Diogelu Gwent
Gwent Safeguarding

VAWDASV

Domestic Homicide Review using the Adult Practice Review (D-APR) Methodology

GWASB 1 / 2018

Brief outline of circumstances resulting in the Review

Legal Context
In 2011 Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). A "domestic homicide review" is now required in circumstances where 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 household as himself

Overall responsibility for establishing a review rests with the local Community Safety Partnership (CSP) or Public Services Boards (PSBs) and will establish a multi-agency review Panel to undertake the review. Reviews are held with a view to identifying the lessons to be learnt from the death.

In October 2017, Assistant Chief Constable Liane James commenced a secondment to Welsh Government to undertake work on the Violence Against Women Domestic Abuse and Sexual Violence agenda. A particular focus was to look to: "Assess the effectiveness of the Welsh Government, Community Safety Partnership and other public services response to Domestic Homicide Reviews and make recommendations as to how they might be fully acted upon by Welsh public services". This work had been informed by Robinson et al. (2018). Findings from a thematic analysis of reviews into adult deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews. Cardiff University, available at http://orca.cf.ac.uk/111010

This DHR was conducted using the Adult Practice Review (APR) methodology. This was a Pilot in agreement with the Home Office, Monmouthshire PSB and Welsh Government, as a result of their review findings.

A separate report about the pilot process and governance arrangements was provided to the Home Office and Welsh Government. The Terms of Reference, including flow charts for the methodology used for the review, are at Appendix 1.

Circumstances Resulting in the Review
This D-APR concerns a married couple. For the purposes of the report, they will be referred to as Adult A (the wife and victim) and Adult B (her husband).

In 2016 Adult A moved into a care home for dementia. In 2017 Adult B took his wife home for the day. He killed her by administering medication prior to suffocation and then took his own life by hanging. The Care Home had contacted the Police after Adult A had not returned as expected which was unusual.

The Police referred the case to the PSB in October 2017 who agreed that this case met the criteria for a DHR. It was discussed at the joint regional case review group in February 2018. In conjunction with the Home Office, Monmouthshire PSB and Welsh Government it was agreed that this review would be carried out using the Adult Practice Review methodology as a pilot.

In line with APR methodology, the time period for the review was agreed as from 4th October 2015 to 4th October 2017. Information was obtained prior to October 2015 to inform the review.

Adult A and Adult B met at University. They were married with two grown-up children and grandchildren. They had successful careers in senior roles within Education and had enjoyed active lives with shared interests such as gardening, walking, cooking and travel.

Adult A was diagnosed with Parkinson's seven years after her retirement. Ten years after her initial diagnosis she developed dementia (as a result of the Parkinson's). Adult B had also had chronic health problems but this did not affect his employment, rather it meant prior to developing Parkinson's and dementia, Adult A was seen by the family as his carer.

Information prior to October 2015. Following her diagnosis, Adult A was seen by a Parkinson's Nurse Specialist for regular check-ups every six months. The first contact with Social Services was in January 2015. Up to this point, they had managed her condition at home.

There were two significant events during the period of the review and one prior to that date.
The first event was in January 2015 when they were assessed for additional support. The records note that Adult A had insight into her dementia and that as a couple they were keen to maintain her independence. Adult B was noted to be her main carer but they had friends who visited with whom they spent time. Following assessment,, they had carers three times a week to support in maintaining independence.

The second significant event was during April 2016 when they were finding it increasingly difficult to manage at home. By this time there was some dementia that resulted in hallucinations and night terrors. Her general mobility had also deteriorated and so a period of respite care was arranged. In the event, following the period of respite, this was extended and she remained at the care home. The placement was self-funded and at this point input from social services ended.

The final event was the time up to her death. Her condition continued to deteriorate and she developed further problems with swallowing. This meant that the care home started to discuss the option of moving Adult A to the Nursing floor of the home. Neither Adult A nor Adult B wanted to move as she was reasonably settled and they had a garden outside her room which they both enjoyed maintaining.

