Findings from a thematic analysis of reviews into adult deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews

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Background

This research project was commissioned by the National Independent Safeguarding Board (via Welsh Government) to push forward the intellectual agenda and learning relevant to policy and practice that can be achieved from a systematic analysis of death/serious harm reviews. Furthermore, this research provides an opportunity to maximise the value from such reviews, which are costly investments that are currently underutilised as learning resources. Clearly, there is much overlap between different types of reviews, although they tend to be considered separate and distinct sources of practice-based learning:

- Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004. A DHR is commissioned by a Community Safety Partnership and takes place in order to review the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect from (a) a person to whom he or she was related or with whom he or she was or had been in an intimate personal relationship, or (b) a member of the same household as him/herself. The DHR is held with a view to identifying the lessons to be learnt from the death.[1]

- APRs[2] are commissioned by regional Safeguarding Boards and take place after an 'adult at risk' has died; or sustained potentially life threatening injury; or sustained serious and permanent impairment of health. The APR may be concise or extended, depending on the circumstances of the case. Under Part 7 of the Social services and Well Being (Wales) Act 2014, an 'adult at risk' is defined as a person who: (a) is experiencing or is at risk of abuse or neglect; (b) has needs for care and support (whether or not the authority is meeting any of those needs); and, (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

- MHHRs are commissioned and carried out by Health Inspectorate Wales (HIW), whose role is to review and inspect National Health Service (NHS) and independent healthcare organisations in Wales to provide assurance for patients, the public, the Welsh Government and healthcare providers that services are safe and good quality. MHHRs are carried out after homicides are committed by individuals known to mental health services in Wales. [3] The decision to undertake such a review is made on a case by case basis (e.g. depending on findings from the Health Board's own internal investigation, the proportion of time the perpetrator spent in contact with mental health services, and consideration of judicial proceedings).

Although these reviews have been taking place for a number of years, it is well established that current arrangements are seen to be insufficient for enabling local areas across Wales to learn from other areas' experience conducting reviews. A contributing factor may be that APRs and MHHRs are devolved to Welsh Government whereas DHRs are governed by the Home Office. Presently it is unclear the extent to which the action plans from such reviews promote meaningful and lasting change 'on the ground'.

[1] Home Office (2016). *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*.
[2] Welsh Government (2016). *Working Together to Safeguard People: Volume 3 – Adult Practice Reviews.*
[3] See http://hiw.org.uk/reports/special/homicide/?lang=en

Existing publications that provide a synthesis of reviews tend to focus on a single type. For example, there are a few analyses of DHRs, although none of focusses on the Welsh context.[4] In 2016 the HIW published an analysis of 13 MHHRs.[5] These publications have all highlighted similar key lessons including the need for: increased training for professionals; improved risk assessment; improved responses to those with complex needs; maximising opportunities for safeguarding; and more thorough record keeping.

As recognised in the specification for this research, there is a lack of 'reading across' different types of reviews to uncover learning that can be considered fundamentally relevant to safeguarding practice (whether it is in the context of domestic abuse, vulnerable adults and/or mental health). There is therefore much learning to be gained from systematically comparing the key themes from these different types of reviews. As noted by Welsh Government, "The output of a review is intended to generate professional and organisational learning and promote improvement in future inter-agency adult protection practice", and the aim of this research is to help to facilitate exactly these types of improvements but on a broader scale through consideration of DHRs alongside APRs and MHHRs. It is hoped that findings from this research will help improve practice amongst those charged with undertaking reviews and inform the governance arrangements going forward for reviews and inspections taking place in Wales.

Methodology

The overall approach to this study is qualitative, involving the thematic coding of reviews complemented by focus group discussions with practitioners from across Wales. As this is the first study to provide a thematic analysis across more than one type of review, the results provide a preliminary foundation to inform future research and practice in this area.

Sample

The sample of reviews to be coded was provided by the NISB. A total of 20 reviews was received and triple coded by the research team: 10 DHRs, 6 APRs and 4 MHHRs. All reviews were carried out in Wales within the past 5 years. All but one of the 20 were reviews into circumstances where an individual died (the other involved a serious sexual assault). Two reviews involved multiple deaths (these were DHRs which involved the death of the partner in addition to other family members, including children). Nine of the ten DHRs involved female intimate partners killed by males; the tenth involved a son killing his father. Two DHRs involved suicide attempts by the perpetrator (one of these was successful) following the homicide. Three of the four MHHRs involved males killing females (two were strangers and one was an acquaintance or possibly a new intimate partner); the fourth involved a male killing a male

[4] Home Office (2013) Domestic homicide reviews: key findings from research; https://www.gov.uk/government/publications/domestic-homicide-review-lessons-learned; Home Office (2016) Domestic Homicide Reviews: Key Findings from Analysis of DHRs https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf; Neville and Sanders-McDonagh (2014) Preventing domestic violence and abuse: common themes and lessons learned from West Midlands' DHRs. http://www.westmidlands-pcc.gov.uk/media/346463/13-spcb-11-sep-14-domestic-homicide-reviews-research-appendix-1.pdf ; Sharp-Jeffs, N. and Kelly, L. (2016). Domestic Homicide Review (DHR) Case Analysis. http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf.

