Domestic Homicide Review Report:

Karen

Died: 8th August 2013

Tony Blockley
Director: Johnston and Blockley Ltd

Date: 14th March 2016

1. Preface

1.1 As one of Wales' newest cities, Newport forms the gateway between Wales and England and the economic motor for the South East Wales region. The geographical area of Newport covers 217.7km2, approximately 1% of the total area of Wales at 21,225 km2.

1.2 Newport is the third largest city in Wales. The current population of Newport is 146,558 based on the most recent ONS 2013 Mid-Year Population Estimate, which is approximately 4.75% of the total population of Wales. The ONS 2011 Census household count for Newport was 63,445, approximately 5% of the total number of households in Wales. The 2014 estimated household count for Newport based on analysis of localised Council Tax and Electoral Registration records is circa 67,000.

1.3 Newport consists of 20 Wards, 14 Community Councils and 95 Lower Super Output Areas. There are two parliamentary constituencies in Newport, Newport East and Newport West, each returning one elected Member of Parliament.

1.4 Domestic abuse now has a much higher profile on the policy agenda both nationally, through the publication of the Welsh Government's Domestic Abuse Strategy, as well as locally through the development of work-based policies for domestic abuse. Strategic governance for domestic abuse and issues linked to the national agenda in Newport is held by the One Newport Local Service Board (LSB), which acts as the statutory community safety partnership for Newport. Newport City Council is leading on the Gwent wide Domestic Abuse Pathfinder Project, sponsored by the Welsh Government.

1.5 Domestic Abuse services for Newport are coordinated from the Multi Agency Unit within the Information Station within Newport City Centre. Within this unit, organisations such as Llamau, BAWSO and Victim Support have been based to deliver a coordinated, seamless service. Newport City Council's Independent Domestic Violence Advocate Service is also based there. Referrals come through Domestic Abuse Case Conference (DACC), with high risk cases being referred to the IDVA service through the Multi Agency Risk Assessment Conference (MARAC). There is also come capacity for drop-in services, links with counseling provision and training facilities.

1.6 Newport is seeing an increase in referrals each year and is expecting this trend to continue. The data shows that there has been a year on year increase in the number of recorded Domestic Abuse incidents from 2,643 in 2011/12 up to 3064 in 2012/13 (16%). There has been a recent increase in recorded Domestic Violence despite a previous year on year decrease. The number of domestic violence crimes has increased from 630 in 2011/12 up to 796 in 2012/13 (26%).

1.7 One Newport Local Service Board (LSB) is leading the Domestic Homicide Review (DHR) process in line with Home Office guidance.

1.8 The circumstances that led to the Domestic Homicide Review

This Domestic Homicide Review Overview Report is about Karen a 46-year-old

women and mother of two who died in Newport, Gwent on 8th August 2013. Her estranged husband, Adult B murdered her. Adult B shot her twice using a shotgun before turning it on him and attempting to take his own life, he survived and was convicted of her murder.

'Karen' is a pseudonym chosen by the report author.

1.9 At 8.43am on Friday 8th August 2013 Gwent Police were called using the 999 systems and were told that 'someone had been shot'.

1.10 The witness making the call had seen Karen go towards the driver's side door of her car when Adult B grabbed her by her identification lanyard that was around her neck. He pulled with enough force that the lanyard came off and fell to the floor.

1.11 The witness describes hearing two shots when Karen was shot in the back from close range. Adult B then knelt on the floor and placed the gun under his chin and fired a third shot.

1.12 Karen's injuries were each fatal and she was pronounced dead at the Royal Gwent Hospital at 9.33am. Adult B survived and after spending a considerable time in hospital was charged with Karen's murder.

1.13 Adult B appeared before Newport Crown Court. Following a trial he was found guilty of murder and received a life sentence with a minimum term of 26 years before consideration of parole.

1.14 There had been limited contact with agencies prior to Karen's death. During the review period there was only one incident that identified potential domestic violence/abuse.

1.15 On 15th September 2015, One Newport Local Service Board (LSB) determined that Karen's death appeared to fall within the criteria of the Multi-Agency Statutory Guidance for the conduct of domestic homicide reviews' issued under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004) in that Adult's death was caused by: *'a person to whom she was related or with whom she was or had been in an intimate personal relationship'*

1.16 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.

1.17 As a consequence the delay of commencing the review enabled the Independent Police Complaints Commission (IPCC) to conduct a separate review of Gwent police handling of incidents involving Karen and Adult B prior to her death.

1.18 The LSB, acting as the Community Safety Partnership (CSP), decided that a

domestic homicide review should be conducted. The Chair of One Newport Local Service Board ratified the decision on 30th September 2015. Notice was given to the Home office on 30th September 2015 of the intention to carry out a domestic homicide review.

1.19 On 11th November 2015 all agencies were asked to seal their records and undertake checks of involvement with Karen and Adult B. They were asked to undertake a review of their records relating to any relevant contact there might have been with Karen and Adult B.

1.20 **Scope of the Review**

1.21 Karen and Adult B had been married for over 20years and it was decided that the review should begin in 2011, five years before Karen died

1.22 The purpose in going further back into the relationship history of Karen and Adult B is to ascertain patterns of behaviour and context in which to consider the Domestic Homicide Review with relevance to their relationship. The panel felt that a five-year time scale would ensure a full picture of their relationship could be obtained.