Adult A as described by her son and friend.

Both children were contacted and Adult C agreed to contribute to the review and was spoken to at length. In addition, a neighbour and friend (Adult D) were also visited and spoken to at length. Adult C was asked if as a family they had a name they would like to use for the report and said they were Mum and Dad and no pseudonym was chosen.

Adult A was born in 1946 to a very affluent family. She had one brother and left the family home to go to university where she met Adult B. At this point she became estranged from her family as they did not approve of him and felt that he was beneath the social class that she was expected to marry into.

After University Adult A was employed in education as was Adult B, and they both had successful careers. They had two children of whom they were immensely proud, who have successful careers.

After the birth of their first child Adult B took Adult A to her family home in the hope that her family would accept her and their grandchild. Their son informed us that she was told that her mother would not see her and she was asked to leave.

Adult C described Adult A as always being around for them as children and that they had a happy childhood and never wanted for anything whilst not being spoilt. Adult A was seen by family and friends as the carer for Adult B who had a chronic health problem and when she was diagnosed with Parkinson's this changed.

Adult C described a happy, close-knit home, with loving supportive parents who encouraged them both in all their interests. They enjoyed family holidays together.

Adult C described both parents as enjoying spending time with their grandchildren and was always supportive of them.

Adult D and her husband had known Adult A and Adult B for over 30 years. They were neighbours and had children of a similar age. They remained close friends even when Adult D and her husband moved away.

Adult D described the husbands as enjoying DIY together which they did for each other and neighbours. Adult A had lots of friends who she would spend time with alone although she spent most of her time with Adult B as they had shared interests and enjoyed one another's company. Adult D said they were a very private couple and that Adult A was more outgoing. When Adult A was no longer able to drive, Adult B would take her to see Adult D and go out so they had time alone to catch up.

Adult D described that they would have meals together as families and spent New Year's together. They spent a lot of time together as a couple but did spend time with their own friends. They were organised and careful. Adult D described that Christmas presents were always bought on the last day of the school holidays for the following year. Both were good cooks and Adult B, in particular, would cook and take them meals when Adult Ds husband was terminally ill.

Adult A had told Adult D about her diagnosis on an afternoon out and shortly afterwards Adult D's husband became ill so they supported each other. Adult D said that she saw Adult A on the Monday before she died and described Adult B as sad and frustrated but that he never complained.

Adult D described them as great teachers, very organised, really good friends who would always do the right thing and who enjoyed being together. At the Learning Event, the Care Home staff described Adult A as full of fun yet very caring. She would ask the staff about their children and then recall when they had tests or an exam and demonstrated self-awareness of her own condition at times which would fluctuate due to her dementia. When Adult D visited Adult A at the Care Home they would go to the Bistro and there would always be laughter, which was replicated with other friends.

Themes and learning points

As part of this D-APR, a Learning Event was held engaging practitioners involved with the couple.

The reviewers would like to thank all those who attended the learning event and for their contribution to the learning from this review. The discussions and suggested learning from the learning event reflected the thinking of the panel.

There were three overarching themes identified which have informed the learning points from this review.

Theme 1 – Organisation vs Coercion and Control

The Panel was mindful that coercive control is a significant factor in predicting DHRs and as such wanted to ensure that this was considered and explored by the panel and at the learning event.

The panel was open to exploring whether the level of organisation shown by Adult B was, in fact, a sign of coercion and controlling behaviour (Section 76 of the Serious Crime Act 2015). Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship. For the purposes of this offence, the behaviour must be engaged in 'repeatedly' or 'continuously'. Another, separate, element of the offence is that it must have a 'serious effect' on someone and one way of proving this is that it causes someone to fear, on at least two occasions, that violence will be used against them. There is no specific requirement in the Act that the activity should be of the same nature. The prosecution should be able to show that there was intent to control or coerce someone. (https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship)

Within agency records, there are typed accounts by Adult B regarding Adult A. The Mental Health team who saw them at home report that for each visit Adult B would have typed a record for them. It would include what Adult A's function had been like and her behaviour and any changes that had occurred. Each record included her medication.