[5] Health Inspectorate Wales (2016) Independent External Reviews of Homicides: An evaluation of reviews undertaken by Healthcare Inspectorate Wales since 2007. http://hiw.org.uk/docs/hiw/reports/160307homicidereviewreporten.pdf

acquaintance. One of the MHHRs also involved the death of the perpetrator whilst in police custody. The APRs involved two elderly people dying in care, one middle aged man dying in the community, and two younger people dying (one committed suicide in prison). The case of the serious sexual assault (not involving a death) was an APR.

An overview table of the sample, containing key details of each review, is contained in Appendix A.

Coding framework

A method and framework to identify key themes was established by the research team. Briefly, this involved reading and discussion of two reviews, which then enabled the development of a coding framework. The coding framework was an Excel worksheet containing sections for each researcher to note approximately five key themes in each of the following categories: Characteristics of the abuse; Agency performance – Police; Agency performance – Probation; Agency performance – Health; Agency performance – Mental Health; Agency performance – Adult Safeguarding; Agency performance – Children's Safeguarding; Agency performance – Other; Multi-agency partnership working; New learning/ Valuable insights; Key recommendations made in the DHR/APR/MHHR; Comments on quality of report; Key themes (e.g. from an academic, practitioner or legal perspective).

As per the research specification, each review was thematically coded by each member of the research team. This resulted in coding being undertaken from an 'academic', 'practitioner' and 'legal' perspective. Weekly team meetings over a four-week period were used to discuss batches of reviews. After the coding was completed, the results were combined into a single Excel database, with one spreadsheet designated for each review. Each spreadsheet contained the codes from every team member, so that these could be evaluated for their similarity and points of divergence. Ultimately, this exercise did not reveal much difference, even though the research team was notionally assembled to bring three different perspectives to the coding. This is discussed later in the report.

From the coding exercise, a group of five cross-cutting themes was identified, to provide the structure for the focus group discussion. These five themes were significant features in all three types of reviews, and thus were not specific *per se* to issues of domestic abuse, vulnerable adults, or mental health. Thus, these are high level themes that go beyond particular operational boundaries or substantive issues. These five themes were subject to a validity check through the discussion and feedback provided by the practitioner focus groups. An overview table depicting how the themes relate to the reviews is provided in Appendix B.

Focus groups

Suitable participants to participate in focus groups were identified by the NISB. One focus group was held in North Wales (Wrexham) and one in South Wales (Cardiff). Each focus group included twelve participants and lasted two hours.

Invitations to participate in a brief online survey to gather background information were sent to the thirty individuals registered to attend one of the two focus groups. Twenty-two responses were received. Participants occupied a variety of managerial and strategic roles within police, social services (adult and children's safeguarding) and health. Participants were asked to indicate their level of experience with each type of review (no experience; have read this type of report; have participated by providing evidence or information; have had overall responsibility for the process; have had strategic responsibility for ensuring that recommendations are implemented). All participants had some level of knowledge and experience with either DRHs, APRs or MHHRs. However, knowledge was weighted towards

APRs (only two without any experience) and DHRs (three without any experience), whereas ten participants had no prior knowledge of MHHRs.

Respondents were unanimous in their belief that these types of reviews would, generally speaking, tend to identify similar failings and missed opportunities for intervention. For example:

> "From my experience there are often common themes across reviews e.g. working in silos, not sharing information, inaccurate risk assessments, full history of case not considered or used to inform risk assessment although known to some or all agencies." (#11)

> "Yes, because the reasons for why things go wrong are generally similar but are very difficult to change." (#13)

These perceptions, expressed so consistently and prior to the focus groups taking place, reinforces the results of the coding exercise, which found more similarity than difference across reviews. Although the focus groups were not recorded, notes were taken at the time on flip charts and then consolidated immediately afterwards into a written account of the key themes. This information was then supplemented by an opportunity for all participants to provide feedback via a short online survey afterwards.

Limitations

A brief comment on the study's limitations is necessary, before proceeding to the main findings. Firstly, the sample was a convenience sample provided by the NISB. It does not necessarily provide a representative sample of DHRs, APRs or MHHRs that have been carried out in Wales. However, they were chosen with a view to ensuring a wide geographic spread of cases within Wales, and to illustrate the diverse range of issues that tend to be found in such reviews. The brief timescale provided for completion of the project (contract awarded 20th December 2017 and the report submitted 30th March 2018) can be considered another limitation. Further research is necessary to substantiate the findings presented here, with a larger sample (and ideally one that includes additional types of reviews e.g. Child Practice Reviews, Serious Further Offence reports from Probation, etc.).

Findings

The five cross-cutting themes identified from the coding exercise and confirmed by the focus group discussion are discussed in the sections that follow.

Theme 1: Crossing boundaries

The room for error seemed to increase when boundaries are 'crossed' or where there is a transition between one type of service user to another, from one service to another, or from one geographic area to another. When boundaries were crossed, individuals were often seen as someone else's responsibility and fell out of sight and/or were deemed to pose a lower risk, or to be experiencing decreased vulnerability. Additionally, transitions could result in information being lost. This theme appeared in the following reviews: DHRs 1, 2, 3, 4, 5, 8 and 9; APRs 2, 3, 4, 5, and 6; and MHHRs 3 and 4 (see Appendix B).

