Domestic Homicide Review Report:

Executive Summary

Karen

Died: 8th August 2013

Tony Blockley
Director: Johnston and Blockley Ltd

Date: May 2016

Executive Summary

1 Introduction

1.1 This executive summary outlines the circumstances of the death of Karen on 8th August 2013 and the subsequent statutory Domestic Homicide Review undertaken by One Newport Local Service Board (LSB). Karen had been murdered by her estranged husband, Adult B, who then made a concerted effort to kill himself.

1.2 Adult B received extensive hospitalisation before criminal proceedings were instigated. He was convicted of murder and was sentenced to life imprisonment. He must serve at least 26 years before he is eligible for parole.

1.3 During the summing up at the trial, Mr. Justice Wyn Williams said *"Your plan was to kill her [Karen] and then kill yourself [Adult B] and but for the intervention of skilled medics your plan would have succeeded… I am satisfied that when you left the home you had a settled intention to kill your wife."*

1.4 There had been limited contact with agencies prior to the murder although from the review it would appear there had been abuse within the marriage for many years.

1.5 Nothing in the review indicted that Karen's death could have been predicted or prevented.

1.6 Following Karen's death the Independent Police Complaints Commission (IPCC) investigated the circumstances and the actions of police officers relating to a number of specific incidents.

They concluded that other actions would have been appropriate in the circumstances and they reported that there were 'misconduct and performance issues for individual officers and a number of organisational shortcomings that Gwent Police needs to address.'

1.7 The matters relating to individual officers have now been finalised and the 'organisational shortcomings' have been addressed, implementing necessary changes to process and procedure.

1.8 In the recent **PEEL: Police effectiveness 2015 (Vulnerability) An inspection of Gwent Police by Her Majesty's Inspector of Constabulary** (HMIC) that officers

'Demonstrated an empathetic approach towards victims and had a good understanding of the force's domestic abuse policy, including the need to take positive action.'

1.9 **Family history Karen and Adult B**

Karen and Adult B had been married for 27 years and had two children, Adult D who was 19 and Child E who was 16 at the time of Karen's death.

1.10 In April 2013, Karen had left Adult B and the marital home, she had moved back to her mothers address and had initiated divorce proceedings. Following this she had

moved into a home with Adult C.

1.11 The first contact with any agency relating to the domestic abuse was in May 2013, three months before Karen's death. She contacted Gwent Police to report Adult B for stalking her.

1.12 **Events of Sunday 8th August 2013**

On the day of Karen's murder, Adult B had followed her from her home that she was now sharing with Adult C and 'flagged' her car down. Adult B told her that he had some property in his car and he would give it to her. During this conversation Karen returned to her car and according to witnesses opened the boot. There then appears to have been an argument and Adult B had grabbed hold of her, pulling at a lanyard around her neck and causing it to snap and fall to the ground.

1.13 Adult B removed a legally held shotgun from the boot of his car and shot Karen twice in the back causing fatal injuries. Adult B then turned the shotgun on himself and in an attempt to commit suicide he shot himself under the chin causing extensive injuries to his face.

2 The review

2.1 On 15th March 2015, One Newport Local Service Board determined that Karen's death appeared to warrant the establishment of a domestic homicide review.

2.2 Karen died in August 2013 and at the time she was living in the One Newport Local Service Board (LSB) area. Karen grew up in Newport before moving out of the area and it was established that she had moved back to the city in the recent months prior to her death. There were discussions regarding the appropriate authority area to conduct the review. Following the decision that Newport should conduct the review the appropriate board met and decided on the scope of the review in accordance with the Home Office guidance.

2.3 There was little information held by agencies with regard to Karen or Adult B, however it was decided to set the scope of the review to identify any information or indication of abuse that may not have been readily identified at the time and shed a light on why the terrible events of 8th August 2013 had happened. The time period for the review began in 2011, five years before Karen's death.

