Domestic Homicide Review
Executive Summary
DHR 02

Report into the death of a man

in August 2015

Independent Author

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February 2021

CONTENTS

LIST OF ABBREVIATIONS

AAFDA - Advocacy After Fatal Domestic Abuse

CAMHS - Child and Adolescence Mental Health Service

CPB - Community Partnership Board

DASH - Domestic Abuse, Stalking and Harassment Risk Assessment Form

DHR - Domestic Homicide Review

IMR - Individual Management Review

MAPPA - Multi Agency Public Protection Arrangement

MARAC - Multi Agency Rick Assessment Conference

NHS - National Health Service

NSPCC - National Society for the Prevention of Cruelty to Children

SARC - Sexual Assault Referral Centre

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The Domestic Homicide Review Panel express their deepest condolences

to the family members that have suffered due to this tragic incident

1.1 Introduction

1.1.1 This Domestic Homicide Review, commissioned by Cardiff Council, concerns the unlawful killing of a 67 year old man by his 16 year old grandson. All family members in this review are white British citizens.

1.1.2 The Victim was attacked in his home by his grandson in August 2015 and died later in hospital. The Perpetrator appeared before the Crown Court, and was convicted of manslaughter on the grounds of diminished responsibility. He was sentenced to 3 years imprisonment.

1.1.3 Throughout this report the deceased will be referred to as the Victim and the individual responsible for the death, as the Perpetrator in accordance with Home Office DHR training. The daughter who is at the centre of the review will be called 'the sister', (of the Perpetrator.)

1.1.4 The legislation by which this review is conducted is the Domestic Violence, Crimes and Victims Act 2004, and Home Office Guidance of 2016,[1] details of which are contained in the Overview Report.

1.2 Process of the Review

1.2.1 South Wales Police notified Cardiff Partnership Board (CPB) of the homicide on 24th September 2015, the CPB reviewed the circumstances of this case against the criteria set out in Government Guidance and decided that a Domestic Homicide Review should be undertaken.

1.2.2 The Home Office was notified of the intention to conduct a DHR on 7th October 2015. An independent company, Winston Ltd was commissioned and appointed a chair for the DHR Panel and an author for the Overview Report. At the first Review Panel terms of reference were drafted. On 26th April 2017 the CPB approved the final version of the Overview Report and its recommendations.

1.3 Contributors to the Review

1.3.1 An Individual Management Report (IMR) and comprehensive chronology was received from each of the following organisations:

Children's Services

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance

Housing
Education
Health
Child and Adolescent Mental Health Services (CAMHS)

1.3.2 As agreed reports for information were received from:

South Wales Police
Welsh Ambulance Service Trust
Barnardo's

1.3.3 Guidance[2] was provided to IMR Authors through local and statutory guidance and through an author's briefing. All IMR authors confirmed their independence as none had direct contact with the family prior to the review being commissioned. Statutory guidance determines that the aim of an IMR is to:

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

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

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

1.4 The Domestic Homicide Review Panel

1.4.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the Review. Mr Ross chaired the Panel and also attended as the author of the Overview Report. The Panel met on 9 occasions. Other members of the Panel and their professional responsibilities were:

Natalie Southgate	Policy and Development Manager, Cardiff Council
Chris Fox	Social Inclusion Manager, Cardiff Council
Nicola Jones	Domestic Abuse Coordinator, Cardiff Council (Independent)
Natasha James	Interim Operations Manager, Children's Safeguarding Services Cardiff Council
Neil Hardee	Head of Performance, Resources & Services, Education and Lifelong Learning, Cardiff Council
Sue Hurley	Protecting Vulnerable Persons Manager, South Wales Police
Nikki Harvey	Head of Safeguarding, Welsh Ambulance Services NHS Trust
Judy Brown	Safeguarding Nurse Advisor – Safeguarding Children Team, Cardiff and Vale University Health Board
Karen Maxwell	Service Standards Manager, Safer Wales (Independent)
Angelina Rodrigues	Deputy Chief Executive, BAWSO (Independent)
Helen Weston	Minute Taker, South Wales Police
Martyn Jones	Independent Report Author
Malcolm Ross	Independent Report Author

[2] Home Office Guidance 2016 Page 20

1.4.2 The Panel members confirm their independency as they had no direct involvement in the case, nor had line management responsibility for any of those involved.

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

1.4.4 The panel met on the following dates: 8th January 2016, 23rd February 2016, 15th March 2016, 23rd September 2016 and 4th November 2016.

