursts. There had been a few very impulsive suicidal actions. He had been increasingly turning to alcohol by drinking 8 or more cans per night. He was hiding this from his family. This was causing tensions at home, his marriage was at risk, and he was unable to sleep without alcohol. His family were afraid of him. He had disclosed to his GP that he was using Valium he had obtained from the internet. The GP stated that he had referred the Perpetrator to the Community Drug and Alcohol Team (CDAT) and was seeking further advice regarding psychological therapists.

3.176 On 8th June 2010, the Perpetrator was caught drink driving He was banned from driving for 12 months and fined £285. This occurred after an argument at home. He told the psychiatrist on 16th October 2010 that he had felt suicidal and drove into a road sign as he wanted to be 'out of it'.

3.177 On 11th June 2010, the Perpetrator attended at his GP stating that he was making good progress and he had cut out drinking altogether.

3.178 On 16th June 2010, he attended at a psychiatric outpatient appointment where he stated that he had been drinking between 10 and 15 pints of alcohol per night twice a week for about a year. He described that since taking his prescribed the medication Risperidone, his aggression had settled down and he was enjoying taking his 14 year old daughter to ride her pony. He was diagnosed with recurrent depression and aggressive personality traits.

3.179 On 29th June 2010, he again went to see his GP, stating he is continuing to do well and was keeping to his abstinence.

3.180 On 14th August 2010, GP records indicate that the Perpetrator was seen 'socially' and his improvement had continued, partly due to his abstinence. This social meeting appears to be at the local rugby club where both the perpetrator and the GP frequented.

3.181 On 20th August 2010, Police were called to the family home by C4 reporting that her mother and father were fighting and she needed the police. The Police call handler could hear a commotion in the background and C3 appeared to be distressed. On arrival officers found that an argument had occurred between the Perpetrator and the Victim over money and the Perpetrator had attempted to forcibly take the Victim's handbag from her. The incident was recorded in line with Police guidance as a 'verbal argument only'.

3.182 On 14th October 2010, the Victim was becoming more reclusive. Her GP increased her medication.

3.183 On 20th October 2010, at a psychiatric outpatient appointment, the Perpetrator said he had stopped drinking and he felt better. He had stopped taking Risperidone with the support of his GP.

2011

C2 aged 21 years this year

C3 aged 16 years this year

C4 aged 15 years this year

3.184 On 25th March 2011, C3 was taken to hospital having taken 14 x 500mg of paracetamol tablets as a result of being bullied. She said she wanted to kill herself but regretted her actions afterwards. A referral was made to Children's Safeguarding but the referral was closed and logged as an enquiry. There are no details recorded as to who was bullying her. The IMR author states that an Initial Assessment would have been appropriate to assess if she had the necessary support service to protect her.

3.185 In June 2011, the Perpetrator had two psychiatric outpatients' appointments. One he failed to attend and the other he attended too late for the appointment and it had to be re-arranged for the 18th July 2011.

3.186 On that day he attended stating that he no longer had any suicidal thoughts, he was drinking a few lagers once in a while and he was working 5 days a week as a builder. Another appointment was made for 6 months-time. There are no recorded attendances for the Victim at her GP during this year for any depression, anxiety or domestic related issues.

2012

C2 aged 22 years this year

C3 aged 17 years this year

C4 aged 16 years this year

3.187 On 2nd February 2012, the Victim was seen by the Community Mental Health Team following a referral by her GP. A Care Programme Approach assessment was completed during which the Victim disclosed that she had been depressed since her son died in 2008 and had been having suicidal thoughts. She also disclosed that she and the Perpetrator had separated in 2011, but they were on good terms and she stated she had a good relationship with her husband and he visits every day, they still claim benefit as a couple. A self-referral to CRUSE for bereavement counselling was discussed and a brief risk assessment form indicated some risk of accidental self-harm and self-neglect or wandering. A referral letter was sent to a Clinical Psychologist.

3.188 It appears that the Victim did not relate any of her problems regarding domestic violence.

3.189 By 12th February 2012, the Victim told the Community Mental Team that she was continuing to see CRUSE and felt better, more in control and less depressed. The CPN wrote to her GP saying that it was thought that the team could offer her no more at this time. She was given telephone numbers to contact should she wish to do so.

3.190 On 20th February 2012, the Perpetrator's GP records indicate that he had stopped taking his medication two months earlier and he felt better for doing so. He disclosed that he was drinking 4 units of alcohol per week.

3.191 The perpetrator failed to attend his psychiatric outpatient appointment on 23rd March 2012. A letter inviting him to attend another psychiatric outpatient appointment was sent to him on 20th April 2012. There was no more contact with him.

3.192 On 21st March 2012, the Victim also failed to attend her psychiatric outpatient appointment.

3.193 On 22nd March 2012, the Victim saw the Community Mental Health Team and a note shows that she stated that although she and the Perpetrator were separated, he still visited her every day as he did not want to let her go. She stated that he drank alcohol heavily and had hit her in the past. She did not feel threatened at the present time. She said he liked the single life but would not let go of her.