1.23 However, if any agency felt there was relevant information outside the time period under review it was agreed that the information should be included in their IMR. As well as the IMR's, each agency provided a chronology of interaction with the identified individuals including what decisions were made and what actions were taken. The IMRs considered the Terms Of Reference (TOR), whether internal procedures were followed, whether on reflection they were considered adequate, arrived at a conclusion and where necessary, made a recommendation from the agency perspective

1.24 A significant issue for the review panel was which area should conduct the review. Karen had lived within the Newport area since April 2013, approximately four months before her death. This meant that if Karen and Adult B had been in contact with agencies the information would have been in Torfaen and not Newport.

1.25 **NB:** It was apparent from the initial information trawl that there was very little known to agencies in the Newport and Torfaen areas. The review was anxious that every effort should be taken to identify any information relating to Karen, Adult B or her children (Adult D and Child E). Unfortunately, despite extensive examination the only records available to the review were those held by Gwent police and the GP. Gwent police provided an overview IMR of their involvement and the GP provided an extensive report outlining their limited involvement. As a consequence there was little information to be considered or analysed. This will be commented on later in the report.

The review acknowledges that the report is heavily influenced by the police IMR and their involvement and that it does not have the personal context creating a disconnection from Karen, however it is limited to the information known to agencies and the engagement of family and friends, which is commented on later.

1.26 Terms of Reference

1.27 The purpose of the review is to:

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

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

- Apply those lessons to service responses and include any appropriate changes to policies and procedures

- Prevent future domestic homicides through the improvement of service responses for all victims of domestic abuse, and their children, through improved intra or inter-agency working

The review will address:

- Whether the incident in which Karen died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence

- Whether there were any barriers experienced by Karen or family / friends / colleagues in reporting any abuse in Newport or elsewhere, including whether they knew how to report domestic abuse should she have wanted to

- Whether Karen had experienced abuse in previous relationships in Newport or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died

- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Karen that were missed

- Whether Adult B had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Karen or Adult B that were missed

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city

- The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

Specific to this review the following will be considered:

- The effectiveness of interagency information sharing across different authority boundaries and whether there are barriers or missed opportunities

1.28 The rationale for the review process was to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide and abuse.

The review identified the following general areas for consideration:

1.29 **Family engagement**

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?

- How matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for it?

1.30 **Legal Processes**

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review

1.31 **Research**

- How should the review process take account of previous lessons learned from research and previous DHRs?

1.32 **Diversity**

- Are there any specific considerations around equality and diversity issues, such as ethnicity, age and disability that may require special consideration?

1.33 **Multi agency responsibility**

- Was the victim (Karen) subject to a Multi-Agency Risk Assessment Conference?

- Was the perpetrator (Adult B) subject to Multi Agency Public Protection Arrangements?

- Was the perpetrator subject to a Domestic Violence Perpetrator Programme?
- Did the victim have any contact with a domestic violence organisation or helpline?
- Was either the victim or the perpetrator a 'vulnerable adult'?
- Were there any issues in communication, information sharing or service delivery between services?

1.34 **Individual agency responsibility**

- Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults and with wider professional standards?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator?
- What was the quality of any multi-agency assessments?
- Was the impact of domestic violence on the victim recognised?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- Was there sufficient management accountability for decision-making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

1.35 **Issues which relate to ethnicity, disability or faith which may have a bearing on this review**

None were identified

1.36 **Other DHRs in the region or nationally which are similar, and the availability of relevant research**

None have been identified at the time of writing.

1.37 **Methodology**

This overview report has been compiled from and analysis of the Internal Management Review of Gwent police. Gwent police were the only agency identified who had any significant involvement with Karen, or Adult B prior to her murder, despite an extensive trawl. The review was limited to this IMR and also the Independent Police Complaints Commission (IPCC) investigation report, which scrutinised the police action and the circumstances surrounding her death. Consequently it does not have a wider perspective that would have been helpful. The review also examined previous reviews and findings of research into various

aspects of domestic abuse.

1.38 In preparing the overview report the following documents were referred to:

- The home office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Call an End to Violence Against Women and Girls – HM Government (November 2010)
- Barriers to Disclosure – Walby and Allen, 2004.
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007
- 'Suicides and suicide attempts following homicide' Barber et al, 2008
- 'Domestic homicide followed by parasuicide' Liem, Hengveld and Koenraadt, 2009.
- Agency IMR
- IPCC investigation report

1.39 **Participating Agencies**

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 Karen's 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

1.40 Only Gwent police have any recorded contact with Karen and adult B prior to Karen's 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 the death of Karen

- Conclusions and recommendations from their point of view

1.41 **DHR Panel Chair/Overview Report Author**

The LSB requested that Johnston and Blockley Ltd would provide the role of the Chair and Overview Report Writer

1.42 One of its partners, Mr. Tony Blockley, undertook the role of Chair and Overview Report Writer. He is a specialist independent consultant in the field of homicide investigation and review. He has senior management experience in all aspects of public protection. He has been involved in numerous homicide reviews throughout the UK and abroad, was chair of MAPPA and was responsible for all public protection issues when he was head of crime in a UK police force. He has been involved in several DHRs and serious case reviews. He is also a special advisor to a 3rd sector organisation that provides domestic abuse services (not in the area covered by the Newport Community Safety Partnership) and a Senior lecturer at the University of Derby, criminology.

1.43 **The DHR Panel**

The LSB agreed the formation of the overview panel comprising of agencies that may have had contact with Karen and Adult B during the period under review, including a representative from a specialist Domestic Violence Service.