Coding the reviews revealed many types of transitions or boundaries being crossed; often several within a single review. Children, for example, were considered less vulnerable when

crossing the boundary into adulthood. Indeed, the transition from child to adult services was not necessarily well-managed. It was found, through analysis of the different types of reviews, that crossing the boundary between childhood and adulthood actually resulted in an increased vulnerability because service provision was being changed and because the individual (now an adult) was deemed to be able to cope as they were now no longer 'vulnerable' (their 'vulnerability' status was tied to their being a child). This occurred in APRs 2 and 3 (and also, to an extent, in DHRs 8 and 10).

The challenge posed to services dealing with an individual transitioning between offender and mental health patient was evident in MHHR 4. Here the perpetrator had recently been released from prison into a hotel, however, he had not been provided with medication or appointments. Agencies tended to focus on his risk of offending with less consideration of his severe mental health issues. Similarly, in MHHR 3, the patient was discharged from a psychiatric hospital and was without accommodation. His transition into the community served to directly increase the likelihood of recurring problems. This was also evident in APR 5: the deceased's condition had improved whilst in hospital (where support was readily available) but deteriorated quickly when moving back into the community. There seemed to be a lack of recognition of how being transferred into the community could increase the individual's vulnerability.

DHRs 3 and 6 illustrated how crossing the boundary between victim and carer resulted in individuals being considered sufficiently able to care for perpetrators' mental health problems without due regard for their own risk of victimisation.

There was also little recognition that someone could cross boundaries between being an adult with capacity and an adult without capacity[6]. Indeed, the focus group discussions noted that assessments of capacity are usually one-off assessments and that this is misleading as capacity can vary depending on the circumstance. Once an adult has been deemed to lack capacity, it is difficult for agencies to later recognise that capacity may have returned (see also Theme 4 Tunnel Vision).

In DHRs 1, 5, 8, 9 (and also APRs 4 and 6), the crossing of boundaries was particularly salient when individuals were moving from one geographical area to another. Indeed, it seemed that perpetrators could evade their past by moving to a new location. What is particularly problematic here was that information did not follow the perpetrator or the victim, was not shared across borders, and/or was not readily accessible. This lack of information and lack of consistency across services provided (due to the move) meant that the victim was at an increased state of vulnerability. Examples of handovers between agencies combined with crossing geographic borders were particularly problematic. When boundaries are crossed, it is important, so far as possible, that there is some consistency in service provision.

Theme 2: Hoodwinking

The notion of hoodwinking came through in numerous reviews (DHRs 2, 4, 5, 7, 8; APRs 2, 3; MHHRs 2, 4; see Appendix B). Hoodwinking relates to individuals who disguised or manipulated their presentation of self, for example, to appear more benign or better able than they actually were. This was especially evident in DHRs, where abuse was often minimised by perpetrators and/or professionals mistakenly recorded disclosures as 'marital /relationship

[6] The Mental Health Act (2005) states "A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary." http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf

difficulties'. When the professional and perpetrator knew each other socially, this can be seen to amount to collusion (DHR 2). Some perpetrators used their difficulties to frame themselves as victims or patients and deflect attention away from their abusive behaviour (DHRs 2 and 5, see also Theme 1 above). One perpetrator (DHR 5) told the homicide victim as well as his previous partners that he had post-traumatic stress disorder from his military service, although this had never been diagnosed, in order to garner sympathy. In this case, the man partially disclosed some of his previous abuse and in doing so further increased the trust of his victims; he was described as 'hiding in plain sight'. Interestingly, in none of the DHRs, even though coercive and abusive behaviour was prevalent, were any of the perpetrators challenged by a professional about their abusive behaviour. This may reflect the lack of confidence of practitioners in recognising and dealing with perpetrators (e.g. the need to up-skill practitioners was noted in DHR 4). It sometimes seemed as though perpetrators were able to coerce professionals in the same way as their victims. For example, in DHR 8 the perpetrator was allowed to stay in the hospital chapel, whilst his partner was in the maternity ward.

In DHR 5 the use of on-line dating sites was highlighted as a means to hoodwink, and a source of particular risk, as the perpetrator was able to create an enhanced impression for the dating site and had access across geographical boundaries to a range of different women of different ages who knew nothing of his past history. This issue resonated with professionals in both focus groups who had experience of working with this situation. Surveillance of social media dating sites is particularly difficult and it was recommended that warnings about them need to be issued more forcibly. This is vital learning that needs to be disseminated across Wales.

None of the men (all were men in our sample) attended a perpetrator programme or received a service for their abusive behaviour. In DHR 4, despite being recommended for a perpetrator programme following assessment, the court chose the option of a suspended sentence, suggesting that this aspect of his behaviour was not prioritised. The significant lack of perpetrator services in Wales was noted within the focus groups, with the prohibitive cost seen to be an additional problem. Certainly, as most perpetrators in domestic abuse cases are prolific and/or serial in their offending[7] (in DHR 5 there were 8 previous victims), it is difficult to see how cycles of violence can be punctuated without addressing abusive behaviour. In every DHR involving intimate partners, the woman was at the point of leaving or had separated from her partner at the point she was killed.