Within the health records there was evidence of reports for hospital visits and the care home also reported the use of reports by Adult B.

Adult B was meticulous in his record-keeping and the care home described that he had a lever arch file with all his reports and documents pertaining to the care home. Adult B would ask carers about an element of care Adult A had received and would then ask the same question of another member of staff. To manage this, the care home identified senior carers that Adult B would liaise with. They said that they recognised that this was Adult B's way of checking for consistency as he had high expectations of the care home staff and expected them to know her well.

He also carried out extensive research on staffing levels in all the care homes for this group which he shared with senior managers. He told staff that he did this to help them get more staff.

The Mental Health team described Adult B as methodical and that he liked things to be in order. Adult A's diagnosis made this difficult and he told staff that he felt the situation was getting out of control. The team described that for Adult A the management of her disease was to manage the environment. This meant that on some days actions would help but not on others which Adult B found difficult. They described Adult B as a practical, intelligent, black and white thinker who would not have been able to cope with the disarray.

All agencies represented noted that Adult B was meticulous, very particular and organised about Adult As care needs, but all noted that this was not unusual behaviour for carers.

Carers describe occasions when Adult A would behave in a way that she recognised could embarrass Adult B. Adult A developed a friendship with another resident. They described Adult A as having fun and on one occasion she was found turning all of the chairs upside down in the living room. On another occasion, she piled up a number of pillows so that she could jump on them. Care staff reported that she would tell them she was tidying up or doing things because she could. Adult A was however aware that her actions could be embarrassing to Adult B and so asked staff not to tell him

When Adult A asked the care home not to tell Adult B some of the things she had done staff described this as Adult A not wanting Adult B to be embarrassed or upset and not out of fear.

Adult B was organised but it was felt that this had always been the case and did not change after Adult A's diagnosis.

Adult C said that both parents were organised and that Adult A was the planner and would decide on a Holiday destination and Adult B would then research and organise the holiday.

Adult A was seen alone by professionals and her friends and there is no evidence that Adult B tried to prevent this, rather he would take her to see friends and leave her with them. When in the care home, he arranged for a friend to visit on the days that he did not so that she would not be alone. Within a coercive and controlling relationship, there is often isolation from friends and prevented from seeing professionals alone which was not the case.

While it is clear that Adult B did like to control the care Adult A received, the staff at the learning event all said that anything he did was for his love of Adult A and would have been what he thought was best for her. This was a view supported by Adult C and Adult D. They also noted that they had other family members like this and that while at times challenging it was not unusual.

Panel members discussed coercion and control at each meeting to ensure that this was considered based on the information provided.

Good Practice
The staff ensured that Adult A saw professionals alone. Adult A's determination was put into practice by care staff.

Learning Point 1
Staff need to have an understanding of coercion and control and how this may present in those they have contact with. Training for this to include Care Home Staff. Consider the work of the Office of the Older Peoples Commissioner for Wales as a mechanism by which coercive control might be raised in Care Homes.

<u>Theme 2 – Professionals understanding the role of and needs of the family</u>
From the learning event, it was clear that the professionals involved knew Adult A and Adult B well throughout their involvement. All agencies described Adult B as very private but wanting the best for Adult A at all times.

When they first had carers in 2015 it was acknowledged that this transition had been really challenging for both of them and that they both required support to accept professionals into their home. The care agency took time to find carers that Adult A and Adult B could accept, however, once they had, they developed a really good relationship with the 2 main carers.

The professionals visiting noted the positive impact that the carers had made. All agencies noted how meticulous Adult B was and that the home was immaculate. They liked to cook and the carers supported Adult A to do this. Her symptoms meant that when she did any cooking or baking she was not able to stay clean, yet carers acknowledged that Adult B would support this activity. Both Adult A and Adult B were keen to ensure that Adult A maintained daily activity skills such as dressing and making tea even though this would often require more time.