1.5 Independent Chair and Author

1.5.1 Home Office Guidance[3] requires that;

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

1.5.1 The Independent Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has over 30 years' experience in writing over 80 Serious Case Reviews, over 50 DHRs and chairing those processes before and since retiring from the police. After retiring from the Police service 21 years ago, he has been performing both functions in relation to Domestic Homicide Reviews. Prior to this Review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the Panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.6 Terms of Reference for the Review

1.6.1 The Terms of Reference for this DHR relate to the period from January 2010 to August 2015.

1.6.2 The scope of the Review relates to the victim, a 67 year old man, his grandson aged 16 years, the Perpetrator, and the female sibling of the Perpetrator, aged 18 years.

1.6.3 The Terms of Reference for this DHR are divided into two categories i.e.

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.

1.6.4 The generic questions are as follows:

[3] Home Office Guidance 2016 page 12

1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?

2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?

4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?

5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

7. What were the key points or opportunities for assessment and decision making in this case?

8. Do assessments and decisions appear to have been reached in an informed and professional way?

9. Did actions or risk management plans fit with the assessment and the decisions made?

10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

11. When, and in what way, were the victim's wishes and feelings ascertained and considered?

12. Is it reasonable to assume that the wishes of the victim should have been known?

13. Was the victim informed of options/choices to make informed decisions?

14. Were they signposted to other agencies?

15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?

16. Had the victim disclosed to anyone and if so, was the response appropriate?

17. Was this information recorded and shared, where appropriate?

18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?

19. Was consideration for vulnerability and disability necessary?

20. Were Senior Managers or agencies and professionals involved at the appropriate points?

21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

22. Are there ways of working effectively that could be passed on to other organisations or individuals?

23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

24. How accessible were the services for the victim and the perpetrator?

25. To what degree could the homicide have been accurately predicted and prevented?

1.6.5 In addition to the above, some agencies will asked to respond specifically to individual questions once they are identified following the submission of IMR's.

1.7 Scope of the Review

1.7.1 The process began with an initial scoping exercise prior to the first Panel meeting. The scoping exercise was completed by the Cardiff Partnership Board to identify agencies that had involvement with the Victim and Perpetrator prior to the homicide. Where there was no involvement or insignificant involvement, agencies were requested to inform the Review by a report.

1.8 Time Period

1.8.1 The DHR focussed on events from January 2010 to the date of the death of the Victim in August 2015 unless it became apparent to the independent chair that the timescale in relation to some aspect of the Review should be extended.

1.8.2 The Review also considered relevant information relating to agency contact with the Victim and Perpetrator outside that timeframe where it impacts on the assessments in relation to this case.

1.8.3 Home Office Guidance[4] recommends that DHRs should be completed within 6 months of the date of the decision to proceed with the Review. However there have been a number of contributing factors that has meant this deadline has not been met in this case. Contributing factors include the necessity to:

- Establish a new multi-agency process for conducting Domestic Homicide Reviews, that is distinct from Serious Case Reviews and which required approval from Cardiff's Public Services Board member organisations.
- Develop a commissioning framework to recruit Independent Chairs/Authors to facilitate Domestic Homicide Reviews

[4] Home Office Guidance 2016 pages 16 and 35

1.8.4 In addition there has also been a delay between the completion of the Overview Report, Action Plans, and submission to the Home Office Quality Assurance Panel. This has been hampered by periods of long-term sickness of key members of staff contribution to Action Plans and the Local Authority Officer who co-ordinates Domestic Homicide Review on behalf of Cardiff Council. However, Cardiff Council have provided regular updates on progress to the Home Office.

1.9 Family Involvement

1.9.1 Home Office Guidance[5] requires the family, friends and colleagues who have details or knowledge of the Victim or the Perpetrator to be given the opportunity to contribute to the review process. In this case, the Overview Author had regular contact with their mother. The mother also had the opportunity to meet the Panel and discuss an early draft report. Their views were faithfully recorded and are included within the Overview Report.

2. Summary of Events

2.1 The Perpetrator was 16 years of age at the time of this incident. He is the youngest of three children (two boys and one girl), their mother being the daughter of the Victim. The Victim lived quite near to the mother and the three children. The Victim's elderly mother had recently died and arrangements were being made for her funeral. The mother and children were close to the grandmother/great grandmother. The Victim's relationship with his mother was not good and he had not seen her for several years.