There was also evidence of hoodwinking in the form of 'disguised compliance'[8] where perpetrators appeared to comply with, for example, taking their medication, when in fact they were not (MHHRs 2, 4). The need for more effective ways to monitor compliance, in order to identify non-compliance, was noted. In MHHR 2, the perpetrator told professionals that receiving medication via injections was making him feel unwell, and he was therefore prescribed oral medication, which he chose not to take. This issue resonated with the focus group participants, especially those working in mental health. Similarly, some mental health patients were seen to be adept at masking their symptoms so that they could avoid detention or further surveillance (MHHRs 2, 4). There is a need for professionals to confidently identify and challenge disguised compliance.

Finally, young people (both victims in DHRs 8 and 10, and APR 2) were seen to disguise their vulnerability by presenting as more mature and able than they really were. This meant that

[7] Robinson, A. L. (2016). Serial Domestic Abuse in Wales: An Exploratory Study into its Definition, Prevalence, Correlates, and Management. Victims & Offenders. http://dx.doi.org/10.1080/15564886.2016.1187691

[8] NSPCC (2014). Disguised compliance: learning from case reviews. https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/disguised-compliance/

professionals attributed them with more agency and ability than they possessed, and in doing so less protection was forthcoming. This masking of vulnerability reinforces the need for professional curiosity and challenge (see also Theme 4 Tunnel Vision).

Theme 3: Faulty assessment

The assessments conducted by practitioners tended to focus on particular aspects of behaviour, neglecting others, thereby reducing the overall accuracy of the assessment. Furthermore, the clinical picture or the assessment could be blurred or obfuscated by multiple factors. This occurred in the following reviews: DHRs 2, 3, 4, 5, 6, 7, and 10; APRs 1, 3, 4, 5, and 6; and MHHRs 1, 2, 3, and 4 (see Appendix B).

Faulty assessments could arise when the individual presented with more than one problem (such as mental health, substance abuse and threats of violence or violent behaviour). As previously discussed, there was no evidence of perpetrators being actively worked with regarding their abuse: assessments, and therefore interventions, focused squarely on alcohol or drugs, or mental health. There was poor recognition and management of the full 'toxic trio'. For example, those who had mental health and abused substances were often not recognised as being mentally ill: the substance abuse was viewed as the cause of the problem rather than a means through which to deal with the underlying issue (DHR 3, MHHRs 1 and 3).

Assessments also failed to take account of how best to respond to someone who was disengaged or chaotic; frequently such individuals would be discharged from services when they failed to engage, as opposed to when their condition actually improved (e.g. in MHHR 4, the perpetrator was deregistered for failure to attend out-patient appointments and his case closed from the Community Mental Health Team). In DHR 1, the perpetrator had been placed on the Severe Mental Illness Register by his GP but was later deregistered when he moved; it was unclear why he was deregistered and by whom. Mental health services experienced difficulty assessing 'aloof' patients and those who rejected their diagnoses. In both MHHRs 2 and 4, the perpetrators experienced difficulties in managing their medication and, whilst this should have resulted in a more rigorous response, their issues led to a decrease or removal of services. Through reading the reviews, it appeared that a failure to engage should actually trigger a new assessment and/or greater service involvement rather than case closure.

Discharge from services also occurred where the individual appeared to be 'doing well'. Not only might an individual be discharged from their current service, they would also be assessed as not needing any services, as was the case in APR 5 and MHHR 2. It seemed that there was a 'rule of optimism' whereby it was assumed (or hoped) that the individual was able to cope with their issues and therefore not to be in need of further help, despite previous histories suggesting this was highly unlikely (see also DHR 6).

Some individuals were assessed as at risk (i.e. vulnerable), rather than posing a risk (i.e. harmful). This was particularly evident in APR 2, where a vulnerable adult who was assessed as lacking capacity was not considered a risk to other residents, despite a known history of sexually harmful behaviour. This adult later committed a serious sexual assault against another resident. There appears to be a tension between a recognition of vulnerability and a recognition of risk: whilst it may be difficult to conceptualise risk and vulnerability in tandem, practitioners must be cognisant that an individual could simultaneously present a risk to others and be at risk themselves.

Mistakes could arise through assessments which narrowly focus on the perpetrator, excluding consideration of those in his immediate environment. For example, in APR 2 and MHHRs 1

and 4, the assessment focussed solely on the individual being placed into accommodation, rather than a holistic approach being adopted so as to assess the risk posed to the other residents. Also, in DHR 3 there was no consideration given to the vulnerability of or risk posed to the perpetrator's grandparents, who were providing his care.

Faulty assessments of victims were evident in failures of GPs to enquire as to the root cause of mental health problems (DHR 2) and in police risk assessments (DHR 7). These are examples of the tendency of practitioners to focus on incidents rather than identifying patterns of behaviour. Furthermore, it was notable that in DHRs 4, 5, and 10, the 'couple' had been in a 'relationship' for less than 3 months and were not living together. This short time frame made it difficult for professional information gathering to take place or for risks to be assessed.

