DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Safer Monmouthshire -

Community Safety Partnership of Monmouthshire Public Service Board

Victim: “Belle” – Date of death - June, 2015

Report Author: Christine Edmondson

Date report completed: October 2017

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THE REVIEW PROCESS

This summary outlines the process undertaken by Monmouthshire Public Service Board domestic homicide review panel in reviewing the homicide of Belle, who was a resident in their area. The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members:

Victim - Belle – aged 35 when she was killed

Perpetrator - Howard – aged 52, Belle's husband

Belle and Howard were both British

Initials were used to protect the identities of other relevant parties as below:

- Mrs M D (Belle's mother) & Mr B D (Belle's step-father)
- Mr D B (Belle's father) & Mrs K B, (Belle's step mother)
- Mrs J S, (Belle's aunt) & Mr K S (Belle's uncle)
- Mrs M C (Belle's aunt)
- Ms G H (Howard's daughter, Belle's step daughter)
- Ms D H (Howard's sister) & Ms S (Howard's niece)
- Ms A M (Howard's second wife)
- Mrs A M – Belle's friend and employer
- Ms H M - Belle's friend and colleague
- Mr MB – Belle's partner
- Dr R R – GP – Vauxhall surgery
- Ms C W - Belle's solicitor
- Mr P B – (B & Son Ltd, Funeral Directors)
- DC C O – Gwent Police Family Liaison Officer
- DCI N B – Gwent Police Senior Investigating Officer

An inquest was held on 11th November 2015 and the coroner's verdict was that Belle had been unlawfully killed and that Howard had committed suicide.

The process began with an initial meeting of Monmouthshire Local Service Board in February 2016 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Belle and /or Howard prior to the point of death were contacted and asked to confirm whether they had involvement with them. Four of the five agencies contacted confirmed contact with Belle and /or Howard and were asked to secure their files.

CONTRIBUTORS TO THE REVIEW

Agencies:

Monmouthshire County Council – Panel membership, administrative support, information

Aneurin Bevan University Health Board - Panel membership, IMR, information

Gwent Police - Panel membership, IMR, information, reports, investigation evidence

National Probation Service - Panel membership, IMR, information

Cyfannol Women's Aid - Panel membership, reports, information

Royal United Hospitals Bath - information

Radio Gloucestershire – information, recording of radio programme

IMR Authors:

Aneurin Bevan University Health Board - Linda Brown, Head of Safeguarding

Linda had no involvement with any of the contacts between ABUHB staff and Belle and Howard. As Lead Nurse for Safeguarding, she was not in a supervisory role for any of the relevant staff.

Gwent Police – Joanne Bull – Chief Inspector, Operations

Joanne had no involvement with any of the contacts between Gwent Police and Belle and Howard. Joanne works in a different role and was not in a supervisory role for any of the relevant officers.

National Probation Service – Debbie Atkins, Team Manager

Debbie had no involvement with any of the contacts between NPS staff and Howard. She was not in a supervisory role for any of the relevant staff or teams.

Individuals

- Mrs M D (Belle's mother) - information via meetings, emails and telephone calls
- Mr B D (Belle's step-father) - information via meetings, emails and telephone calls
- Mr D B (Belle's father) – information via meetings and telephone calls
- Mrs K B, (Belle's step mother) - information via meetings and telephone calls
- Mrs J S, (Belle's aunt) – information via meeting, emails and telephone calls
- Mr K S (Belle's uncle) - information via meeting, emails and telephone calls
- Mrs M C (Belle's aunt) - information via telephone calls
- Ms G H (Howard's daughter, Belle's step daughter) - information via meeting, emails, text messages and telephone calls
- Ms D H (Howard's sister) - information via meeting, emails and telephone calls
- Ms S (Howard's niece) - information via meeting
- Ms A M (Howard's second wife) - information via telephone calls
- Mrs A M – Belle's friend and employer - information via meeting, emails and telephone calls
- Ms H M - Belle's friend and colleague - information via meeting
- Mr MB – Belle's partner - information via telephone calls
- Dr R R – GP – Vauxhall surgery – information via telephone calls
- Ms C W - Belle's solicitor – information via telephone calls
- Mr P B – (B & Son Ltd, Funeral Directors)

- DC C O – Gwent Police Family Liaison Officer- information via meetings, emails and telephone calls.
- DCI N B – Gwent Police Senior Investigating Officer - meeting, emails and telephone calls, provision of evidence files.