1.44 The DHR Review Panel consists of:

• Tony Blockley	Johnston and Blockley Ltd Chair and Report Writer
• Caroline James, LSB Coordinator	Newport City Council
• Supt Glyn Fernquest	Gwent Police
• Chris Humphrey	Newport City Council
• Vanessa Griffin	Newport City Council – Education Services
• Mary Ryan	Newport City Council – Adult and Children's Safeguarding
• Annette Morris	Aneurin Bevan University Heath Board
• Lin Slater, Assistant Director of Nursing (Safeguarding)	Aneurin Bevan University Heath Board
• Heather Nicholls	National Probation Service

• Carole Parsons,	Independent Domestic Violence Advisor
• Bernadette Anderton	Torfaen County Borough Council
• Tracey Pead	Torfaen County Borough Council
• David Phillips, Director	SEWREC
• Natalie Williams	Newport Women's Aid
• Jane Oates	Llamau
• Mariam Elmirghani, Director South East	Bawso

1.45 The DHR Panel would like to extend its sincere condolences to Karen's family and the offer to comment on the review remains open to them all.

In light of the limited agency involvement the panel were keen to gather information from family and friends of Karen's to provide a better understanding of the relationship with Adult B and the time preceding her untimely death. Efforts were made to contact the family in order to engage them with the review. Karen's mother and her adult daughter were invited to participate but they have chosen not to be involved and the panel respects their wishes but the option to take part in the review remains open.

Neighbours and colleagues of Karen's were contacted as part of the review process and did not engage with the review. Advice was taken regarding the involvement of their son Child E and it was felt not appropriate to involve him at this time. He is now been supported by social care and the offer to be involved or discuss the circumstance surrounding his mother's death remains. If at some point later he feels able to or would like to discuss the circumstances then he will be supported in that process.

Adult B has been written to in prison inviting him to participate in the DHR process, but to date he has not responded.

1.46 **Parallel processes**

1.47 **Inquest / Criminal Investigations**

There was a thorough police investigation into the circumstances of the death of Karen resulting in the murder trial. Adult B was found guilty of murder and sentenced to life imprisonment with a minimum term of 26 years before he can be considered for parole.

1.48 Although the death of Karen was referred to the Coroner, no inquest will take place because all the evidence and information about his death was aired during the murder trial.

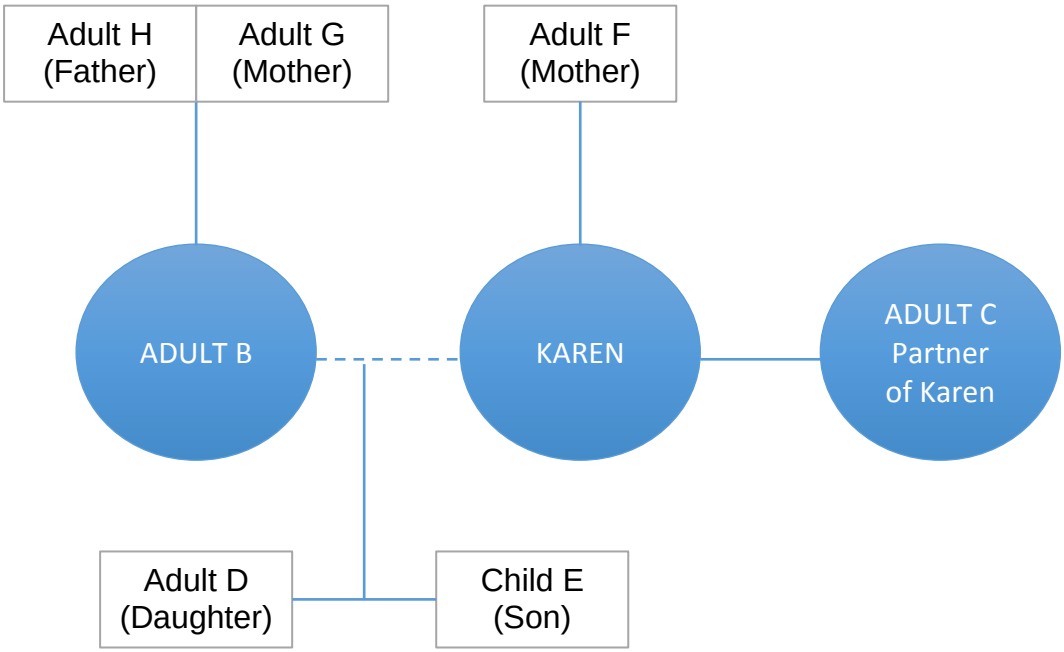
1.49 The Independent Police Complaints Commission (IPCC) conducted an investigation into the circumstance of police involvement within the three recorded incidents prior to Karen's death.

This review was extensive and examined all police contact and involvement with Karen and Adult B prior to her death.

1.50 **The involvement of family members**

Family composition (Of those referred to in the review)

1.51



1.52 The panel agreed that the review would benefit from the involvement of family members; it was recognised that they may have an important role to play to provide background information, not known to services and to provide information about Karen and Adult B.

1.53 Adult C, Adult D, Child E and Adult F were contacted after the trial to inform them of the DHR process. Whilst the panel acknowledges this was not strictly within the Home Office guidelines, it was felt appropriate, after consultation with the Police Senior Investigating Officer, to delay the notification and invitation because many of the family were likely to be called as witnesses during the criminal proceedings.

1.54 Adult C, Adult D, Adult F and Adult B have all been written to, together with contact made with friends, neighbours and colleagues of Karen, inviting them to participate in the review however to date none have responded.