Focus group participants noted that assessments can be process driven, resulting in them being seen as a 'tick-box' exercise (arguably as a result of the impact of Key Performance Indicators). It was agreed that a holistic, ongoing assessment was needed and assessments should be 'living' documents. Assessments were considered to be more robust when they were routinely revisited or updated; involved input from and consideration of impacts on the family; and drew upon multi-agency perspectives.

Theme 4: Tunnel vision

There was a tendency for practitioners to focus solely or predominantly on certain aspects of someone's vulnerability or risk, and to exclude or fail to recognise other aspects. This theme appeared in the following reviews: DHRs 2, 3, 5, 6, 7, 8, and 10; APRs 2, 4, and 5; and MHHRs 1 and 3 (see Appendix B).

Tunnel vision meant that a narrative would be constructed and practice would be shaped so as to fit this particular narrative. In MHHR 3, the patient was diagnosed by the psychiatrist as 'malingering'; he was seen to be manipulating the situation to remain in hospital, rather than genuinely suffering from psychosis. Although evidence continued to challenge the 'malingering' diagnosis, this was never re-evaluated by other professionals. This was also the case in MHHR 1 (where the perpetrator was only diagnosed with schizophrenia after the death of the victim) and where a lack of consensus amongst professionals resulted in a view of him as primarily suffering from substance misuse rather than psychosis (see also MHHR 3, and Theme 3).

Tunnel vision was also apparent in the lack of recognition that someone's situation or condition could change over time. The abuse that a victim encounters, for example, does not remain static over time but can escalate. Abuse was also downplayed as merely criminal damage and therefore not seen as in the broader context of coercive, controlling abuse, as was the case in DHR 8, or was trivialised as 'play-fighting', as in DHR 10. Physical and mental health can also deteriorate over time, such as in the case of DHR 6, APR 5 and MHHR 1. In APR 5, the deterioration occurred after release from hospital; whilst in hospital he had been doing well but upon release his situation and health rapidly deteriorated. Finally, those who have addictions, whilst potentially on the road to recovery during assessment, can relapse.

Due to this tunnel vision, the range of options open to the individual would narrow rather than broaden. Cases could become 'stuck'; tunnel vision reinforces a particular view of the person, which results in a particular set of options being tried. When these do not work it is rarely the case that practitioners 'step outside of the tunnel' to re-evaluate their options. When things became stuck practitioners did not reflect on what type of approach had gone well in the past (i.e. taking a strengths-based approach) and therefore how they might adapt their practice so

that it was more palatable or acceptable for the individual. Indeed, focus group participants felt that, due to limited time and resources, there was a tendency to pigeon-hole individuals, particularly where there is a volume of contact (exacerbated by the 'tick-box' manner of some assessments, discussed previously). In such instances, the approach was to assume that the same problem had emerged yet again, without fully appreciating the ways in which it might be different. Practitioners recognised the need to 'step back' but felt that there was a tendency to try to identify and deal with the immediate problem, or what was perceived as the immediate problem.

Theme 5: Knowledge

This theme is positioned last, as it ran through many of the reviews (DHRs 2, 3, 6, 7, 8, 10; APRs 2, 4, 5, 6; MHHRs 1, 2, 3) and also contributes to the other four themes already discussed. It therefore underpins and is central to the findings. Firstly, from reading all of the reviews it was evident that some sources of knowledge were privileged and therefore dominant. Professional knowledge took precedence over personal knowledge. This was particularly the case for medical knowledge, where much time was spent searching for a diagnosis (see Theme 3 Faulty Assessment), and once decided upon by psychiatrists (DHR 6; MHHRs 1, 3, 4) was not challenged or reviewed (see Theme 4 Tunnel Vision). In particular, the view of the psychiatrist was revered despite this often being the person who had the most limited information and/or had spent the least amount of time with the individual (typical appointments being quite short). In several cases, 'locum' doctors (those who temporarily fulfil the duties of another) were key decision-makers although, due to their role, were inherently less knowledgeable of the full background history (DHR 2; APR 2; MHHR 4). By contrast, the views of families or para-professionals were not often drawn upon or were seen as less credible in contributing to assessments of risk although they may see the individuals concerned on a daily basis and therefore may be far more attuned and alert to changes in condition and presentation.

In several cases (MHHR 2, DHR 3) the contact with the family was the lynchpin in providing professionals with information about the client and when this was no longer available, all contact with the client was lost (MHHR 2). Families often highlighted deterioration and increased risk; and, for example, advised against release from hospital (DHR 6; MHHR 2) but were not often listened to. This resonated with focus groups, where participants noted that families were often seen as part of the problem or as a 'nuisance', as was the case in APR 6. It was notable however, especially in the process of completing DHRs that family members and the information they could provide was seen as central, when it had not been during the course of the case. Furthermore, in none of the cases were any children seen alone: the knowledge they could have contributed was thus lost. Clients were often de-coupled from their families and seen in isolation. In DHR 2 both the perpetrator and victim were seen regularly by their two separate GPs but this information was never joined up. In several cases, there was little thought about the impact of extreme mental health difficulties on family members and indeed on children (see also DHR 2).