THE REVIEW PANEL MEMBERS

Christine Edmondson	Independent Chair - report author	Independent
Rebecca Haycock	Regional Adviser for violence against women, domestic abuse and sexual violence (VAWDASV)	Gwent
Will McLean	Head of Governance, Improvement and Engagement	MCC
Jane Rodgers	Head of Children's Services	MCC
Linda Brown	Lead for Safeguarding (till 19.8.16)	ABUHB
Annette Morris	Lead for Safeguarding (from 19.8.16)	ABUHB
Bronwen John	Head of Partnerships and Networks	ABUHB
CI Joanne Bull	Chief Inspector, Operations	Gwent Police
Debbie Atkins	Team Manager	National Probation Service
Helen Swain	Chief Executive Officer	Cyfannol Women's Aid

The Panel first met on 15th April 2016 and on 4 subsequent occasions. None of the panel members had any professional involvement with either Belle, Howard or any of their family members.

AUTHOR OF THE OVERVIEW REPORT

Christine Edmondson, the chair and report author of this review is a freelance portfolio worker with a wide knowledge of local public service provision. Much of her work is as an independent person – she was for four years the independent chair of Monmouthshire Local Service Board, she was for eight years an independent member and chair of the Care Council for Wales Registration and Conduct Committees and also an independent lay member of the General Teaching Council for Wales and Education Workforce Council Professional Conduct Committees, and is currently an independent lay member of the Gwent Police Misconduct Panels. She has worked independently in a variety of roles for fourteen years after a career in senior management in the public and voluntary sectors.

TERMS OF REFERENCE FOR THE REVIEW

Purpose of the panel

- To establish the facts about events leading up to and following the deaths of Belle and Howard
- To examine the roles of organisations involved in the case, the extent to which Belle and Howard had involvement with those agencies, and the effectiveness and appropriateness of single agency and partnership responses to the case.
- To establish whether there are lessons to be learned from this case about the way in which local organisations and partnerships worked individually and together in carrying out their responsibilities to safeguard the wellbeing of those deceased.
- To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.
- To identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Monmouthshire in order to improve our work to better safeguard victims of domestic abuse.
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The scope of the panel review

- To produce a chronology of events and actions leading up to, and in relation to the deaths of Belle and Howard from the period from 1st April 2006 until 19th June 2015 * (with earlier information if needed and available) seeking information from:
    - Organisations who had contact with them
    - Local community organisations
    - Their family, friends and employers

- To review current roles, responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what might have happened to result in a different outcome.
- To review this against what actually did happen to draw out the strengths and weaknesses and other possible practice.
- To review national best practice in respect of protecting adults from domestic abuse
- To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse at local, regional and national levels.

The review will also specifically consider:

- Whether family, friends and employers are prepared to participate in the review.
- An assessment of the extent to which family and friends were aware of abusive or concerning behaviour from the perpetrator to the victim (or other persons)
- An assessment of the extent to which family and friends were aware of any abusive or concerning behaviour from the victim to the perpetrator (or other persons).
- A review of any barriers experienced by the family in reporting abuse or concerns, including whether they (or the victim) knew how to report domestic abuse had they wished to.

- A review of any previous concerning conduct or a history of abusive behaviour from the perpetrator and whether this was known to any agencies.
- Whether it would have been possible to conduct a Multi-Agency Risk Assessment Conference.
- An evaluation of any training or awareness raising requirements necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in Monmouthshire.
- Whether the perpetrator had any previous history of abusive behaviour towards the victim, or any previous or current partner and whether this was known to any agencies
- To review communication to the public and non-specialist services about available specialist services related to domestic abuse or violence.
- Whether the work undertaken by the services in this case is consistent with their professional standards, protocols, guidelines, policies and procedures.
- Any other information that becomes relevant during the conduct of the review

SUMMARY CHRONOLOGY

A summary of the key facts from the background and combined chronology of agency interaction with the victim and perpetrator and their family; what was done or agreed. The summary should provide sufficient facts to give context for the key issues arising from the review. Background information which also gives context to the victim's and perpetrator's story.

2006 – unspecified date - Belle and Howard met and began an intermittent relationship

13th May 2008 – First contact with police after a member of the public reported a “violent argument” – both refused to explain and Belle was taken to her mother’s house for the night.

24th January 2009, Belle attended A & E service in Bath with “left sided rib pain” .

16th February, 2009, Belle’s mother called the police to report that Howard had threatened to commit suicide – she also reported several past threats and attempts – denied by Howard.

March 2009 – Howard failed to attend a mental health appointment – this was to occur regularly despite many reminders.

29th April 2009 – Police called by a member of the public reporting shouting, screaming, lots of noise, a recurring problem – described as a “minor argument by Belle and Howard, who both refused to complete a domestic violence recording form (DV1).

24th July 2009 - Belle attended A & E service in Royal Gwent, Newport saying she had tripped and banged her head after an evening’s drinking.