2.2 Some time prior to the incident on 15th August 2015, the Perpetrator walked into a conversation between the mother and his sister where they were discussing the fact that the Victim had allegedly sexually abused the sister on at least two occasions, one at his home and another at a caravan on a holiday in north Wales. These offences were some time in 2010.

2.3 It appears that on making the initial disclosure to the mother by the sister about the abuse, the mother, being unsure what to do, contacted ChildLine and NSPCC but it seems that ChildLine did not return the call. The mother then contacted Children's Services Emergency Duty Team in Cardiff on 18th January 2010. The sister was 13 years of age at this time.

2.4 The Children's Services Key Directions Management Document the same day raised the following points to be considered with the referral:

- The fact that reports had allegedly been made to ChildLine and NSPCC, but neither organisation had made a referral to Children's Services;
- Why mother took so long to report the incident;
- To explore the details of the alleged incident with the sister;
- Has mother stopped the children's contact with the grandfather? and
- Does the sister want to make a complaint to the police?

2.5 A Social Worker made an assessment the following day and an appointment made for a home visit on 20th January 2010, but it was cancelled due to the workload of the Social Worker. There was no referral to the Sexual Assault Referral Centre.

[5] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Home Office 2011 Revised 2016 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*

2.6 Another appointment was made by letter for 26th January 2010, 8 days after the initial report. On that day the mother stated that she was unsure about the effects of making a formal complaint to either the Police or Children's Services and that doing so may result in teasing or embarrassment for the sister by other students at school. However the mother signed an agreement with Children's Services to ensure that the grandfather had no contact with any of the family's children. Mother volunteered the information that the sister had an eyesight problem and was possibly suffering from Asperger's Syndrome but there is no medical evidence to confirm this. The Social Worker arranged to call again within a week to see if the mother had come to a decision about making a formal complaint.

2.7 The Social Worker went off sick and a Team Manager wrote to the mother asking if she had arrived at a decision. There is nothing to indicate there was a reply to that letter. The case was dealt with as a single agency response instead of a Section 47 joint agency investigation. There was no further support offered to the family. This is subject of a recommendation.

2.8 The action of Children's Services in not referring the matter to the Police, irrespective that the mother was undecided, resulted in no risk assessment being made in respect of the grandfather. His access to other children was not considered and the opportunity for him to be seen by the Police did not arise as the Police were unaware of the allegations. Other than the mother and children having no access to the grandfather from that point on, no more action appears to have been taken. It is not known if the grandfather was ever informed of the sister's alleged allegation until the day he was attacked by the Perpetrator.

2.9 During 2012 and again in 2014, the mother made several applications to Cardiff Council to move house on the basis that she was finding it difficult to live in the same area as the grandfather after the alleged allegations had been made by the sister. She considered that the grandfather posed a threat to her children, especially the sister, who was having constant problems coming to terms with what happened. She disclosed the reasons for her applications and although her name was put on the housing list, housing staff did not make any referrals to Children's Services or make any safeguarding considerations. This is subject to a recommendation.

2.10 In August 2012, the mother contacted the family GP by telephone and reported that the sister was sleeping a great deal and appeared isolated and withdrawn. The mother informed the GP of the details of the alleged allegation of sexual abuse. The GP offered the sister a routine physical examination, but the sister declined to attend the surgery. There was no further contact with the GP until 2014 when the GP made a referral to CAMHS for the sister.

2.11 In August 2014, the sister attended the Emergency Department of the local hospital after taking an overdose of medication and alcohol. She had disclosed the details of the alleged abuse to her boyfriend. She was not seen by CAHMS until 9 days later. She was not referred to the SARC, (Sexual Assault Referral Centre) or Children's Services. On her discharge from hospital her GP put a 'safety net plan' in place where she could contact the surgery at any time.

2.12 Both the sister and the Perpetrator are recorded as having been referred to CAMHS in their formative years. Both also had issues with school in that both are recorded as displaying behavioural problems, trouble-making and a reluctance to work within school rules. This is subject to a recommendation.

2.13 In relation to the Perpetrator, he disengaged in school year 11, at the age of 16 years. The school attempted to address this but without success. It appeared that the Perpetrator was so upset about the alleged allegation of abuse by the grandfather on his sister that he would stay awake at night outside the bedroom door of his sister to prevent his grandfather returning to repeat the abuse on his sister. In reality that was unlikely to happen but the Perpetrator felt so strongly he did this on a regular basis. The effects of that manifested itself in school, where he was too tired to concentrate through the school day. He would get his admission mark and then walk out of school, go home and sleep. It is the Perpetrator's recollection that he was stopped by the Head of Year one day as he was leaving school to go home to rest after getting his mark. He was quizzed as to why he regularly left school and he states that he broke down in tears and disclosed all of the detail to the Head of Year about the alleged abuse by his grandfather. He states that nothing was done by the Head of Year or the School. The Head of Year and School state that they were not aware of this and such a conversation with the Perpetrator did not happen. The school was totally unaware of the alleged allegations of abuse.