It may be that it is even more difficult to challenge the views of medical staff, given the professional hierarchy. In MHHR 1, the para-professionals took the client to the GP on numerous occasions highlighting their concerns, and whilst this information was fed 'upwards' to mental health professionals, information about assessment and treatment was not sent back down to those working with the individual 'on the ground'. Para-professionals (including third sector workers) and family members were not invited to decision-making meetings.

The role of the community psychiatric nurse (CPN) was significant in several of the reviews (MHHR 1, DHR 6) and the need for more home visiting and assertive outreach would seem to be invaluable for a more nuanced understanding and increased knowledge of people's situation and family support networks. CPNs formed meaningful, longer term relationships with people (MHHR 1; DHR 6). Conversely, in MHHR 1 the person was seen by nine different GPs, which meant that there was little opportunity for relationship building and more room for error in information sharing.

Discussion

The reading and analysis of the three different types of review is both unique and innovative and has not been undertaken before. The learning from reading across this diverse sample of reviews allows for an 'aerial' view to be taken to determine patterns and cross-cutting themes that cannot necessarily be gleaned or be seen when working within a single (type of) review, although there are undoubtedly benefits from exploring individual reviews and taking more of a 'worm's eye view'.

Another distinctive aspect of this research is to have a research team of professionals from three different disciplines – criminology, law and social work – code and analyse the data. Each professional evaluated the reviews from their own disciplinary perspective and thus applied a different lens to understand the features of the case. This helped the team to avoid 'silo thinking' and the privileging of one particular discipline over another, and facilitated the corroboration of findings through triangulation. Future research taking a similar approach would benefit from having a fourth coder from a medical discipline (e.g. psychologist, psychiatrist, mental health or medical professional).

All three researchers independently identified very similar themes from each of the review documents. Many of the same themes also emerged across the sample of reviews, regardless of whether the type was DHR, APR or MHHR (see Appendix B). A key finding of this research is therefore that the emerging themes are not 'new' per se, but rather that the five overarching themes were identified in multiple reviews originating from different inspection/review processes and representing a diverse sample of cases from across Wales.

The similarity of the key themes identified across reviews, corroborated by the discussions in the focus groups, provides evidence to suggest that having separate reviewing processes may not be the most efficient and productive way to promote multi-agency and multi-local authority, pan Wales learning from these tragic events. Currently, each review is commissioned and held separately, as specific to that context, situation, team or setting. The current commissioning process does not encourage or facilitate the spread of knowledge across local authorities and disciplines. Multiple, separate reviewing processes inhibits the learning and 'reading across' these incidents. Although the examples are diverse, the common thread drawing them together is that they involve agencies responding to people who are vulnerable, in a way that could be improved and may be reasonably expected to have been better.

The duplication of evidence gathering, where single incidents trigger numerous reviews (e.g. both MHHR and DHR) would seem to be unwieldy, unfair to family and not in the spirit of multi-professional, inter-agency working. This was highlighted as a concern in both of the focus groups and in survey feedback; for example, "I feel that the reviews work well but the issue is the impact of multiple reviews on families and other agencies in the duplication of work" (#7). These separate processes could be seen to be potentially deepening the silos in which people work and are expensive and time consuming.

The quality and scope of the reports was found to differ markedly. The reviews look back over a range of differing periods, from 2 months prior to death (APR 6) to 20 years (DHRs 1, 2; MHHR 4). Some reports are of far better quality in terms of their level of detail and analysis than others and writers of reviews would benefit from guidelines, training, a consistent standard and benchmarking. Family involvement (as discussed in Theme 5 Knowledge) in the reviewing process appears to be more prominent in DHRs. MHHRs are more uniform in their structure and comprehensive in their level of detail compared to the other types, including more medical discourse, although care is taken to define and explain treatments and medication. APRs are often devoid of background detail, which is difficult for those outside of the situation to follow, although they can convey helpful analysis and learning points for those involved. Unpredictable variability both within and across types of reviews was also highlighted as a barrier to learning in the focus groups; participants felt that a more consistent approach was required. For example, as a priority to improve learning across Wales there was a high level of support for:

> "Consistency - establish an All Wales Independent Review Team." (#2)

> "One review process which ensures learning and no blame but more importantly the learning is shared pan Wales." (#22)

This research suggests a number of ways in which the reviewing process could be streamlined and improved to enhance the likelihood of wider, deeper learning. Many of the focus group participants expressed a desire for a more centralised, proactive, structured approach to facilitate learning from reviews, which is specific to Wales. For example:

> "The ideal situation would be if an overarching body could take ownership of collating reviews, extracting and putting the learning in to themes, disseminating the learning and ensuring that this was being acted on." (#11)

> "I think the findings need to be collated centrally and fed back, so that we can all learn from them, not just the services involved." (#4)

> "To raise the profile when these are published, not only for professionals but the wider communities. To ensure clear access to learning experiences for all those who may be involved in similar situations." (#19)

Recommendations

The evidence contained in this report suggests a number of recommendations, which are listed below.

To improve the ***process*** of conducting reviews in Wales, we recommend that:

1. The process of commissioning reviews is streamlined so that for any incident only one review is undertaken. This would involve the development of protocols to guide decision-making as to which type of review should be carried out. Alternatively, one type of broader review could be created to incorporate all aspects of the case (e.g. the MHHR could include the DHR information or vice versa).
2. Additional training to improve the consistency of the quality of review is developed for and completed by all those charged with undertaking reviews in Wales. This needs to include cooperation, responsibilities, and information-sharing by different agencies contributing to reviews.