3.194 It appears that the Victim was referred to ARC (Assisted Recovery in the Community). It also appears that the Victim was encouraged by this referral. Indeed she worked well with the ARC project, being referred to differing agencies and services for support. On 10th April 2012 her case with ARC was closed, she having been referred to various services.

3.195 In November 2012, the CMHT made a referral for the Victim to be placed on a waiting list for psychological therapy.

3.196 There are records of the Victim visiting her GP at least once per month throughout 2012 with depression related conditions. On most occasions she was tearful but had no suicidal thoughts. Her condition worsened in October 2012, when her dog died causing her additional upset.

2013

C2 aged 23 years this year

C3 aged 18 years this year

C4 aged 17 years this year

3.197 On 15th April 2013, the Perpetrator presented at his GP with a deep laceration to his lip saying he had a fight two days previously. He was advised to attend at the hospital. There is nothing recorded as to the cause of the injury or who he had fought with.

3.198 On 19th April 2013, the Victim attended at an appointment with a psychological therapist. It was identified that she was suffering from a complex grief reaction. Arrangements were made for an appointment with a psychological therapist on 3rd May 2013, but she failed to attend as she was on holiday in Tunisia.

3.199 She attended on her return, on 17th May 2013 and discussed the loss of her son. She stated that she intended to return to Tunisia for a further holiday.

3.200 She was seen again once she had returned from a further holiday in Tunisia on 4th July 2013. She disclosed that she had met a male friend there and intended to return again in October. She said that her mood was brighter and she felt better after the holidays.

3.201 According to family members, on her return from Tunisia, the Victim told her children that she intended to go to Tunisia again. There was a family discussion about telling the Perpetrator and although some of the family members were against that idea, the Victim chose to do so.

3.202 Some members of the family expressed a surprise that the Perpetrator took the news so well, which they say was out of character for him. The Victim booked flights to Tunisia for the 17th July 2013. The Perpetrator's sister, with whom he lived, described how during this time, the Perpetrator was not washing and not eating. He was described as being in a state.

3.203 On Saturday 13th July 2013, the Perpetrator went to the home of the Victim and they went together walking their dogs. It appears that they went for an Indian meal and then returned home where everything seemed fine. He later returned to his sister's house where he was living.

3.204 The following day, Sunday 14th July 2013, at about 9.am the Perpetrator again went to visit the Victim. He later took his daughter C3 to work at a fast food outlet locally and arranged to collect her when she had finished work at 10.00 pm. However, at 10.00pm the Perpetrator failed to collect his daughter from work. C3 tried telephoning him and her mother but without reply. She then called her sister who collected her from work. They both went to the Victim's house but could not get the key into the door lock.

3.205 Knowing that the Victim had previously threatened suicide the police were called. Officers attended, forced entry and found the Victim in an upstairs bedroom. She had a dog lead round her neck and through her mouth, an injury to the back of her head and other minor bruising and scratch marks to her arms.

3.206 Police were informed that the family car had been taken. Details were circulated and the vehicle was found on an industrial estate where the Perpetrator had a part share in a business. He was traced by officers who found him with self- inflicted cut wrists and finger scratches to his face. He was arrested and taken to a local hospital for treatment. He was detained at hospital for 4 days.

3207 He was interviewed at hospital with consent of the hospital authorities on both the 18th and 19th July 2013. He made no comment during the interview of 18th July, but in the 19th July he gave an account that he visited to take the dogs for a walk, he had the dog lead in his hand. He reported that the Victim then told him that she was going to Tunisia, at which he blacked out and when he regained consciousness, the Victim was dead.

3.208 A Forensic Post Mortem was conducted the initial result of which failed to find a cause of death. The Perpetrator was charged on his release from hospital with the murder of the Victim.

3.209 The Perpetrator underwent psychiatric assessments during his time in police custody. He was found not to be suffering from any mental illness that would warrant his transfer to hospital. He was fit to be interviewed by the Police and subsequently fit

to stand trial. Following his appearance at Court he was remanded to HMP Cardiff to await trial.

3.210 The Perpetrator appeared before Crown Court. He pleaded guilty to Manslaughter by Provocation, but this was not accepted by the Prosecution and a trial for murder was arranged.

3.211 After a trial lasting four days, he was convicted of Murder and he was sentenced to life imprisonment with a recommendation of 18 years to serve.

3.212 Following the conviction, HM Coroner, being satisfied that the facts of the case had been heard in a criminal trial, resumed the Inquest and recorded a verdict of Unlawful Killing under the Provisions of Section 16 Coroners Act 1988.

3.213 On 28th September 2013, C4 was taken to the Emergency Department at Hospital following an overdose. This was following her father being charged with the murder of her mother.

The Views of the Family

3.214 As stated earlier in this report, the Author of the Overview Report has had significant contact with the family members, including the three daughters and the Victim's mother and sister.

3.215 They were asked to consider anything that they wished to contribute towards the report and their views are faithfully recorded here.