2 The Facts

2.1 Karen and Adult B had been married for 27 years and had two children, Adult D who

was 19 at the time of Karen's death and Child E who was 16 at the time of his mothers death.

2.2 There had been no contact with any agencies relating to domestic abuse prior to the first contact with Gwent police in May 2013, three months before Karen's death.

2.3 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.

2.4 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 Karen, pulling at a lanyard around her neck and causing it to snap and fall to the ground.

2.5 Adult B removed a legally held shotgun from the boot of his car and shot Karen twice in the back causing fatal injuries. The pathologist at the trial of Adult B stated that either injury would have been fatal.

2.6 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. Due to the skills of the medical teams they saved Adult B and he was subsequently tried and convicted for murder. He received a life sentence with a minimum term of 26years.

2.7 During the trial Adult B claimed depression was the cause of his actions and he had intended to commit suicide in front of Karen. A psychiatrist gave evidence during the trial and stated that depression is not associated with violence and that *"Killing her (Karen) would have come from anger, vengeance and a desire to cause her serious harm."*

2.8 In his summing up the judge at the trial Mr Justice Wyn Williams said

> *"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. You had loaded the gun with three cartridges and your actions were consistent with someone planning to kill. The killing took place in a quiet residential area… it was a terrible thing to do…By your actions you have deprived your wife her life, your daughter and son of their mother, and brought grief and unhappiness to very many people, and your own life is in ruins."*

3 Chronology

3.1 The chronology is limited to a number of visits to his GP and three incidents that involved Gwent Police, no other agency appears to have had contact with Karen, Adult B, Adult D or Child E until Karen's murder.

3.2 On 18th April 2013 Adult B visited his GP and stated that his wife had left him the week previously. He was very anxious, not sleeping not eating and felt depressed although he had no suicidal thoughts. Adult B asked the GP for advice and what he

should do. He also asked the GP for a reason why she would leave him and asked the GP if it was connected to his wife's hysterectomy. Adult B also asked the GP why his wife had lost weight; the GP explained that he could not discuss Karen. At this appointment Adult B was prescribed Citaloprim.

3.3 *This was a standard appointment; Adult B was given support regarding a matrimonial separation. Separation is a high risk factor for domestic abuse, however there was no history of violence or abuse and nothing within Karen's medical records that indicated domestic related incidents or issues. There was nothing disclosed and no signs within the appointment to suggest domestic violence was an issue.*

3.4 24th April 2013 Adult B went to the GP and had a long discussion about the marital breakdown and disclosed similarities to grief reaction and bereavement. The GP discussed coping mechanisms and how short term sleeping tablets may help but they would not be prescribed in the longer term. After consideration of what the GP had said to Adult B, he had decided not to take anti-depressants, as they would not change the situation.

3.5 *Similar to the previous appointment this was a standard appointment; Adult B was given support regarding a matrimonial separation. There was nothing disclosed and no signs within the appointment to suggest domestic violence was an issue.*

3.6 **Incident 1:**

On 1 May 2013 Karen contacted Gwent Police using the non-emergency 101 number to report that she had separated from her husband (Adult B) some three weeks before and that he had been stalking her.

3.7 She said that he had been possessive and controlling during the marriage and that she was concerned because he had shotguns. Karen also said that Adult B had taken the separation very badly, that he had seemed '*very on edge today*' and '*didn't seem himself*'.

3.8 During the call Karen could be heard speaking to her mother (Adult F) and said '*I got to, see mum, for my own safety*.' She said that Adult B had dealt with his shotguns in an '*above board*' manner previously but that she was concerned because '*he's so upset over this marriage breakup, he's just not in the right frame of mind at this moment, so who knows really?*'

The mention of firearms and the concern raised by Karen should have immediately caused concern for the officers. The possession of firearms is a significant risk factor, which when associated with separation can only heighten the risk to Karen and Adult B.

There is a complete lack of appreciation of this escalation and consequently the risk was not identified and therefore not managed.

3.9 Police officers from Gwent Police went to Karen's mothers address on the same evening and met Karen and Adult F. Karen provided the police with some background on her relationship with Adult B - she told the officers that she had left

Adult B about three weeks before and had moved out of the marital home, moving in with her mother (Adult F).

3.10 Karen also told the officers that during their 27 year relationship, Adult B had been very jealous, quite controlling and that she was largely unhappy. She explained that her teenaged son (Child E) and daughter (Adult D) were both still with Adult B.

3.11 Karen explained the reason for calling the police, that earlier in the day she had collected Child E from school and dropped him at her marital address. Whilst at the address, she had seen Adult B who seemed fine and there were no issues at that time. Karen then left the address to visit a friend and when she arrived at her friend's address she discovered that her Adult B had followed her there. Adult B was upset, asking why they had broken up and that he wanted to know if she (Karen) was having an affair. Karen asked Adult B to leave, which he did, however the incident left Karen distressed.

This possessive and controlling behaviour demonstrates the coercive nature of her relationship with Adult B, that he was able to track her, and harass her. There is a clear indication of risk factors which when coupled with separation and the psychological effect on Adult B should have raised significant concerns for Karen's safety.

3.12 A Domestic Abuse Stalking and Harassment risk assessment form (DASH) was completed and the risk was assessed as standard.

3.13 The risk assessment grading's for Gwent police are

- ***High Risk Victim***
  There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Serious Risk of Harm "A risk which is life threatening and or traumatic and from which recovery, whether physical or psychological can be expected to be difficult or impossible".