To improve the *outputs* from undertaking reviews in Wales, we recommend that:

3. A central repository or national library is established to promote the accessibility of completed reviews to facilitate learning pan Wales. Each review should be indexed according to the issues arising within it, so that others working in the same area may benefit from this easily accessible information.

4. An overarching body is established to take ownership of collating reviews, extracting and synthesizing the learning, and disseminating the learning. We note that the Welsh Government has recently established the Wales Learning Panel but this is limited to DHRs only.

5. A regular publication of the major themes emerging is produced and disseminated widely in order to enhance learning across Wales. This should occur at least bi-annually and adopt the robust methodological approach used here (i.e. thematic coding of multiple types of reviews by an interdisciplinary team).

6. The use of creative methods is explored to disseminate the messages from the reviews, for example, one survey respondent suggested the use of 'webinars'. These could provide excellent opportunities for teaching and learning and could form the basis of team or interdisciplinary supervision.

We anticipate that improving the process and the outputs in these ways will result in improved *outcomes* (i.e. practice across agencies will be improved through practitioners having better access to relevant learning from reviews taking place in Wales, with the ultimate aim to reduce the number of incidents requiring reviews over the longer-term).

As a final note, we would like to acknowledge that we feel privileged to have had access to such a broad range of reviews, which have proved illuminating for our future work. We are also very grateful to the busy practitioners who took time to participate in the focus groups and online surveys.

APPENDIX A

Descriptive table to provide a snapshot of each review and overview of the sample.

	Region	Date of Publication (Index Offence)	Period of review	Victim/s	Perpetrator	Children	Description of index of offence	Broader circumstances of the case
DHR1	Mid	2015 (2014)	Health records going back to 1990s	66-year old female	60-year old male	Yes (not present at incident)	Multiple stab wounds inflicted during sustained attack; also self-inflicted stab wounds	Elderly couple in a long-term relationship (he was both lodger and partner). No known history of domestic abuse. Perp previously on Serious Mental Health Register. Couple moved to Wales in 2011.
DHR2	South West	2015 (2013)	From 1996 (first incident known to police)	45-year old female	45-year old male	Yes (four children; significant negative impact from exposure to abuse)	Strangulation with a dog's lead; convicted of murder	Extensive history known to agencies. Perp had history of suicide attempts and alcohol abuse. Victim had separated from perp in 2011 although sexual abuse continued. Coercive control.
DHR3	South West	2014 (2012)	From perp's 16th birthday	49-year old male	23-year old male	Yes (perp was the child)	Multiple stab wounds inflicted on both parents, killing father; also self-	Perp had history of suicide attempts; diagnosis of schizophrenia; military

							inflicted stab wounds; convicted of manslaughter (diminished responsibility)	service. Family conflict; perp was in care of elderly grandparents.
DHR4	South West	2014 (2012)	From 2008, when perp moved back to Wales	37-year old female	29-year old male	Yes (each had 3 from past relationship)	Stab wound; convicted of murder	Short relationship; victim vulnerable due to previous abusive relationships and substance misuse. Serial perpetrator relocated to Wales in 2008.
DHR5	North East	2017 (2014)	From 2005 (review covered 8 prior victims as well as homicide victim)	45-year old female	47-year old male	Yes (victim had 2 children; other victims had children directly abused by perp)	Sustained attack and strangulation; convicted of murder	Short relationship initiated through dating website. Perp claimed PTSD; military service; biker orgs. Serial perpetrator with wide geographic reach (online dating).
DHR6	North West	2013 (2012)	From 2007, when services became involved with family	35-year old female	44-year old male	Yes (3; 10-year old daughter called 999; 3-year old son also died)	Multiple stab wounds on mother and child; convicted of manslaughter (diminished responsibility)	Domestic abuse not known to agencies. Perp had serious mental health (psychotic delusions); safeguarding of family members.

DHR7	South East	2016 (2013)	Five years prior to death	46-year old female	Male	Yes (two teenaged children)	Two fatal gunshot wounds; perp survived self-inflicted gunshot would; convicted of murder	Long abusive marriage. Perp claimed depression. Victim had separated from perp in 2013 although stalking continued. Coercive control.
DHR8	South East	2014 (2012)	From 2009, when agencies became involved with family	46-year old female; 17-year old female; infant female	27-year old male	Yes (infant was also killed)	Three generations killed in house fire; convicted of murder	Significant age gap between (intimate partner) victim and perp; CSE risk known to agencies. Serial perpetrator with known history of fire-setting moved to Wales.
DHR9	Mid	2017 (2016)	From 2012, when relationship started	51-year old female	45-year old male	Yes (each had children from past relationship; not present at time of incident)	Strangulation; perpetrator committed suicide	Alcohol abuse by victim and perp. Perp served time in prison. Couple recently moved to Wales. Victim disclosed abuse to work colleagues.
DHR10	South East	2015 (2014)	One year prior to death	21-year old female	Male	No	Multiple stab wounds and strangulation; convicted of murder	Victim vulnerable due to learning disabilities; also from child sexual abuse. Short term relationship, not known to agencies but she disclosed abuse to friends. Serial perp.