3.216 The Victim and the Perpetrator were married on 11th June 1994 and since then their relationship has been 'up and down' (family's description). The Perpetrator was a binge drinker and started to drink heavily following the suicide of his brother. Their perception was that the Perpetrator was jealous of the Victim's relationship with her son. That caused him to feel guilty and that turned him to drink. The Perpetrator had been to a local clinic for his alcohol and overdosing problems. He had been on medication but he was erratic in taking them.

3.217 The family describe the Victim's depression after the death of her son. They also describe how the Perpetrator would 'smash things up - including TVs'. He set fire to furniture in the house including the sofa whilst the Victim and children were in the house. He poured petrol over the carpet and threatened to set fire to it.

3.218 They went on to describe how in the last two years, the Perpetrator became increasingly physically violent towards the Victim, grabbing her round the throat and attempting to strangle her. The Victim's family stated that he was a very possessive person. They said that the Victim had taken photographs of her injuries and showed them to her GP and gave that information to Women's Aid. The Victim sought help from ARC. There was no formal referral to Women's Aid.

3.219 The daughters described how their father saw a psychiatrist for years at the local hospital. He had moved out of the family home for the past 2 years and was living with his sister. He would get drunk at the weekends, but his drunkenness was worse years ago when they (the daughters) were younger. He would smash the household windows from outside. He had been to prison and court numerous times.

3.220 The daughters described how their mother started divorce proceedings but their father would not accept that this was what the mother really wanted. Their father

would visit the Victim every day. This was so that he could control her. The Victim's mother illustrated that the Perpetrator would follow the Victim into the kitchen to see what she was doing and demanded to know who she was telephoning. She described how the Victim would have to go to the local Supermarket car park to make a telephone call so the Perpetrator would not know or find out. There is a suggestion that the Perpetrator would insist on having intimate relations with the Victim every day.

3.221 At the times of the fires in the house, Social Services came to see the children, but the Perpetrator would not allow any social workers to speak to the children without him being present. The children have not seen anyone from Social Services since.

3.222 The children described how the Perpetrator would seek help from a nurse at a local clinic[13] but only usually after a crisis had arisen. He would control the victim financially as well as physically. He worked as a partner in a building company. The Victim used to work in a local shop but once her son died she became too depressed to work.

3.223 Another member of the family described the Perpetrator as being able to 'play the system' and be able to 'hoodwink' professionals. This particular member of the family described how they foresaw the death of the Victim. They said that nothing that the Perpetrator did would surprise them and he was capable of doing anything.

3.224 At a subsequent meeting with the family members to discuss the findings of the review, it was established that the truth behind the Victims intention to return to Tunisia was only for a holiday and that she had no intentions whatsoever to leave her children and grandchildren. She had initially gone to Tunisia to chaperone C3 who had decided to holiday there and the Perpetrator had paid for the Victim to travel there as well in order to 'keep an eye' on C3. Whilst the Victim may have met a man there, it was only a friendship.

4. Analysis and Recommendations

4.1 This review attempts to examine the lives of a total of 6 people over a thirteen year period from 1st January 1996 until the time of the Victim's death in July 2013.

4.2 Throughout that time, the Victim and the Perpetrator, having married in June 1994, had four children, three female and one male. During that time there were also a number of deaths of family members that had significant effects on the family. The Perpetrator's brother took his own life, and the Victim's son, (the Perpetrator's step-son) was killed in a tragic incident. Both deaths took their toll on the Perpetrator and the Victim. The Victim especially was deeply affected by the death of her son and evidence exists that she mourned his death until the day she died at the hands of her husband in July 2013.

4.3 Besides these sad circumstances, the family were troubled by the Perpetrator's behaviour, which appeared to be fuelled by drinking and episodes of depression. There was no doubt a considerable degree of domestic abuse occurred, either physical violence and/or emotional abuse and control by the Perpetrator towards the Victim. Family members describe how the Perpetrator would watch and follow the Victim where ever she went and whatever she did. He is described as very insecure and constantly distrusting of the Victim, so much so that she reported to relatives that he controlled her. Even after being separated he would visit her daily and possibly

[13] Previously Bridgend substance misuse patients were seen in a ward at Adult Mental Health Unit in a local hospital. Now there is a designated substance misuse detox ward in Neath Port Talbot Hospital that can be accessed by Swansea, Neath Port Talbot and Bridgend patients.

demand intimate relations with her. Relatives say that she went along with his demands to prevent trouble and aggression.

4.4. Over the period of time this review covers, several significant changes have already taken place in respect of multi-agency responses to domestic abuse and information sharing.

4.5 There are, however, several themes worthy of comment that arise from this review. They include:

- Organisation of mental health services
- Missed opportunities to consider the future risks to the Victim and the family.
- Lack of risk assessment and sharing of information.
- The Perpetrator's ability to manipulate.
- Communications between agencies related to domestic violence reports.
- Police responses to incidents of less severe domestic violence.

Organisation of mental health services

4.5 It is recorded that as far back as 1996, both the Perpetrator and the Victim were well known to Mental Health Services but appears that there was a lack of consideration as to how the excessive drinking of the Perpetrator was affecting the rest of the family.