- ***Medium Risk Victim***
  There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drugs or alcohol abuse.

- ***Standard Risk Victim***
  Current evidence does not indicate likelihood of causing serious harm.

3.14 *Following the IPCC investigation it was concluded that the risk assessment should have been identified as high due to Karen agreeing that Adult B had stalked her, controlled her and shown jealousy. That he had said things of a sexual nature that made her feel bad; that he had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life; that he had threatened or attempted suicide and that they had recently separated.*

In the event of being identified as high risk a referral would have been made to the Multi Agency Risk Assessment Conference (MARAC) where agencies would have met and discussed the case before determining a course of action. This did not happen and the IPCC report concluded that this was a missed opportunity.

This incident was discussed at the Domestic Abuse Conference Call (DACC) and is considered in more detail later in the report

3.15 The following day Gwent Police attended the address of Adult B to warn him of his conduct and check his firearm certificate. Following a discussion with Adult B, the police officer identified that there was a licence in place and the guns were being kept in accordance with the requirements of the certificate, no other action was taken.

3.16 During the conversation Adult B appeared calm but was upset. He explained to the officer that Karen had left him after 27 years of marriage and he (Adult B) believed this was due to the fact she was having an affair.

3.17 Adult B told the officer that the previous day he had followed Karen in an attempt to discover whether she was having an affair. Adult B was advised that this behaviour was not acceptable and that he should contact Karen through a third party, for example a solicitor.

3.18 The officer updated the incident log with the following

Spoke to [Adult B] this morning. He is upset that his wife (Karen) has left after an alleged affair and states he wants to know for certain if she is having an affair. There is [sic] no concerns that he will harm himself and appears to be keeping things together for the children's sake. He is no risk to himself or others. I have suitably advised him re. contact and to communicate via a third party only. He seemed happy with the advice and will be contacting a solicitor regarding the house.'

3.19 *The current Gwent police domestic abuse policy contains a section relating to firearms and states (This was not in place at the time of the incident but has since been implemented)*

Initial Safety Planning

Attending officers must consider the threat, risk and harm they have identified in their primary risk assessment and they must take immediate positive action to mitigate these risks. Officers should always aim to support the needs and wishes of the victim in formulating their initial safety plan but must always consider their primary duty to protect life and limb, which includes the victim, but also the wider public.

Any action taken and any follow-up action required must be documented on the primary risk assessment for review by the Public Protection Unit

Where intelligence checks identify a firearms licence holder as being involved

in a domestic abuse incident, attending officers must consider taking possession of weapons and, in all cases, must immediately notify Firearms Licensing Department at [redacted] so that consideration can be given to revoking the licence.

A Detective Sergeant will be available 24/7 to provide advice and guidance to Neighbourhood Patrol officers in relation to domestic abuse safety planning. During core hours, the first point of contact will be the Public Protection Unit.

It is quite clear that officers did not follow the policy and guidance and neither did they explain any rationale for their decision making. This is a failing by the officers and was commented on in the IPCC report.

3.20 That same day, the incident of the 1st May was discussed during a Domestic Abuse Conference Call (DACC). No previous history was identified, neither party were known to Probation, Women's Aid, Health or Social services and it was recommended that Newport Women's Aid should make contact with Karen and offer support.

Karen was contacted by Newport Women's Aid on the same day and given information regarding the services that were available. Karen agreed that she would call in to access the services the following week although there is no record to suggest she did.

3.21 *The DACCs are managed using a SharePoint site, which partner agencies can access; this site is available to Gwent Police via the force intranet. A dedicated Domestic Abuse Investigation Unit (DAIU) Detective Constable or Police Constable chairs the DACC; he or she is responsible for researching cases prior to the meeting and updating the DACC SharePoint site.*

3.22 *Partner agencies include Health, Social Services, Housing, local Women's Aid and sometimes the Local Education Authority. There are five DACC units, one for each of the Gwent Police Local Policing Units: Newport, Caerphilly, Torfaen, Blaenau Gwent and Monmouthshire. Each DACC is led by experienced domestic abuse staff, either from the DACC team or from the investigative team, which also has safeguarding officers.*

3.23 *The minutes made in relation to Karen at the DACC held on 1 May 2013, indicate that there were no previous reported incidents and that the couple was not known to Probation, Women's Aid, Health Services or Social Services. The notes went on to state that the 'standard risk DASH [was] received with consent, the panel advised to maintain the risk at this time,'*

3.24 *The reference to 'with consent' referred to Karen's consent to her data being disclosed to statutory and non-statutory agencies to prepare a risk strategy.*

3.25 *The DACC minutes made no reference to Adult B's status as a shotgun certificate holder, or to Karen's concerns about his mental health and possession of weapons and this clearly should have been part of the discussion.*

3.26 *The risk level agreed at the DACC did not correspond to the risk factors set out on the completed DASH form. The number of high risk questions with 'yes' responses should have prompted the DACC to amend the risk assessment upwards and to note that the officer who had completed the DASH form had completed the question about separation incorrectly.*

3.27 *No risk level was completed on the DACC SharePoint site, which resulted in 'not graded' appearing on the Domestic Abuse Management System (DAMS) that is a computerised system available to all officers and staff via the Gwent police intranet site. This allows officers and staff to access records, identify previous and ongoing incidents and risk. They are also able to update and add notes as appropriate to those records.*

It is clear that the decision making process was flawed; the information in the minutes did not correlate to the events on 1st May 2013. There was no mention of the shotguns, Karen's concerns regarding Adult B's state of mind or the wider consideration for Karen's safety, this is a clear failing of the process and a significant opportunity to identify significant risks towards Karen.