The Mental Health Team who saw Adult A and Adult B at home noted that they both struggled with the loss of roles and the lives they had led. Both were aware of the impact on the other. Professionals described that on visits they would attend in pairs so that one member of staff would see Adult A, and

the other Adult B so that they had time alone to express their concerns. They describe the need to support families as much as the patient.

Neither Adult A nor Adult B wanted her to leave the family home and initially, this was for respite but became a permanent move. Adult A told staff that while she would not have chosen to go into a home she recognised that they could no longer cope at home and that this was the right decision at that time.

This support and recognition of what families need were evident in the care home as well. Staff said that had they concerns about a partner they would refer to social services using a Duty to Report (Social Services and Well-Being (Wales) Act 2014). Likewise, the panel heard that should there be no family involved advocacy services would be sought to ensure the needs of the person were at the centre.

On admission, staff reported that Adult B provided detailed information about the care Adult A required in the form of a detailed care plan. While Adult A did have dementia she did up to her death have insight.

Adult B would visit daily at the same time and when present followed the same routine. Staff supported this but on occasion, Adult A would choose not to return to her room or would want to take part in an activity and so Adult B would wait in her room. Staff recognised that Adult A was more outgoing and when Adult B was not there they would support her to attend a variety of activities.

From the agency timelines, there was an account of the events and actions taken. From this, it was clear that Adult B was meticulous and organised. Up to her diagnosis Adult A too was described as very organised. At the learning event, it felt as if Adult A came alive and her insights into her own life and the impact of her diagnosis came through the discussions she had with staff. This came through from all agencies.

At the learning event staff noted that following admission to the care home social services input stopped as they were funding the placement themselves. They relied on Adult B for the care plan, and the home acknowledged that this had been very detailed, normally this would be from the Social Worker. Had Adult B not been as meticulous there may have been gaps in the care planning that could have impacted on the care Adult A received.

When they first received care in 2015 Adult B was given information about support groups which at that time he declined. While in the care home Adult B was an active member of a relative support group which demonstrates a shift in his thinking and ability to accept support. Staff report that Adult B found it helpful to talk to a relative who had similar experiences, both had loved ones with dementia.

Staff at the learning event felt that this was a potential risk as many of the external support mechanisms were stopped at the point that Adult A entered the care home.

Adult B's change in role was acknowledged by practitioners, particularly the move to the care home. Up to this point, Adult B had been Adult A's carer and had a voice and support from the paid carers. Staff at the learning event queried whether a carer's assessment would have been helpful for Adult B. A carer's assessment would have identified practical care and support but would not have addressed the emotional impact of managing the loss.

Good Practice

All professionals and carers recognised that they both had needs and all described how they balanced the needs of both while ensuring Adult As needs took precedence.

Adult B was identified by staff as someone who may benefit from a support group. While he did not take up the offer in the community he did in the care home.

Learning Point 2
When residents enter a care home on a self-funding basis, staff rely on the family for information. Care home staff should with the permission of the person contact the Local Authority of residence to establish previous care and support needs.

Theme 3 – Loss following a diagnosis of a life-limiting condition.

Any diagnosis such as Parkinson affects not only the person but the whole family. Adult C described that they had both worked and been very active and enjoyed travelling. They had planned to travel extensively following their retirement. This diagnosis will have changed those plans and been a loss for each of them.

They used to visit their children and enjoyed spending time with them but following Adult A's diagnosis this became more difficult and in the later years, they could no longer travel. Both children had busy lives and so were unable to visit as often and they both missed that contact.

Their friend described them as a devoted couple who had many shared interests but whom both had friends they would see alone. As Adult A's condition deteriorated she was unable to visit friends independently. Adult B lost some independence due to Adult As care needs.

Although they managed for 10 years without additional support in the home this was a big change for them both. Suddenly a very private couple had strangers providing intimate care in their home. This was a really difficult transition which they managed with the support of carers and Health Staff.