4.6 It is recorded that as far back as 1993, both the Perpetrator and the Victim were known to Mental Health Services. He presented with a number of problems including problematic alcohol use, depression, and aggressive behaviour. There were frequent references to domestic violence but opportunities to recognise the ongoing risk of violence were missed.

4.6 During the time that the Perpetrator was receiving mental healthcare he was prescribed various medications for such conditions as depression, anxiety, and mood disorder. In the early years he took a number of overdoses of his medication.

4.7. It is beyond the scope of this report to comment on the appropriateness or effectiveness of the interventions provided to the perpetrator during his period of contact with mental health services. However, it is apparent that he had a fluctuating presentation and a number of different interventions were offered to him that with the benefit of hindsight, do not appear to have had any sustained impact on his violence risk.

4.7 The Victim often attended appointments with the Perpetrator and there were frequent references to his aggressive behaviour and incidents of violence described. Despite

this, the vulnerability of the Victim was not addressed explicitly in any of the healthcare records and she was sometimes recruited to assist the Perpetrator in managing his medication.

The Mental Health IMR Author states:

> "His wife was not considered as a victim rather as a carer. It does appear that she also minimized the violence risk and appears to have been an active and enthusiastic carer for the most part, although it is not clear whether she had adequate opportunity to talk alone and on her own behalf with mental health professionals."

When the Victim did seek mental health care in her own right, she did speak of domestic violence in the past, but did not allude to ongoing domestic abuse.

4.21 Domestic abuse awareness is identified as a need for all mental health professionals and this review recommends that training in domestic abuse awareness and signposting be provided to all mental health practitioners.

Recommendation No 1

Bridgend Community Safety Partnership to ensure Western Bay Adult and Safeguarding Boards commission a multi-agency partnership to develop strategy to ensure the implementation of the NICE Guidance 2014[14] and the Domestic Abuse and Sexual Violence (Wales) Bill[15]

Missed opportunities to consider the future risks to the Victim and the family.

4.44 It is clear throughout this report that there were numerous opportunities to consider the risk that the Perpetrator posed to both the Victim and the children in the family.

Opportunities were missed by a range of professionals, Police, GPs, Mental Health and Health professionals. The Perpetrator admitted drinking to excess, violent behaviour, setting fire to parts of the family home and general aggressive attitudes towards his wife and children. It is also stated that the Perpetrator was prone to outbursts of spontaneous violence, sometimes using weapons. The Victim complained of his aggression, violent attacks and attempts to strangle and drown her in the bath. It has to be remembered that during the time of these episodes of aggressive violent behaviour there were three or four children present in the household. Only on a few occasions did these incidents result in a referral being made to either Adult Social Care or Children's Social Care. There is little evidence that the Victim was referred to support from voluntary aid for domestic abuse services.

[14] Domestic Violence and Abuse: how health services, social care and the organisations they work with can respond effectively - NICE February 2014

[15] Domestic Abuse and Sexual Violence (Wales) Bill 2015 Currently being considered by the National Assembly

The incident on 12th May 2005 resulted in a referral to MARAC. However at that time MARAC was in its infancy and minutes from meetings from that period are now unavailable. Today the structure of MARAC is far more robust.

However, since these incidents, much has improved across all agencies with regard to the identification of domestic abuse, preventative measures are now in place and training by all agencies have improved, however the Author considers, based on the evidence contained in this report, to reiterate the below recommendation for GPs.

Recommendation No. 2

Bridgend Community Safety Partnership to ensure that all GPs are complying with the General Practitioners Guidance on Domestic Violence issued in 2011 and that within six months from the date this report is accepted by the Bridgend CSP Board, each GP surgery confirms with the Bridgend Community Safety Partnership that the guidance had been adhered to and training for all medical and none medical staff is underway.

Lack of Risk Assessment and sharing of information

4.57 Throughout this report there are numerous occasions when formal risk assessments should have been conducted and were not. Risk Assessments in this context are an important measure by which a person can be deemed safe or to demonstrate that they posed a risk to themselves or others in a particular way.

4.58 On 31st May 2005, the Perpetrator's bail conditions were amended allowing him to return home to the family. The Social Services Team Manager requested an assessment of the risk that he posed to the children and the Victim but no such re-assessment was carried out.

4.59 Social Services were not content for him to stay with the family until a further risk assessment was completed. It appears that irrespective of the concerns of Social Services the Perpetrator was allowed to return home.

4.61 With regard to his Criminal Court hearing in August 2005, Wales Probation conducted an OASys Risk Assessment which looked at, among other things, drug misuse, alcohol misuse, emotional well-being and lifestyle, relationships etc. The result of the assessment was that the Perpetrator was measured at medium risk of harm to the public (family members) and staff (police). There is nothing to suggest that Police or Children's Services were contacted to add to the assessment, given what was known about his unreliable behaviour around drug and alcohol use.

4.62 Given the recent re-design of the Probation Service into Probation and Community Rehabilitation Company (CRC), this problem ought not to exist with the risk assessment being completed within 24 hours of arrest and often before any court appearances.