APR1	South West	2016 (2012)	Safeguarding concerns since 2010	76-year old female	None	Yes (not present at incident)	Died following surgery for incision and drainage of an abscess	Older person died following surgery. Repeated hospital admissions. Adult protection measures not implemented following receipt of information about abuse.
APR2	South East	2017 (2015)	31 months prior to death	18-year old (presumed female; gender not specified)	None	No	Died from combined toxicity; day before death found collapsed on train and hospitalised	Death of young person who was previously Looked After by the Local Authority on multiple occasions. Extensive agency involvement. CSE risk.
APR3	South East	2016 (2015)	Two years prior to death	18-year old male	None	No	Suicide whilst in custody	Death of young person who was previously Looked After by the Local Authority. Convicted of a serious sexual offences against a minor.
APR4	South West	2016 (2014)	From 2014, when perp moved into care home	Male with learning difficulties	Male with learning difficulties	No	Sexual assault	Perp and victim were both vulnerable adults with learning disabilities and challenging behaviour who were living in a privately managed residential care home.

APR5	North East	2017 (2015)	Two years prior to death	Male in his 40s	None	No	Cause of death: Hypothermia, Diabetes, Peripheral Vascular Disease and Neglect	Man known to agencies for self-neglect and mental health. His wife was a hoarder. Adult risk assessment and protection plan did not trigger the appropriate actions.
APR6	North East	2016 (2013)	From first fall in residential care (2 months before death)	Elderly female with dementia	None	Yes (not present)	Died in hospital due to injuries sustained from a series of falls	Falls of elderly woman not being recorded properly; care home staff and victim's family had different perspectives on her health and care.
MHHR1	South East	2014 (2011)	Contact with mental health services since 2009	Male	27-year old male	No	Killed his acquaintance (another resident in hostel); convicted of manslaughter (diminished responsibility)	Perp had long history of homelessness, alcohol and substance misuse. No consensus over the existence of a serious mental health problem until after the murder, when he was diagnosed with schizophrenia.
MHHR2	South East	2014 (2012)	Contact with mental health services since 2003	Multiple	Male	No	Assaulted 21 members of the public with crook lock and van (one died); convicted of manslaughter	Perp had history of mental illness; untreated psychosis at time of incident. Non-compliance with treatment.

							(diminished responsibility) along with 18 other offences	
MHHR3	North East	2014 (2011)	Contact with mental health services since 2010	Female	28-year old male	No	Killed woman unknown to him in another country	Perp was a foreign national who was diagnosed as 'malingering'. Equality and diversity issues.
MHHR4	South West	2016 (2014)	Contact with mental health services since 1995	Female	34-year old male	Yes (not present at incident)	Killed acquaintance (or new intimate partner?) in hotel (approved premises following release from prison); perp died whilst in police custody	Perp was a prolific offender (including domestic violence) and drug user; diagnosis of schizophrenia. Multiple periods of incarceration, insecure housing and poor compliance with treatment.

APPENDIX B

Overview table illustrating how the themes map onto the reviews.

	Brief title	**Theme 1** Crossing boundaries	**Theme 2** Hoodwinking	**Theme 3** Faulty assessment	**Theme 4** Tunnel vision	**Theme 5** Knowledge
DHR1	Lodger/partner kills older woman	Yes	No	Yes	No	No
DHR2	Perp kills ex-wife with dog lead	Yes	Yes	Yes	Yes	Yes
DHR3	Mentally ill son kills father	Yes	No	Yes	Yes	Yes
DHR4	Vulnerable victim killed by serial perp	Yes	Yes	Yes	No	No
DHR5	Serial perp kills new partner; online dating	Yes	Yes	Yes	Yes	No
DHR6	Psychotic perp kills wife and son	No	No	Yes	Yes	Yes
DHR7	Perp shoots ex-wife; attempts suicide	No	Yes	Yes	Yes	Yes
DHR8	Serial perp kills three generations in house fire	Yes	Yes	No	No	Yes
DHR9	Perp strangles girlfriend then hangs himself	Yes	No	No	No	No

DHR10	Perp kills woman with learning disabilities	No	Yes	Yes	Yes	Yes
APR1	Older woman dies following surgery	No	No	Yes	No	No
APR2	Care leaver dies from toxicity	Yes	Yes	No	Yes	Yes
APR3	Care leaver commits suicide in prison	Yes	Yes	Yes	No	No
APR4	Vulnerable adults; sexual assault	Yes	No	Yes	No	Yes
APR5	Self-neglect	Yes	No	Yes	No	Yes
APR6	Older woman dies after falls	Yes	No	Yes	Yes	Yes
MHHR1	Perp kills hostel resident	No	No	Yes	Yes	Yes
MHHR2	Perp commits multiple offences with van	No	Yes	Yes	Yes	Yes
MHHR3	‘Malingering’ perp kills woman	Yes	No	Yes	Yes	Yes
MHHR4	Prolific offender kills woman in hotel	Yes	Yes	Yes	No	No