3.28 **Incident 2:**

On 20 May 2013 Gwent Police received a call from Adult B's father (Adult H) stating that Karen had assaulted his wife (Adult G).

two minutes later, Karen also called Gwent police using the 101 service reporting that Adult B was outside 'the house' (the marital home) being aggressive towards her and that she was inside her house with Child E and Adult D. Karen also told the police that she had recently reported Adult B for stalking her

3.29 Police officers were sent independently to the two incidents although neither officer was aware of the other incident due to the incidents being merged on the control system.

This merging also meant that both officers attended the marital address of Karen and Adult B, however the officer attending the first reported incident by Adult H should have gone to his address.

3.30 At the marital address the officers spoke to Karen who told them that she had come to the marital address to collect her belongings and that whilst she was doing so, her husband (Adult B) and her mother-in-law (Adult G) had arrived; Karen stated that she and her mother-in-law then had a verbal argument.

3.31 One of the officers then went to the address of Adult G and spoke to her. When the officer arrived at the address Adult B was present, Adult G was upset and crying. She said that she had gone with her son Adult B to his address because she knew Karen was there taking things without the police being present.

Adult G said that when they arrived there was a verbal altercation instigated by Karen and that Karen had 'grabbed her by her chest' it is recorded in the police notebooks that Adult G reported this as causing her pain and discomfort. Adult G

also said that Adult B had witnessed the assault and Adult B agreed he had. During the conversation she told officers that she wanted Karen arresting for assault.

3.32 The officer did not see any injuries to Adult G although she was short of breath due to her asthma condition.

3.33 The officer returned to the marital address where Karen, Adult D and Child E were and repeated the allegation. Karen denied the assault and stated that it was a verbal argument and Adult G had been 'the more aggressive party.' Both Adult D and Child E agreed with Karen that Adult G had been the more aggressive party and no assault had taken place.

3.34 The officer returned to Adult G's address and informed her and adult B that they would not be arresting Karen. This caused upset with the family and Adult B's brother who had now arrived contacted Cwmbran police station and spoke to the sergeant regarding the incident. As a result of this call the police officer at the address also contacted the sergeant and explained the circumstances, the sergeant agreed with the officer's course of action and confirmed that Karen should not be arrested.

3.35 When an ambulance arrived at Adult G's address she refused any medical treatment. The police officer at the address spoke to Adult B and explained that he would require him to make a statement about the matter and he also made Adult B aware that he (Adult B) would be liable to prosecution if he (Adult B) wilfully stated in it anything which he knew to be false, or that he didn't believe to be true. Adult B declined to provide a statement or to corroborate Adult G's allegations.

3.36 Adult B signed the following statement recorded in the officers notebook,

> "I have had explained to me the consequences about making a written statement about the alleged assault upon my mother [redacted] that is alleged to have happened outside my address this morning and the consequences about making a written statement that is false. At this time I do not wish to make a statement or confirm that such an assault took place. I make this statement of my own free will and have not been placed under any pressure not to make a statement. I have fully cooperated with the police this morning and I have done everything that has been asked of me."

3.37 Adult G refused to make a complaint of assault; declined to sign the officer's notebook and declined to participate in providing information for a DASH risk assessment.

3.38 As a consequence no DASH risk assessment was completed for Adult G, however after all the enquiries it was apparent that Karen was the victim and a DASH risk assessment should have been completed in relation to her as a victim; it was not.

3.39 This incident was discussed at the DACC, although no date is recorded. It is recorded that the DASH risk assessment had been refused and that there had been no previous incidents recorded, this is incorrect.

The DACC determined that this incident should be recorded as medium risk and

monitored through the DACC process. There is no reference to the previous incident or the referral to Torfaen Women's Aid and this should be seen as a missed opportunity.

The lack of identification of the previous incident demonstrates the limited ability to make informed decisions based on flawed information. The significance is that Karen was now being reported as the aggressor and it shows that efforts were being made to discredit Karen and shift the victim status from her to Adult B. This is a clear demonstration of the manipulation of services and controlling behaviour on the part of Adult B, with the support of his family and also indicates the pattern of abuse that had been established in the relationship.

3.40 30th May 2013 Adult B attended his GP and explained that he was feeling depressed, low and flat, not sleeping well had no motivation with an inability to experience pleasure from activities usually found enjoyable. He felt he needed time off work because he could not concentrate. The GP explained to Adult B the importance of keeping going and suggested making a plan for each day to get him out of the house.

3.41 *There is nothing from this appointment that would suggest any issue of domestic violence or abuse. There is nothing recorded within the GP notes that either of the two previous incidents involving the police and Karen was discussed and as a consequence there is no suggestion or signs to indicate domestic violence or abuse as an issue.*

3.42 In early July 2013, Adult B attended the GP and explained he was feeling better; he was now back at work, felt stable and found there was benefit form the current medication. The decision was to continue with the medication and review in three months.

3.43 *Again there is nothing from this appointment that would suggest any issue of domestic violence or abuse. There is no suggestion or signs to indicate domestic violence or abuse as an issue or his*

3.44 **Incident 3:**

On 20 July 2013, Karen contacted Gwent Police, to report that Adult B refused to return her passport; she also said that he had her driving licence. Karen explained that she had been separated from Adult B for three and a half months and that he was refusing to give her a lot of her documents.

3.45 Over the following days a number of contacts were made with Karen and Adult B regarding the passport. Adult B denied the passport was in the house and that he was not keeping it against Karen's will.