4.63 In addition the Police host a MASH, a Multi-Agency Safeguarding Hub which conforms to an information sharing protocol called 'Wales Accord for Sharing Personal Information – WASPI . There are now avenues for sharing information from Child Protection, WASPI, MARAC, Mental health through the Police Liaison Group,

MAPPA and Core Groups. In this case the sharing of information through the Child Protection avenues would have been the key for possible positive action.

4.64 Mention has already been made regarding the lack of risk assessment following the completion of the ETSC course, which would have informed the OASys assessment and the Child Protection process.

These circumstances offer an ideal time to invite an interagency review of training to ensure that there is commonality across all agencies regarding the understanding of risk procedures and its various meaning to differing agencies.

Recommendation No 3

DASG (Bridgend Domestic Abuse Steering Group) to ensure all agencies to conduct a review of their training programmes regarding information sharing and the completion of risk assessments to ensure that there is common knowledge across all agencies of the implications and meanings of the various risk assessment tools and models used by agencies. DASG to also ensure and ISP (WASPI) is produced and agreed. This is also an opportunity to embrace joint risk assessment training.

The Perpetrator's ability to manipulate.

4.65 What is obvious in reading the IMRs from various agencies and also from talking to family members is how easy the Perpetrator was able to manipulate different professionals and to obtain whatever he wished through that process.

4.66 Some examples of his manipulation are:

4.67 Whilst engaged in working on building sites and driving lorries, riding horses and taking boys on rugby tours, the Perpetrator sought the assistance of mental health professionals to support him in applying for Disability Living Allowance.

4.68 He was persuasive when he said that he had not taken alcohol for months when his blood test results showed that he had been drinking recently. He readily admitted to his Mental Health Team that he had been 'less than truthful about his mental condition and his drinking.'

4.70 His persuasive tendencies however, turned to bullying with regard to the Victim. He told her that if she left he would take his own life, so she stayed in this abusive relationship. He gave the impression that when she declared that she was going to live abroad, the Perpetrator had no objection. Even family members thought he had mellowed somewhat about that idea, until he fatally attacked her.

4.72 As well as being manipulative, the Perpetrator was a very possessive person, who needed to know every movement the Victim made.

Communications between agencies related to domestic violence reports

There is evidence within this review that agencies were slow to exchange information about the Perpetrator and his aggressive behaviour and his misuse of alcohol. The GP failed to refer the Victim to any support organisations when she disclosed to him that she was being abused by the Perpetrator and there was an absence of liaison

between Probation, the Police and Children's Social Care when the Perpetrator's Probation Order was revoked.

5. Conclusions

5.1 The Victim was in a relationship throughout which, she suffered violence and aggression for many years and for many differing reasons, she remained. She had four children until one tragically died. That had a lasting effect on her and it was whilst grieving for her son the relationship between her and her husband deteriorated.

5.2 There is little evidence however that the relationship had ever been reasonable. She suffered for years at the hands of the Perpetrator, physically, emotionally and mentally. He was a bad tempered drinking man, violent and very possessive. He manipulated the systems, including the benefit system and the health system. He spent years associated with mental health services threatening to take his own life on numerous occasions, but other than overdosing on drugs and medication he did no physical harm to himself in a serious quest to end his life.

5.3 There were significant missed opportunities to help the Victim. She suffered with depression but the GP seldom explored the reasons, other than contributing the depression to the loss of her son which may have blinded the GP to other reasons for her depression.

5.4 Other likely issues such as domestic abuse was not explored and indeed during the period of this review the GP did not have a robust Domestic Abuse policy within the surgery.

5.5 The lack of various risk assessments concerning both the Victim and the Perpetrator resulted in a holistic view of her situation not been identified.

5.6 The Victim finally gathered enough courage to announce that she was prepared to put up with her life style no longer and she was going abroad to start a new life. Whether that life would have solved any problems no one can say but after many years she was prepared to try.

5.7 Having stated her intention, there followed a brief period of relative settled relationship with the Perpetrator. They went walking with the dogs and went for a meal together, only for the Perpetrator to later attack her in her home which resulted in her death.

5.8 Whilst the Perpetrator's violence towards the Victim had often been severe, in more recent times the degree of violence had subsided somewhat although he still controlled her every day movements. Her announcement that she was to leave for another man was the catalyst for the final attack.

5.9 However, had referrals been made previously and had she received support and intervention from statutory services, she may have been advised to go about stating her intentions in a different manner, perhaps with someone else present and at a different time. She may have probably been advised not to be alone with the Perpetrator once she had declared her intention to leave thereby reducing the risk he posed to her under the circumstances. Support and intervention may also have given her the confidence and courage to make a complete break from the Perpetrator long before this situation developed, knowing that there would have been support and guidance available.

5.10 There were missed opportunities by agencies to support the Victim and encourage her to disengage from the Perpetrator.

5.11 Perhaps it is unconventional to include a reference in the conclusions of such report, but Dobash and Dobash[16] make such a pertinent point that, in the Author's view, relates directly to this case.

> 'A repetitive cycle of violence involving three stages supposedly binds women to physically abusive partners, tension building – explosions of acute violence – calm loving respite This cycle is repeated unaltered by time or circumstances and as a woman participates in this cycle she becomes an accomplice to her own abuse. Seemingly the repetition of the third phase is when the abused woman's victimization becomes complete, chaining her to her abuser.'