When they were no longer able to manage at home and Adult A needed full-time care this was another loss for each of them. The agencies involved described the loss that they both felt and how they tried to support them.

Adult B was very ordered in his home and work life, and in his thought processes and actions. Staff described the need to be able to explain to him why her behaviours were changing and the physiological cause. They acknowledged that he was able to process the "why" but found the emotional impact much more difficult to manage. Adult B would need time and space to be able to understand these changes in behaviour. He described to a health professional that it felt as if the disease was working against him.

The Mental Health team describe the need to balance the autonomy of the patient and the autonomy of the carer. This meant that Adult B's autonomy was not looked at in the same way once Adult A moved into the care home and his status of carer changed. For Adult B his role changed from being her carer and making decisions to a husband who would advocate her needs to staff but no longer provided the care. This was further compounded in that the children had joint Lasting Power of Attorney. When Adult A lacked Capacity for a decision the children would be the point of contact, although they would refer back to their father, stating that he would know what was needed.

Adult A was not always able to articulate her needs and so Adult B would. Adult B became an advocate for Adult A. The care home gave an example of Adult B choosing her menu each day. He would always choose a healthy option based on their life together. However, her condition resulted in some weight loss and so a high-calorie diet was indicated. Adult B saw this as unhealthy and felt that's staff were not listening. However, when he spoke with the GP and was given a medical explanation he was able to accept this.

Good Practice
The staff listened to both of them and would acknowledge Adult B's concerns but would always act on Adult As wishes.

Learning Point 3

Recognising the loss that Carers experience when they transition from being a carer to an advocate.

Other Learning
On the day of her homicide staff contacted Police when Adult A did not return as expected. When contacting the Police they had initially been advised that Care Home staff should visit the family home. A subsequent call led to the Police visiting the home. At the learning Event, it was clear that Care Home staff gave a factual account but were not aware of the language to use that would articulate the risk to Police. In this case, Adult B was meticulous about the care Adult A received and so she would not return late and would certainly not miss medication. Care Home staff expressed concern that had they did not know what they should tell Police in cases when residents do not return. In this case, an earlier call would not have affected the outcome.

The panel was mindful that a Care Home may never experience events such as the homicide of Adult A and as such any recommendation needs to be proportionate to the risk. The Police will have more expertise in identifying risk factors when a person does not return as planned.

For the staff involved the homicide of Adult A was a very difficult time. They knew Adult A and Adult B well and had been shocked by what had happened. They spoke of their sadness at not being able to talk about what had happened and would have liked the opportunity to attend the funeral. The Learning Event provided a forum for staff to talk about what had happened and what if anything they could have done that would have made a difference. Staff from the Care Home stated that they were offered support which is good practice. They reported that they had found the multi-agency forum of the learning event very supportive.

Following the unexpected death of a child or adult, there is the option to convene an Immediate Response Group that has representation from all core partners and identifies any support required for individual agencies.

Good Practice
Care Home staff were offered support immediately and after the event.

Learning Point 4
Police to facilitate risk assessment when Care Home report missing residents.

Learning Point 5
To consider developing an Immediate Response Group that would identify actions required following the homicide of a person in receipt of care.

<u>Good Practice / Improvements already made</u>

- The staff ensured that Adult A saw professionals alone. Adult A's determination was put into practice by care staff
- All professionals and carers recognised that they both had needs and all described how they balanced the needs of both while ensuring Adult As needs took precedence
- Adult B was identified by staff as someone who may benefit from a support group. While he did not take up the offer in the community he did in the care home
- The staff listened to both of them and would acknowledge Adult Bs concerns but would always act on Adult As wishes
- Care Home staff were offered support immediately and after the event

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SCB and its member agencies and anticipated improvement outcomes:-