2.14 There were several attempts by the school to engage with the Perpetrator and get him back to school. On two occasions members of staff from school went to the family home to speak to the mother and/or the Perpetrator and reported that they could smell cannabis as they stood on the doorstep of the house. There is no evidence of a referral about this being made to any agency.

2.15 Around July 2015, the Victim's mother, the great grandmother, died aged 90 years. The mother and children arranged to go to her funeral but learned that the Victim also wanted to attend his mother's funeral. This upset the mother and children as they did not want to see the Victim.

2.16 On 3rd August 2015, the Perpetrator, on his way out socially, visited the Victim. The Perpetrator claims it was to persuade him not to go to his mother's funeral. An argument started during which the Perpetrator took possession of a knife from the kitchen and stabbed the Victim, who was seriously wounded at that time. The Victim however, managed to call for the emergency services and refused to make a formal complaint about the attack to the Police. He was admitted to hospital but died of his injuries 5 days later, on 8th August 2015.

2.17 The Perpetrator was arrested, initially for wounding but after the death of his grandfather he was charged with murder. He was subsequently convicted of manslaughter by reason of diminished responsibility and was sentenced to 3 years in a secure until. He was released on licence on 28th March 2017.

3. Analysis and recommendations

3.1 During the process of the Review several issues came to light.

3.2 The first of these was with regard to the initial disclosure of the sister to her mother about the alleged abuse by the grandfather. The Social Worker that was allocated the case did not conform to Child Protection Procedures that were in force at the time of the disclosure. The Social Worker dealt with the incident as a single agency enquiry rather than a joint inter-agency investigation of child sexual abuse. There was no Police involvement and no opportunities for the Police or any other agency to consider the risk the grandfather posed to the sister or any other children he may have had access to. There was no referral of the sister to the SARC. The mother was given time to consider whether she and the sister wished to make a formal complaint but the mother

did not respond. The Social Worker went on sick leave and her Manager wrote to the mother saying the case was being closed.

3.3 Children's Services acknowledge the mistakes that were made regarding this disclosure and can say that there is now more robust supervision, and stricter policies and procedures in place today that would prevent such mistakes happening again.

3.4 The next issue for comment concerns the delay of months between the sister being referred for treatment from CAMHS by her GP and her case being closed. Once referred the sister waited for an appointment but the CAMHS worker went on long term sick leave. Months went by without the sister being seen. The initial plan was to refer her to CAMHS and then to Barnardo's for support. Due to the delay by CAMHS, it appears that there was no one else available to see the sister. She was not seen by Barnardo's.

3.5 The significance of both of these comments is that there may have been opportunities for action to be taken which may have resulted in the alleged allegation of sexual abuse by the grandfather being investigated in a more appropriate manner. Also the consideration that treatment and support for the sister was not delivered.

3.6 In May 2012, the mother made applications to housing in order to try and obtain a move of accommodation due to the stress living so close to the grandfather was causing. The Council Housing Department rejected her application as she was not deemed homeless at that time. She found her own alternative accommodation. She tried applying to the Housing Department on more occasions but without success. The mother was admitted onto the housing waiting list, but again no safeguarding considerations were made and no referral to Children's Social Care made even though the details of the alleged sexual abuse had been explained by the Mother.

3.7 The family GP was made aware of the details of the alleged allegations of abuse by the grandfather. The sister was offered support and a routine examination but no referral was made to Children's Services.

3.8 The suggestion made by the Perpetrator that he was stopped by the Head of Year from leaving school on one occasion, (the day or date of which he is not aware) and that he broke down, disclosed all of the detail of the alleged abuse and stayed awake all night 'guarding' his sister in case the grandfather returned, is not agreed with by the school or the teacher, who says that such an incident did not happen.

3.9 The accuracy of that allegation will never be known as there are no witnesses on either side but it is not for this Review to suggest that either version is more accurate than the other. However, irrespective of the validity of the allegation, a recommendation is made that a review is conducted to ensure all education staff are aware of the All Wales Child Protection Procedures of 2008.