5.12 The Panel are of the view that as far as the Perpetrator is concerned there was an emphasis on referring him back to Mental health Services rather than looking at the root cause for his violence. He presented as being dependant with avoidance as if he was one who needed help and in doing so he appears to have 'hoodwinked' professionals. His involvement with Mental Health Services was a way of maintaining his position within the family in that he gave the impression that he needed the Victim's support and could not live without it.

5.13 Based on his history, the Perpetrator would be at risk of future repeated suicide attempts. There was also a high risk of continued domestic abuse in one form or another. The nature of his violence and abuse changed over the years. At first he was extremely physically violent and that remained for some years. His physical violence was seen to reduce but he continued with emotional abuse and possibly sexual abuse on his daily visits to the Victim. What was constant however was his control over the Victim from the start until her death.

5.14 In relation to the Victim, it appears she felt unable to leave, no doubt in circumstances described by Dobash and Dobash above. Her actions in intending to go abroad, was an indication that she had decided to break the bonds with him, and to the Perpetrator this may have been the last straw. No agency could have known or prevented the perpetrators motivation or intentions. Ultimately the responsibility for the murder lay entirely with the perpetrator. Had the victim left him at an earlier stage she may well have been in the same danger of being killed.

5.15 There were numerous opportunities missed where positive action could have been taken to support the Victim throughout her life with the Perpetrator. Domestic Abuse was not recognised or considered by the GP. Opportunities to share Information regarding both the Victim and the Perpetrator between agencies were missed and she was not referred to those agencies designed to support women in her situation, such as Women's Aid and other voluntary organisations.

5.16 Had those missed opportunities mentioned above been taken, she may well have had the confidence and courage to walk away and leave him earlier that there was strong support and assistance available to her. At the time of announcing her intentions to leave and despite family members telling her not to do so, she was alone, without the support she could have had and without a structure for her to fall back on as she moved away from him.

[16] Women, Violence and Social Change Dobash R.E., Dobash R.P.1992 Routledge page 226

The Panel are satisfied that if those structures and support had been in place the outcome may very well have been different.

List of Recommendations

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Bibliography

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Pen-y-bont ar Ogwr
Mwy Diogel

Safer Bridgend
www.saferbridgend.org.uk

DOMESTIC HOMICIDE REVIEW
DHR 02 13

ACTION PLAN

PART ONE: RECOMMENDATIONS FROM THE DHR PANEL INTO THE DEATH OF A WOMAN ON 14 July 2013

Overview Report Recommendations						
Overview Recommendation 1: Bridgend Community Safety Partnership to ensure Western Bay Adult and Safeguarding Boards commission a multi-agency partnership to develop strategy to ensure the implementation of the NICE Guidance 2014 and the new Domestic Abuse and Sexual Violence (Wales) Bill.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
1	Western Bay Regional multi- agency undertaking	Head of Adult Safeguarding	On-going	The NICE guidelines are still relevant and are applicable to the UK as a whole. They still stand even with the implementation of the Welsh Government. Violence Against Women Domestic Abuse Sexual Violence Act 2016 – complement each other. NICE links with the Act in relation to targeted enquiry - Ask and Act. Departments such as midwifery, health visiting, etc., still use routine enquiry as opposed to targeted enquiry.	Western Bay Children and Safeguarding and Adult Protection Board. Covering Swansea Neath Port Talbot and Bridgend	The recommendation within the DHR review fits well with the SAB's strategic priorities and business action plan 2015-16; which contains the strategic priorities, the desired outcomes to be achieved and objectives in which to achieve them.

Overview Recommendation 2: Bridgend Community Safety Partnership to ensure that all GPs are complying with the General Practitioners Guidance on Domestic Violence issued in 2011 and that within six months from the date this report is accepted by the Bridgend CSP Board, each GP surgery confirms with the Bridgend Community Safety Partnership that the guidance had been adhered to and training for all medical and none medical staff is underway.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
2	Rolling Programme of training for all medical and none medical staff	Acting Head of Primary Care and Planning	End of 2016	All GP surgeries in Bridgend County Borough will be complying with General Practitioners Guidance on Domestic Abuse issued in 2011	Presentation by Acting Head of Primary Care and Planning to CSP Executive Group members on 17.06.2015. Confirmed DHR guidance had been adhered to and above training for all staff is underway.	January 2016 further progress update to CSP Executive Group by Acting Head of Primary Care and Planning.

Overview Recommendation 3: DASG (Bridgend Domestic Abuse Steering Group) to ensure all agencies review and agree a personal Information Sharing Protocol (ISP - WASPI) which includes the competition of risk assessments.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
3	Multi-agency Localised Information sharing Protocol Underpinned by the Wales Accord for Sharing of Personal Information (WASPI)	Domestic Abuse Co-ordinator	September 2015	This Information Sharing Protocol (ISP) is supplementary to the Wales Accord on the Sharing of Personal Information (WASPI), and has been agreed between the participating partner organisations. Partners have given consideration to its contents when drawing up this document. This ISP has been prepared to support the regular sharing of personal information for dealing with high risk cases of domestic abuse through the Multi-Agency Risk Assessment Conference (MARAC) process in the Bridgend area.	Undertaken through the local Domestic Abuse Steering Group (DASG)	Welsh Government (WG) audit team have scrutinised the protocol and confirmed the document as 'Assured', whilst the protocol has no legal status, its see by WG; as good practice in the event of any later legal challenge etc.