1. **Learning Point 1**

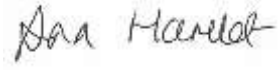
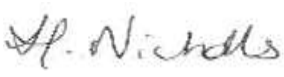
- **Staff need to have an understanding of coercion and control and how this may present in those they have contact with. Training for this to include Care Home Staff. Consider the work of the Office of the Older Peoples Commissioner for Wales as a mechanism by which coercive control might be raised in Care Homes.**

2. **Learning Point 2**
   - **When residents enter a care home on a self-funding basis, staff rely on the family for information. Care home staff should with the permission of the person contact the Local Authority of residence to establish previous care and support needs.**
3. **Learning Point 3**
   - **Recognising the loss that Carers experience when they transition from being a carer to an advocate.**
4. **Learning Point 4**
   - **Police to facilitate risk assessment when Care Home report missing residents.**
5. **Learning Point 5**
   - **To consider developing an Immediate Response Group that would identify actions required following the homicide of a person in receipt of care.**

Appendix 1: Terms of Reference

Statement by Reviewer(s)

Reviewer 1	**Reviewer 2 (as appropriate)**
Statement of independence from the case *Quality Assurance statement of qualification*	**Statement of independence from the case** *Quality Assurance statement of qualification*
I make the following statement that prior to my involvement with this learning review:- ▪ I have not been directly concerned with the child or family, or have given professional advice on the case ▪ I have had no immediate line management of the practitioner(s) involved ▪ I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review ▪ The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	I make the following statement that prior to my involvement with this learning review:- ▪ I have not been directly concerned with the child or family, or have given professional advice on the case ▪ I have had no immediate line management of the practitioner(s) involved ▪ I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review ▪ The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference

Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	
Name *(Print)*	Ann Hamlet	**Name** *(Print)*	Mary Ryan
Date	16-04-2019	**Date**	16-04-2019
Chair of Review Panel *(Signature)*			
Name *(Print)*		Heather Nicholls	
Date		16-04-2019	

D-APR Process

To include here in brief:

- The process followed by the SCB and the services represented on the Review Panel
- A learning event was held and the services that attended
- Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them

Gwent Safeguarding notified Welsh Government and Monmouthshire PSB notified the Home Office that it was commissioning a pilot D-APR in respect of a couple, the wife was killed by her husband who then took his own life.

Reviewer: Ann Hamlet, Head of Safeguarding, Aneurin Bevan University Health Board
Reviewer: Mary Ryan, Safeguarding Service Manager, Newport Social Services
Chair of Panel: Heather Nicholls, Head Gwent, HM Prison & Probation Service

The services represented on the panel consisted of:

- Monmouthshire Adult Services
- Newport Adult Services
- Bryn Ivor Care Home
- Community Care Provider (Monmouthshire)
- Gwent Police
- Aneurin Bevan University Health Board
- Welsh Ambulance Service Trust

Observers were:

- Cardiff University
- Home Office
- Public Services Board – as a governing body. Pilot progress will be reported to PSBs by PSB Coordinator who is a panel member.

Co-opted professional advisors were:

- Advocacy After Fatal Domestic Abuse (AAFDA)
- VAWDASV

The Panel met regularly from June 2018 in order to review the multi-agency information and provide analysis to support the development of the report.

<u>Learning Event</u>
A Learning Event took place during October 2018 and was attended by 16 practitioners from the following agencies:

- Monmouthshire Adult Services
- Bryn Ivor Care Home
- Community Care Provider (Monmouthshire)
- Gwent Police
- Aneurin Bevan University Health Board
- Welsh Ambulance Service Trust

<u>Family Members</u>
Relevant family members were informed and contributed to the review as did one of her friends.

Appendix 1

Terms of Reference

Concise Domestic - Adult Practice Review

(D-APR)

These Terms of Reference set out the scope of this pilot which intends to carry out a Domestic Homicide Review (DHR) using the Adult Practice Review (APR) process. Therefore, these Terms of Reference represent a hybrid of DHR and APR methodologies which will guide the pilot process and will be used to inform the development of future review procedures.