2.4 The following agencies were asked to identify if they held any information relating to Karen or Adult B. If they did have information they would give chronological accounts of their contact with Karen and Adult B prior to her death:

- Newport City Council
- Torfaen County Borough Council
- Gwent Police
- Aneurin Bevan University Health Board (ABUHB)
- Newport City Homes
- National Probation Service
- Third sector organisations as identified in the review:

- Newport Women's Aid
- Torfaen Women's Aid
- South East Wales Regional Equality Council
- Bawso

2.5 Only Gwent Police have any recorded contact relating to domestic violence and abuse with Karen and Adult B prior to her death, consequently only Gwent Police completed an IMR. Within that IMR they provided

- A chronology of interaction with Karen, her family and/or Adult B
- What action was taken and analysis of those actions
- Whether internal procedures were followed and if those procedures are appropriate in light of Karen's death
- Conclusions and recommendations from their point of view

2.6 Karen and Adult B's respective GP's did have contact with both of them, however in the case of Karen this related to medical issues unconnected with domestic abuse.

2.7 Adult B reported depression and similar anxieties associated with separation, however at the time they were not connected to domestic abuse and on subsequent reflection during the course of this review they could not be associated with predictors of violence or abuse.

2.8 Contact has been made with Karen's family and Adult C however no one has wished to take part in the review. Adult B has also been contacted and has not responded to the invitation to take part in the review.

2.9 **Involvement of Gwent police**

There are three incidents involving Gwent Police, the first in May 2013 when Karen reported that Adult B had been stalking her. During this contact with the police she revealed the extent of the abuse within the marriage and that during that time he had been possessive and controlling and that she was concerned because he had shotguns.

2.10 This incident was identified as a standard risk however during the IPCC investigation it was concluded that the assessment should have been high.

2.11 During the second incident later in May 2013, Adult B's father reported that Karen had assaulted Adult B's mother. Following an investigation by police officers it ascertained the allegations were false and as a consequence no action was taken against Karen.

2.12 The final incident prior to her death was in July 2013, Karen contacted Gwent police and reported that Adult B had refused to return her passport and driving licence which was in the marital home.

A visit was made to the marital home and officers spoke with Adult B who said that he did not have the documents and they were not in the home. It was during the subsequent investigation that the IPCC felt other actions would have been

appropriate and officers should have taken positive action to determine the location of the documents and the voracity of Karen's complaint.

3 Key issues arising from the review

3.1 Due to the limited agency involvement the only key issues relate to Gwent Police. Consideration has been given to the access of services by victims and the availability of services and support, together with educational information concerning abuse and the impact on victims and families however this review has not identified any of these to have been barriers in this particular review.

3.2 A number of key issues have been identified within this review that are replicated in the IPCC investigation; that suitable and appropriate risk assessment process should be undertaken, taking account of all the available information and there should be an attention to detail when completing risk assessment forms.

3.3 The key high-risk factors relating to domestic abuse should be recognised and reported to ensure appropriate services and support are provided to victims.

3.4 Information should not be taken at face value and sufficient scrutiny should take place to understand and evaluate the strength of the information and it's reliability.

3.5 Positive action should be taken when investigating any incident involved in a domestic setting and this should be seen as a priority.

4 Conclusions from the review

4.1
- There had been limited involvement with agencies prior to Karen's death and the three contacts with Gwent Police were within three months of her death.

4.2
- There is no doubt that Adult B had intended to kill his wife, Karen. The murder was planned and calculated. It was not a crime that occurred during a specific incident, it was one that had been considered and premeditated.

4.3
- Having reflected on the police involvement together with the findings and recommendations from the IPCC investigation it is not felt that identifying Karen as high risk or managing the incidents as per the recommendations would have had an impact on the behavior of Adult B.

- This reflection takes account of the comments by, Mr. Justice Wyn Williams, who said at Adult B's trial *"Your plan was to kill her and then kill yourself and but for the intervention of skilled medics your plan would have succeeded… I am satisfied that when you left the home you had a settled intention to kill your wife."*

4.4
- There is nothing to suggest an escalation of violence and it is doubtful anyone would have predicted the behaviour of Adult B.

4.5
- The findings of he IPCC investigation have been implemented and a subsequent assessment in the recent **PEEL: Police effectiveness 2015**

(Vulnerability) An inspection of Gwent Police by Her Majesty's Inspector of Constabulary (HMIC) found that officers

'Demonstrated an empathetic approach towards victims and had a good understanding of the force's domestic abuse policy, including the need to take positive action.'

5 Recommendations from the review

5.1 Within this review a number of issues have been highlighted that were identified by an independent investigation by the IPCC. Gwent Police has implemented the recommendations made within that report and consequently there is nothing in this review from the analysis, lessons learned or conclusions that is outstanding.