Overview Recommendation 4: Bridgend Community Safety Partnership considers organising a 'Learning Event' involving practitioners involved in this case once the Overview report has been presented and accepted by the Community Safety Partnership Board, in order that the recommendations and learning from this review can be disseminated.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
4	Multi-agency review/refresh learning event.	CSP Team Leader	Held on 21 November 2014	**Opportunity-** To raise awareness of DHR's along with the Domestic Abuse, Gender-based Violence Domestic Abuse and Sexual Violence (Wales) Act;(so far key links for Health and local authorities to work on local strategy) Raise awareness of domestic abuse definition; Raise awareness of other domestic abuse services available. 'Ask and Act'; Raise awareness around sharing of information and knowledge of PPD1 (amended to PPM) referral pathway; Raise awareness care plans; Raise awareness concerning the ability/capacity of families to support care plans.	Linked updates provided to the CSP Executive Group chaired by the Leader of BCBC; during 2015/16.	• Full days event; formally opened by the Leader of BCBC and CSP chair with over 65 delegates in attendance representing 15 different agencies of which 75% were managers and 25% operational staff; • All recommendations from DHR 1 and 2 were fully debated, emanating in some very interesting discussion; particularly in relation to IMR findings. • Overall feedback on the day was excellent with some representative's standing up to record their approval.

Probation Recommendations						
Probation Recommendation 1:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
1	For the OM to ensure the timely completion of OASys assessments during the course of an Offender's Order.	Team Manager	March 2014	For the OM to ensure that all cases have an up to date OASys assessment that is reviewed and updated in line with Professional Judgement.	Cases and interventions discussed in supervision and through TM performance information drawn monthly. This identified improvements.	5% case audit in supervision demonstrated improvement in completion of OASys reviews. Performance information reports exceptions in reviews needed so that action can be pinpointed at an earlier stage.
Probation Recommendation 2:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
2	To improve the quality of each OASys assessment completed	Team Manager	March 2014	For the OM to ensure that each OASys assessment completed is of sufficient quality, containing all relevant information required.	OM's Team Manager to actively monitor this via Supervision, Countersignature processes and OASys QA.	Team Manager has made use of the countersigning process to increase the quality of the OAsys assessment and this will continue as continuous development. QA audits have reported satisfactory OASys

Probation Recommendation 3:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
3	To improve the frequency and quality of recording on DELIUS.	Team Manager	March 2014	For the OM to ensure that each contact with an offender, professional or any significant information is clearly and promptly recorded on DELIUS.	Through case audit at supervision	5% case monitoring during supervision to ensure that there are sufficient entries and this will be ongoing as practice development.
Probation Recommendation 4:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
4	To refresh Offender Managers within SNB LDU understanding of Professional Judgment principles.	Deputy LDU Head	February 2014	Team Managers in SNB LDU to deliver briefing session on Professional Judgement to their teams by February 2014	Reported back at Management meetings	Team Managers to monitor through supervision process and team meeting discussions their Team members use of professional judgement.

Wellbeing (Adult's Services) Recommendations						
Wellbeing (Adult's Services) Recommendation 1:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
1	Establish a multi-agency forum to discuss complex and high risk individuals (that do not meet MAPPA criteria)	Group Manager – Adult Services Wellbeing	April 2015	Information is shared and decision making is consistent by agencies dealing with complicated, challenging and high risk individuals.	Six monthly audit	Statistics from meetings held. Six monthly audit of cases discussed to: • Monitor engagement and contribution of agencies. • Evaluate robustness of risk management plans. • Ensure actions progressed by the agencies involved in managing the case.
Safeguarding (Children's Services) Recommendations						
Safeguarding (Children's Services) Recommendation 1:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
1	Closure Document required ensuring Management Oversight prior to case closure.	ICS Project Team	Implemented December 2009.	Closure record and all documents on DRAIG are now scrutinised by Team Manager prior to closure of a case.	Interactive DRAIG reports are available to highlight where case closure documents are awaiting sign off.	Continuation of DRAIG information and management oversight / sign off for case closure.

Safeguarding (Children's Services) Recommendation 2:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
2	Social Work assessments to be informed by historical and current information from family members, agencies / professionals.	All Team Managers and Senior Management Team.	April 2014 and ongoing.	Inform & Educate staff re: Core Assessment and Analysis. *Training planned to achieve desired outcome:* *Two day Multi- Agency training days on September 26/27 2013* *Two day Multi- Agency training days on November 4/5 2013* *Two day Multi- Agency training days booked for February 26/27 2014* *Two day Multi- Agency training days to be confirmed in April 2014*	Quality assurance audit Supervision and management oversight. IRO scrutiny of LAC / CP care plans. *LAC – Looked After Children *CP – Child Protection	Quality assurance audits. Quality of court reports within the Public Law Outline process. CP / LAC process.