"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:

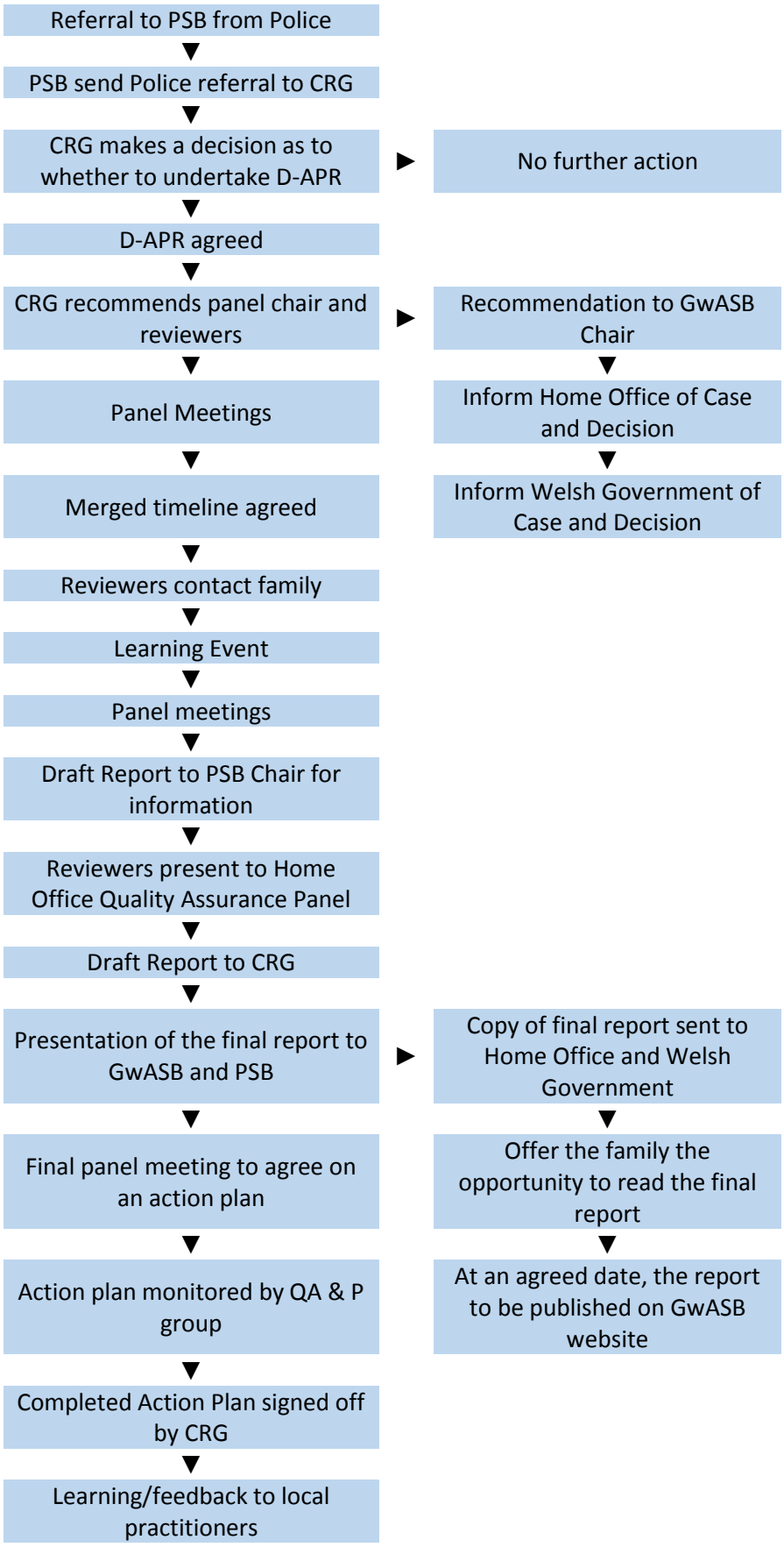
a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
b) a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death. (Home Office, Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016)

The above criterion for a Domestic Homicide Review needs to be satisfied in order for a case to qualify to be reviewed using the Adult Practice Review process.