3.10 Throughout the review process the Report Author has been in contact with the family on a regular basis and on one occasion the mother of the Perpetrator met with the Panel members to discuss the process. Both the mother and the Panel members felt that the meeting was a valuable experience.

3.11 The Perpetrator was seen on two occasions in the secure unit whilst serving his sentence. On both occasions he emphasised the accuracy of his version of events

especially with the Head of Year. The family are being supported by a worker from a Domestic Homicide charity, AAFDA[6].

4. Conclusions

4.1 The alleged sexual abuse of the sister was disclosed and the mother says she sought help and assistance from several agencies. Eventually Children's Services became involved but because the sister was unsure at that stage about making a complaint for reasons set out above, little action was taken other than to decide that this was to be a single agency referral and therefore opportunities to involve the Police and possibly for the Victim to be interviewed were lost. The sister could have been reassured by the Social Worker about the process but she was not. Had this matter been referred this would have likely resulted in the situation for the Perpetrator and his sister being managed better as well as the school being informed.

4.2 Barnardo's and CAMHS did not provide the sister with the Transition Service that was required due to the sickness of a Psychologist. It appears there was no attempt to provide another Psychologist to take on her case.

4.3 Had these issues been addressed in the recognised manner that child protection guidance and legislation requires, it is possible that a full investigation into the actions of the Victim may have taken place and agency involvement would have been more robust including a plan of care to protect the sister whose vulnerability may have been recognised.

4.4 The Panel are of the opinion that there ought to have been proper robust action by agencies with regard to the concerns raised. There were numerous opportunities missed to consider safeguarding of the sister and the Perpetrator. Because the original disclosure of alleged abuse by the Victim was not progressed according to procedures, the risk he posed to the rest of the family and other children was not assessed.

4.5 It is appreciated that the Victim's voice in this case cannot be heard. There is little known about him. The allegation of the abuse of his granddaughter was never put to him, so it is not known what his views of that allegation were.

5. Lesson Learned

5.1 The analysis of the circumstances of this tragic death as outlined above, indicate that there were identified shortcomings within agencies and between agencies. As a result of this review improvements have been made with the introduction of the Multi-Agency Safeguarding Hub, supplemented by the Cardiff Family Advice and Support Service, together ensure that families receive the right help at the right time and, where necessary, cases can be escalated for a partnership safeguarding response that includes Education, Children's Services, Adult Services, Police, Health and third sector specialist partners. These services are also supported by improved safeguarding procedures and training for all staff.

[6] AAFDA – Advocacy After Fatal Domestic Abuse

List of Recommendations

Overview Report:

Recommendation 1

It is recommended that Cardiff Council ensure that all front line practitioners receive training, supervision and support to be able to effectively identify, report and respond appropriately where significant harm or abuse is alleged, including any allegation or suspicion of sexual abuse. Also, that all front line practitioners apply the appropriate thresholds to the management and allocation of cases where there is risk of significant harm as defined by The Children Act 1989 and the All Wales Child Protection Procedures.

Recommendation 2

Cardiff Council to conduct a review of the referral and continued support arrangements for pupils who have significantly disengaged from school.

Recommendation 3

Cardiff Council ensures that all education staff, including school-based staff, are aware of and compliant with the All Wales Child Protection Procedures 2008.

Recommendation 4

Child and Adolescence Mental Health Services examine its working practices and resilience to ensure that children receive appropriate support and care even in the event of sickness of senior member's staff.

Recommendation 5

Cardiff Council (Housing) review policies, practice and training in the duty of staff to make referrals to other agencies when there is information regarding safeguarding issues, whether concerning children or adults, to ensure that all staff are fully conversant with the referral procedures of both child and adult protection legislation.

Individual Management Report Recommendations

Children's Social Care – City of Cardiff Council

Recommendation 1

Practice reviews raised within this review, specifically around the undertaking of Sec 47 investigations and robust initial assessments, will be discussed in a learning event with Children's Services frontline staff of all levels. This will cover lessons to be learnt and act as a means of improving future practice.

Recommendation 2

Periodic internal audits by a Quality Assurance Officer of a random selection of Child Protection and Child in Need cases is recommended to ensure correct procedures are being followed and decision making is robust in future

Health – Cardiff and Vale UHB

Recommendation 1

Cardiff and Vale UHB conduct a review of referral guidelines to Children's Services for A&E Dept. at UHW regarding young people up to 18 years of age who present with overdose and or disclosures of sexual abuse and ensure the safeguarding consideration record is completed in every case.

Bibliography

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
Revised August 2013 Home Office revised again by 2016 guidance