3.46 *Officers did not arrest Adult B and following the IPCC investigation the officers stated that they did not think a crime had been committed and so did not have any legal powers to enter and search Adult B's address.*

3.47 *Karen and adult B jointly owned the address, consequently they could have*

searched the address with Karen's consent. In light of the previous domestic incidents and the suspicion that an offence may have been committed officers should have searched that address for the passport and other documents.

3.48 *Gwent Police's current domestic abuse policy dated 1st July 2015 includes the direction that*

> *"The first priority of the attending officer is to ensure the safety of the victim and any other persons present at the incident. In carrying out their duties, officers will take positive action to assess the risks, reduce or remove the threat, secure and preserve evidence, and to identify the needs of victims "*

3.49 *It is clear from the IPCC investigation that they considered 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.*

3.50 *They also added that*

'It is, however, impossible to say whether [Karen's] tragic and brutal death could have been prevented, had Gwent Police dealt differently with [Adult B].

It appears that this incident as with the previous two had been dealt with in isolation. There does not appear to have been any consideration or acknowledgment of the other incidents and so they were unable to recognise the escalating behaviours. Whilst agencies attend individual incidents it is important that they manage those incidents but also recognise the escalation and accumulating risks. The withholding of the passport added to the controlling behaviours exhibited by Adult B and the police lack of positive action could have increased his confidence in continuing with the abuse.

It is important for all agencies to understand the holistic impact of abusive behaviours in their consideration of risk.

3.51 7th August 2013, the day before Karen was murdered adult B attended the GP for a medication review. It is recorded that *'the patients [Adult B] condition improved feeling much better – decided not to take Fluoxetine and been helped greatly by friends and relatives and exercise discussed.'*

3.52 *This is the day before Adult B killed Karen and it would appear to be a standard appointment. There were no domestic violence or abuse risk factors identified or suggested, nor where there any indications of his intentions to kill Karen.*

4 Analysis of involvement

In this section practice is analysed and evaluated against policy and procedure via the IMRs. Further analysis takes place in the following section directly answering the TOR questions.

4.1 Gwent Police

Gwent police were the only agency to have had contact with Karen (the victim) or Adult B (the perpetrator). This contact was limited to three incidents that have been fully examined by an independent review from the IPCC and the findings and comments have been mentioned throughout.

4.2 Aneurin Bevan University Health Board

Karen and Adult B both attended the GP on several occasions. There is nothing in Karen's notes that relate to this review, they are connected to other medical complaints including blood pressure checks and venipuncture.

Adult B had five visits to the GP following the separation of Karen and Adult B focusing on his depression and an initial inability to manage the separation. By the last visit (the day before Karen was killed) it appeared Adult B's condition had improved and he was now coping with the separation. There is nothing in the GP notes to suggest domestic violence and abuse was discussed and there are no signs that could indicate it was a factor.

5 Addressing the terms of reference

5.1 Whether the incident in which Karen died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence.

- The incident in which Karen died was not a one off. There had been three previous incidents although nothing in those incidents indicated the level of violence Adult B used when he killed Karen.

- Due to the circumstances of those previous incidents and the levels of engagement with agencies it is not clear what else could have been done to raise the awareness of services. The behaviours of the police have been examined by the IPCC and their failings have been identified. This does not appear to have been a systemic failure, as the officers have not followed their own guidance, therefore it appears to have been individual failings.

5.2 Whether there were any barriers experienced by Karen or family / friends / colleagues in reporting any abuse in Newport or elsewhere, including whether they knew how to report domestic abuse should she have wanted to.

- There does not appear to have been any actual barriers to report abuse for Karen, however it is apparent that she had suffered abuse within the marriage. This review is unable to ascertain why the abuse was never reported.

5.3 Whether Karen had experienced abuse in previous relationships in Newport or elsewhere, and whether this experience impacted on his likelihood of seeking support in the months before she died.

- Karen had not been in any other relationships, she had been married to Adult B for 27years. In the previous incidents and during the trial it is very clear that Karen was subjected to controlling, coercive and threatening behavior from Adult B throughout their marriage.

5.4 Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Karen that were missed.

- There were no missed opportunities for professionals to routinely enquire as on each occasion Karen presented to an agency it was to report an incident and the Police were involved.

  There was no need for individuals to routinely enquire as Karen gave them all he information on which to base their assessment. The individuals failed to recognise or address these issues and so were unable to make accurate assessments leading to flawed information being passed on. Each incident was dealt with on an individual basis with no consideration of the cumulative effect of the behaviours on Karen or how those behaviours began to shape the overview of Adult B's state of mind.

5.5 Whether Adult B had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

- Adult B had not had a previous relationship.

5.6 Whether there were opportunities for agency intervention in relation to domestic abuse regarding Karen or Adult B.

- Only the identified incidents that Gwent police were involved with and on each occasion they were fully aware of the circumstances. However within the review there is a clear indication where officers failed to adequately intervene and so Karen was not afforded the appropriate level of support and guidance.

5.7 The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city.

- The IPCC investigation found a number of issues within individual officer and corporate governance. Gwent police have revised their domestic abuse policies, the individual officers received training and awareness.

- It has been reported 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.'

This review and the previous IPCC review did not find systemic failings or issues, but that individual officers had not followed appropriate procedures, nor had they adequately identified the risk factors associated with domestic violence and abuse. The follow up PEEL report shows that there is now a clearer understanding of roles and responsibilities and awareness of domestic violence and abuse.

5.8 The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim and perpetrator e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

- None were identified.

5.9 **Family engagement**

How should friends, family members and other support networks and where appropriate, the perpetrator contribute to the review, and who should be responsible for facilitating their involvement?

As previously described, the panel were keen to gather information from family and friends of Karen's to provide a better understanding of the relationship with Adult B and the time preceding her untimely death. Karen's mother and her adult daughter were invited to participate but they have chosen not to be involved and the panel respects their wishes but the option to take part in the review remains open.

Neighbours and colleagues of Karen's were contacted as part of the review process and did not engage with the review. Advice was taken regarding the involvement of their son Child E and it was felt not appropriate to involve him at this time. He is now been supported by social care and the offer to be involved or discuss the circumstance surrounding his mother's death remains. If at some point later he feels able to or would like to discuss the circumstances then he will be supported in that process.

5.10 How matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for this?

- The panel decided that Newport City Council would manage all media and communication matters.

- An executive summary of the review will be published on the One Newport LSB website, with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed through the partnership website, the partnerships operational and strategic domestic abuse groups and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

5.11 **Legal Processes**

How will the review take account of a Coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process?

- There will not be an inquest into Karen's death because all the matters relevant to such proceedings were aired during the criminal trial.

- An IPCC investigation has been concluded and the recommendations implemented

5.12 Does the Review Panel need to obtain independent legal advice about any aspect of the proposed review?

- No conflicts or issues have been identified that would suggest this will be necessary.

5.13 **Research**

How should the review process take account of previous lessons learned i.e. from research and previous DHRs?

- Previous DHR's have been scrutinised during this review to elicit best practice. Research has extended to include academic sources including: Kemshall (2013), Walby and Allen (2004); Bain (2008); Munro (2007); Nash (2010); Brandon et al (2009); Barry (2009); Barber et al (2008), Liem, Hengveld and Koenraadt (2009).

Specific documents have also been considered

- The home office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Call an End to Violence Against Women and Girls – HM Government (November 2010)
- Barriers to Disclosure – Walby and Allen, 2004.
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007.
- 'Suicides and suicide attempts following homicide' Barber et al, 2008
- Domestic homicide followed by parasuicide Liem, Hengveld and Koenraadt, 2009.

5.14 **Diversity**

Are there any specific considerations around equality and diversity issues, such as ethnicity, age and disability that may require special consideration?

- None have been identified

5.15 **Multi agency responsibility**

Was Karen or Adult B subject to a MARAC/ MAPPA?

- Neither Karen nor Adult B was subject to MARAC or MAPPA. During the IPCC investigation it was identified that Karen's risk assessment for incident 1, should have been high and this would have triggered a referral to MARAC however the assessment was reported as standard consequently a referral did not take place and was a missed opportunity.

  There was a second opportunity to assess the risk, however due to the flawed information the risk was not fully identified and so no accurate assessment could have been made, in the circumstances this would have been high risk and so trigger a referral for MARAC.

5.16 Did Karen have any contact with a domestic violence organisation or helpline?

- Karen had contact with Newport Women's Aid and was provide with details of the support services they could offer her. Karen agreed to call in to access services the following week but it appears that contact was not made.

5.17 Consideration should also be given as to whether either the victim or the perpetrator was a 'vulnerable adult'

- Neither Karen or Adult B were vulnerable adults

5.18 Were there any issues, in communication, information sharing or service delivery, between services?

- Only Gwent police were involved and the relevant incidents (Incident 1 and 3) were discussed at the Domestic Abuse Conference Call (DACC).

  As described earlier the DACCs are managed using a SharePoint site, which partner agencies can access and a dedicated Domestic Abuse Investigation Unit (DAIU) Detective Constable or Police Constable chairs the DACC. As a result all agencies were aware of the incidents involving Karen and adult B.

  The unfortunate flaw in the system is that is reliant on the information provide to the meeting. This information was flawed and so no accurate assessment was made.

5.19 **Individual agency responsibility**

Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults, and with wider professional standards?

- The IPCC have conducted a thorough and independent review into the actions of Gwent police and have published their findings. There were a number of recommendations for individual officers and the Gwent police that have now been implemented.

5.20 Was the impact of domestic violence on the victim recognised?

- Although Gwent police did recognise domestic abuse, the full impact was not recognised.

5.21 Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

- The review comments on this throughout. The review has identified that an assessment was not adequate and therefore appropriate services were not offered or provided.

5.22 Was there sufficient management accountability for decision-making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

- On the basis of the information available for the review there was sufficient accountability. However as has been articulated, there was an occasion whereby a lack of knowledge and incorrect judgments caused a failure to act appropriately.

6 Lessons to be learned from the review

6.1 There are a number of lessons to be learned and those have been implemented within the policy of Gwent police.

6.2 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.

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

6.4 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.

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

6.6 Wherever firearms are present in an incident of domestic abuse they should be considered for seizure and should always be seen as a high risk factor and a potential for causing serious harm.

7 Conclusions

7.1 There is nothing in the review that indicates the homicide could have been predicted or prevented.

7.2 Karen was escaping an abusive marriage and reported several incidents indicating patterns of behavior from her abuser. Those behaviours should have been identified and managed to the appropriate level, which they were not.

7.3 Gwent police have now changed their policies and have highlighted the need for positive action in terms of managing domestic abuse incidents, particularly when there are firearms in the household or there is access to firearms.

8 Recommendations

8.1 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. Feedback has also been provided to the agencies involved in this review.