Safeguarding (Children's Services) Recommendation 3:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
3.	Children must be spoken to alone for the purposes of Assessment and protection.	All Team Managers, Senior Management Team and Bridgend County Borough Council Social Care Workforce Development Team.	April 2014 and ongoing.	Inform & Educate staff re: Core Assessment and Analysis. Training planned to achieve desired outcome: *Two day Multi- Agency training days on September 26/27 2013* *Two day Multi- Agency training days on November 4/5 2013* *Two day Multi- Agency training days booked for February 26/27 2014* *Two day Multi- Agency training days to be confirmed in April 2014*	Quality assurance audit / supervision and management oversight. IRO scrutiny of LAC / CP care plans. Performance Indicators	There is a specific performance indicator linked to ensuring children are spoken to alone within assessment.

Safeguarding (Children's Services) Recommendation 4:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
4	Completion of a Risk Assessment when recommended	ICS Project Team	Implemented 2008 and ongoing.	To ensure children are protected from harm by the completion of an appropriate risk assessment.	Quality assurance audit / supervision and management oversight. IRO scrutiny of LAC / CP care plans.	Quality assurance audits. Quality of court reports within the Public Law Outline process. CP / LAC process.
ABMU Mental Health Recommendations						
ABMU Mental Health Recommendation 1:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
1	All qualified mental health professionals providing one to one interventions should have training in formal violence risk assessment	Service Manager Adult Mental Health	2018	WARRN will be commissioned to provide 'train the trainers' for the Asking Difficult Questions course Qualified mental health staff will be trained in using a formalised risk assessment protocol in line with other health boards in Wales, using the WARRN risk assessment model	Regular reports to directorate board on numbers of staff trained Evidence of WARRN risk assessments included in patients' healthcare records	90% of qualified mental health staff will be trained on WARRN Audit of healthcare records will show the presence of a WARRN risk assessment at the point of initial assessment for part 2 mental health services

ABMU Mental Health Recommendation 2:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
2	There will be domestic violence pathways in place for service users, involving staff being able to ask about domestic violence and act to sign post people to appropriate services or alert appropriate safeguarding bodies.	Lead nurse, domestic violence and abuse	December 2017	ABMU will be an early implementation site for the Welsh Government Ask and Act training Ask and Act steering group will manage and monitor policy and pathways for signposting service users where domestic violence is a concern. A range of training opportunities will be provided to staff to support awareness of domestic violence and actions to be taken.	Reporting to safeguarding committee	Training needs analysis to be completed. An 'Ask and Act' policy will be produced by the 'Ask and Act' steering group Statistics on numbers of staff attending current domestic violence will be collated and reported to the 'Ask and Act' steering group. Ask and Act training to be rolled out in 2016

ABMU Mental Health Recommendation 3:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
3	For service users presenting with serious mental ill health and domestic violence, specialist forensic mental health consultation will be available to staff	Clinical Director	September 2016	Health care records contain rationale for decisions about referral for specialist assessment and consultation when serious mental ill health and domestic violence are identified.	Audit of healthcare records and care and treatment plans	Quality audit of healthcare records and care and treatment plans. Will show compliance with standard.
ABMU Mental Health Recommendation 4:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
4	The risk assessment tool for mental health will contain a section on children and their safeguarding needs	Service Manager, Adult Mental Health	September 2016	Risk assessment tools include details of children living in the household with service users under part two of the Mental Health Measure. Details of where childcare cases are signposted will be included in the risk assessment tool completed on service users.	Audit of risk assessment tools.	Audit will show levels of compliance with the standard.

ABMU Mental Health Recommendation 5:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
5	Domestic violence perpetrators will be signposted to appropriate services	Service Manager, Adult Mental Health	September 2016	Evidence of signposting and referral to appropriate services for help in regards to reducing domestic violence risk will be contained in healthcare records and risk assessment plans.	Audit of risk assessment tools and healthcare records.	Compliance with standard.
ABMU Mental Health Recommendation 6:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
6	Service users with personality disorder will be identified and their needs reflected in care and treatment plans.	Clinical Director	September 2016	Personality disorder awareness training will be provided to staff across the mental health directorate. A bid for funding for the development of specialist personality disorder services will be submitted to Welsh Government.	Training dates available for staff Audit of care and treatment plans Review of progress with service development	Personality disorder related needs will be included in care and treatment plans. Personality disorder services will be in place or in development.

ABMU Mental Health Recommendation 7:						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured? Details of success and outcome to be included when feedback is provided.**
7	Care and treatment plans will include details of prescribing and changes in prescription will be recorded in patients' healthcare records	Clinical Director	September 2016	Changes in medication will be accurately recorded in patients' healthcare records and care and treatment plans.	Quality audit of healthcare records and care and treatment plans.	Details of medication changes are recorded in care and treatment plans and healthcare records. Arrangements for psychiatric review in relation to medication changes is recorded in healthcare records and care and treatment plans.