14th November 2010 – 999 call from neighbour – Belle told police that Howard had held her down and attempted to strangle her – police found Howard’s injuries were worse than Belle’s, so he wasn’t charged. Further help declined by both.

Late 2010 / early 2011 Belle and Howard split up.

26 February 2011 – Police (from outside the Gwent Police area) attended after a 999 call from a neighbour reporting Belle screaming as Howard tried to force his way in through a window. He left before the police arrived.

10th April 2011 – Police attended incident of fight between Howard and Belle's new partner. No charges.

Late 2011 – Belle became engaged to her new partner.

Early 2012 – Belle and Howard resumed their relationship

1st June 2012 – Belle and Howard married

31st March 2013 – Belle called 999 to report a "verbal argument" with Howard and said she "wanted him out of the house". Belle taken to her mother's house for the night.

13th May 2013 – Belle and Howard had a violent argument in the car park of the hotel where Belle works. Howard hit Belle and was arrested and later convicted of assault.

29th May 2013 – Howard commenced a 12-month community order

9th August – Howard commenced a "Respectful Relationships" course as part of the above order

6th March 2014 – 999 call made from the couple's house during a violent argument. Belle refused to complete a DASH form and went to her mother's house for the night.

7th March 2014 – Case discussed at a Domestic Abuse Conference Call and graded medium.

28th May 2014 - Howard completed his community order

April 2015 – Belle entered a relationship with a new partner – friends describe her as very happy from this time.

Early June 2015 – Howard's second wife, A, heard that Belle may be planning to leave Howard. She has been attacked by Howard after leaving him and contacted Belle to warn her of the danger she might face in leaving.

18th June 2015 – Belle visited a solicitor with her mother for advice about leaving Howard. Both her mother and the solicitor urge her to leave at once.

18th/19th June 2015 - Howard attacked Belle with a kitchen knife, causing fatal wounds and then stabbed himself several times and also died. Belle's clothing and other possessions were found to be packed into bags and suitcases in the kitchen of their house.

RECOMMENDATIONS FROM THE REVIEW

N.B. The individual recommendations have been suggested by the agencies involved in the review but have been wholly discussed and are supported by the DHR panel. The DHR panel recommendations have been drafted by the panel which includes representatives from all the participating agencies.

Aneurin Bevan University Health Board Recommendations

Recommendation ABUHB 1

In line with the National Training Framework (NTF), ABUHB ensure Ask and Act training is implemented across own organisation

Recommendation ABUHB 2

ABUHB ensure Ask and Act training focused initially on targeting Primary Care Services, specifically GPs.

Recommendation ABUHB 3

Domestic Abuse included within the planned Continuous Professional Development (CPD) sessions for GPs on Safeguarding.

Recommendation ABUHB 4

The WARRN (Wales Applied Risk Research Network) training package is reviewed to include the importance of completing the WARRN as soon as possible during the assessment process for all people accessing a Community Mental Health Team (CMHT).

Recommendation ABUHB 5

An alert is sent to Community Mental Health Teams (CMHTs) teams reminding them of the importance of completing an agreed risk assessment at initial assessment for all people accessing a CMHT, and a documented risk assessment is completed for all people accessing Primary Care Mental Health Support Services (PCMHSS).

Recommendation 6

All Community Safety Partnerships, police and other agencies have clear, lean protocols to enable Domestic Homicide Reviews to commence as quickly as possible after death.

Recommendation 7

A briefing note to be compiled to raise awareness of coercive and controlling behaviour and to be signposted to Gwent GPs.

Recommendation 8

All practising solicitors in Gwent dealing with marital and family issues to be signposted to information to highlight the dangers are trained to understand the dangers that may be faced by a woman leaving an abusive relationship.

Recommendation 9 (a)

Initial interviewing of suspected victims of domestic abuse, whether violence or coercive and controlling behaviour always takes place out of sight and hearing of the suspected perpetrator.

Recommendation 9 (b)

Intervention visits e.g. by Gwent Police Domestic Abuse Officers or by National Probation Service officers take place in a neutral location, well away from the suspected and/or convicted perpetrator. Such visits are always made after Community Orders finish and following incidents where police have attended.

Recommendation 10

All hospitals, clinics, health centres and GP surgeries in Gwent be provided with public information material offering signposting and information regarding domestic abuse including coercive and controlling behaviour.

Recommendation 11

When family members, friends or other personally interested parties appear at the scene of a homicide, a Duty Supervisor is always appointed to support them, act as an information conduit and explain crime scene procedure. They also ensure that other close relatives are promptly informed either by themselves or by other officers.