The following process flowchart has been included for the purpose of this pilot to demonstrate the methodology used.

Domestic-Adult Practice Review Pilot Process Flowchart



Key:
GSBU – Gwent Safeguarding Business Unit
PSB – Public Services Board
GwASB – Gwent-wide Adult Safeguarding Board
APR – Adult Practice Review
CRG – Case Review Group
QA & P – Quality Assurance and Performance Group

Core Tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board
- Examine inter-agency working and service provision for the individual and family
- Determine the extent to which decisions and actions were individual-focused
- Consider whether family and friends are prepared to participate in the review
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress
- Assess the extent to which family and friends were aware of abusive or coercive/controlling behaviour from RS to JS (or other persons)
- Assess the extent to which family and friends were aware of abusive or coercive/controlling behaviour from JS to RS (or other persons)
- Review any barriers experienced by the family in reporting abuse or concerns, including whether they (or JS) knew how to report domestic abuse had they wished to
- Review any previous concerning conduct or a history of abusive or coercive/controlling behaviour from RS and whether this was known to any agencies
- Assess whether it would have been possible to conduct a Multi-Agency Risk Assessment Conference
- Assess whether RS had any previous history of abusive behaviour or coercive/controlling towards JS, or any previous or current partner and whether this was known to any agencies
- Review communication to the public and non-specialist services about available specialist services related to domestic abuse or violence
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources

In addition to the review process, to have particular regard to the following:

- Whether previous relevant information or history about JS and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of JS, the family and their circumstances. How that knowledge contributed to the outcome for JS.
- Whether the actions identified to safeguard JS were robust, and appropriate for JS and their circumstances
- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for JS. Whether the protocol for professional disagreement was invoked
- Whether the respective statutory duties of agencies working with JS and family were fulfilled
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues)

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the Review Panel in accordance with the guidance for concise and extended reviews
- Agree on the timeframe

- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken
- Relevant panel member agencies are:
  - Monmouthshire Adult Services
  - Newport Adult Services
  - Bryn Ivor Care Home
  - Community Care Provider (Monmouthshire)
  - Aneurin Bevan University Health Board
  - Gwent Police
  - Welsh Ambulance Service Trust
- Observers are:
  - Cardiff University
  - Home Office
  - Public Services Board – as a governing body. Pilot progress will be reported to PSBs by PSB Coordinator who is a panel member
- Co-opted professional advisors are:
  - Advocacy After Fatal Domestic Abuse (AAFDA)
  - VAWDASV
- Produce a merged timeline (from 4th October 2015 to 4th October 2017), initial analysis and hypotheses.
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post-event, and arrangements for feedback
- Plan with the reviewer/s contact arrangements with family members prior to the event.
- Ensure that advocacy options are offered to family members, including a 'consent to share' option. Even if not accepted, this will attempt to ensure that family members are fully aware of what is available to them at every stage of the review process. To review the offer of these advocacy options regularly throughout the review process. To ensure that when making family members aware of their advocacy options that this is done in a way that is respectful of the family's choice.
- Receive and consider the draft adult practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Review best practice in respect of protecting adults from domestic abuse.
- Contribute to the independent evaluation programme, conducted by Cardiff University, which intends to assess the perceived benefits and challenges of the D-APR pilot compared to existing practice (APRs and DHRs).
- 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.
- Agree on conclusions from the review and an outline action plan, and make arrangements for presentation to the Home Office QA Group, the Public Service Board, the Case Review Group and the Gwent-wide Adult Safeguarding Board for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Safeguarding Adults Board

- Consider and agree on any Board learning points to be incorporated into the final report or the action plan
- Review Panel completes the report and action plan

- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website
- Agree on dissemination to agencies, relevant services and professionals
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed