Domestic Homicide Review
Overview Report

Review into the death of Julia, who died in February 2017 in Bristol

Review Panel Chair and Report Author:
Deborah Jeremiah

Report completed: October 2023
Report published: September 2024

Contents

1.0 Introduction

1.1 This report relates to a Brazilian couple (Julia and David) who came to live and work in the UK in 2016. Julia died in February 2017. Her partner David was convicted of her murder in April 2018.

1.2 It is known from GP records that in the weeks leading up to Julia's death she was concerned about David's mental health and suspected he was mentally ill. They attended David's GP together on 24th January 2017.

1.3 Julia told the GP that David had experienced significant mental health challenges in Brazil with the requirement of psychiatric care and medication. The review has not been able to verify the authorities in Brazil.

1.4 The GP made an urgent referral to Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), the local mental health trust. David was seen by a mental health nurse on 6th February 2017 when it was recorded that 'he did not appear psychotic'. It was also noted by the nurse that David presented as 'being well with no evidence of mental illness, nor of posing any risk to self or others'. There was a commitment on the part of AWP to obtain further information from the GP as to why they suspected psychosis given their assessment of him.

1.5 Julia and David had only recently moved to the UK. The only contact they had with any agencies prior to Julia's death were David's GP and in turn, Mental Health services.

1.6 The couple both held a number of jobs as casual workers. Julia had one sister living in the UK. Other than this, all family members and significant others lived in Brazil.

1.7 The review panel give their sincere condolences to Julia's family.

2.0 Timescales

2.1 The DHR Advisory Group of the Safer Bristol Partnership (now the Keeping Bristol Safe Partnership) met on 6th March 2017. The group recommended a DHR be commissioned as the circumstances of Julia's death met the criteria for undertaking a Domestic Homicide Review (DHR) under Section 9(3) of the Domestic Violence, Crime and Victims Act 2004.

(1) In this section "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, with a view to identifying the lessons to be learnt from the death.

2.2 The decision to undertake a Domestic Homicide Review (DHR) was taken by the Safer Bristol Partnership (now the Keeping Bristol Safe Partnership) on 6th March 2017 and the Home Office were informed on the 24th of March 2017. An independent Chair/author was commissioned on 5th May 2017. The first panel meeting took place on 15th September 2017, after which, in accordance with section 90 of the DHR statutory guidance, the review was pended at the request of the police until after the outcome of any criminal proceedings.

2.3 The trial of the matter was deferred twice and did not conclude until April 2018.

2.4 By 2020 the panel was of the view that as there would appear to be little learning with regard to domestic abuse the findings may be better presented as a mental health learning review. Communications with the Home Office confirmed that a Local Learning Review was permissible in all the circumstances but that this was ultimately a decision for the Keeping Bristol Safe Partnership. Following a meeting with the Independent Chair of Keeping Bristol Safe in May 2021, the reviewer was asked to prepare the report as a DHR. It was decided on balance the report would be submitted to the Home Office in the DHR format but with correspondence to explain the unusual path this review has taken.

2.5 It is acknowledged that this report is being produced some considerable time after the DHR was commissioned. The reasons for delay are due to the ongoing trial, efforts to locate and access family members outside the UK, as well as attempts to engage David. The pandemic also created significant delay throughout 2020 and early 2021. The report was substantively finalised by the author in 2021 but was further amended by the Keeping Bristol Safe Partnership due to some reservations regarding the report content and this has taken some time. The report was presented to the local safety partnership in November 2023 who made the decision to make further amends internally as they felt that the recommendations needed to be strengthened. The Executive Summary was not provided by the reviewer, so this was drafted internally by the KBSP team based on the Overview Report. The Chair was sent the report in December 2023 before it was submitted to the Home Office.

2.6 The main timeframe for the review was identified as February 2016 to February 2017 but with the caveat that if there was significant relevant information prior to this point, this was to be included to give context.

2.7 The DHR was presented to the Keeping Bristol Safe Partnership on 29th November 2023 and concluded on 26th January 2024 when it was sent to the Home Office.

3.0 Confidentiality

3.1 The content and findings of this review were strictly confidential during the review process. Information provided was only available to the identified participating officers and professionals and their line managers until the Overview Report was approved for publication by the Home Office Quality Assurance Group.

3.2 Until the report is published it is marked confidential to comply with Official Sensitive Government Security Classifications April 2014.

3.3 Pseudonyms were chosen by the independent Chair to maintain anonymity due to there being no contact with the family despite significant efforts to engage them. Julia for the victim and David for the perpetrator are used throughout.

4.0 The Terms of Reference

4.1 The following Terms of Reference for the DHR was agreed at the outset. At this point the family member was not engaged in the review.

4.2 The purpose of this review: -

- Conduct an effective analysis and draw sound conclusions from the information related to the case, according to best practice.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence.
- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims through improved intra and inter-agency working.
- Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life.

4.3 Specific Terms of Reference

Could improvement in any of the following have led to a different outcome for the victim and perpetrator considering:

a) Communication and information sharing between services with regard to the safeguarding of adults
b) Communication within services
c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards
b) Domestic abuse policy, procedures and protocols

The response of the relevant agencies to any referrals relating to the victim concerning domestic abuse or other significant harm from February 2016. It will seek

to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:

- Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim and perpetrator.
- Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
- Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.
- The quality of any risk assessments undertaken by each agency in respect of the victim and perpetrator.
- Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.
- Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded. This should include any aspects relating to immigration status, modern slavery, and access to services of those visiting the UK rather than being permanent UK residences. At this point the family member was not engaged in the review.

5.0 Methodology

5.1 At the time of the review the existing government definition of domestic abuse was followed:
Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: -

- Psychological
- Physical
- Sexual
- Financial
- Emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

It is acknowledged that the Domestic Abuse Act (2021) now provides an updated definition of domestic abuse.

5.2 The methodology of this Domestic Homicide Review is in accordance with Home Office Guidance. This Review examines the responses of all the relevant agencies that had contact with Julia and David and considers whether there were gaps in services or wider learning about domestic abuse. In line with the expectations of a DHR, full consideration was given to the involvement and potential contribution of key family members and friends.

5.3 The review panel determined that individual management reviews were required from:

- Avon and Wiltshire Mental Health Partnership NHS Trust
- Avon and Somerset Police
- Bristol North Somerset and South Gloucester Clinical Commissioning Group (now Integrated Care Board) with regard to contact with the GP service.

5.4 These reports were brief in detail given the limited contact between agencies and the couple. Julia was not registered with a GP and as far as could be ascertained had not accessed any services and David had only accessed a GP once and mental health services.

6.0 Involvement of family, friends, neighbours and the wider community

6.1 Julia had one family member already settled in the UK that being her sister, her brother-in-law and their children. She was sent a letter advising them of the review and inviting them to contribute from the outset. Also delivered at the same time, was the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet. Initially it was not possible to engage with Julia's sister, who was the only family representative in the UK, as she was due to be interviewed as part of the criminal trial and this could have prejudiced proceedings. The family liaison officer from Avon and Somerset Constabulary was tasked to liaise with the family and work friends and this information was shared to support the review. It is collectively understood that no-one was aware of any abusive element to the relationship.

6.2 All other key family members live in Brazil. With the assistance of Bristol City Council; the relevant Embassy; and an interpreter, efforts were made to gather further information from family outside the UK, but this has not been possible.

6.3 Information from family has been gathered from police information and others involved in David and Julia's life. While they had not been in the UK for that long when Julia died, they had developed friendships mainly at work and also attended church.

6.4 While under the DHR process, attempts were made to involve David who has remained in prison; however, input has not been possible due to David's mental health.

7.0 Contributors to the Review

7.1 Individual management reports (IMR) were received from the following agencies:

- Avon and Somerset Constabulary
- Bristol, North Somerset, South Gloucestershire Clinical Commissioning Group
- General Practitioner
- Avon and Wiltshire Mental Health Trust

7.2 The IMRs contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. None of the authors of the IMR's had management of the case or direct managerial responsibility for the staff involved.

7.3 Consideration was given at the outset and considered during the course of the review, to inviting others who might bring a specialist knowledge, particularly in relation to Domestic Abuse, to be members of the Review team. One panel member was from NextLink, a local domestic abuse organisation, who had expertise in domestic abuse and victim support. This service had no direct contact with Julia or David. More specialist advice was also sought from Bristol City Council's Equalities Officer regarding Brazilian culture and from a Catholic Church as Julia was known to be a practising Catholic.

7.4 NHS England also contributed to the review.

7.5 The timescales for this review have been outlined in paragraphs 2.2 to 2.5 above. Given the extended timescales, KBSP contacted both the Church of England Diocesan Safeguarding Advisor and the Clifton Diocese (the Catholic Diocese covering the West of England) Safeguarding Officer to secure their current policy positions regarding the Church and domestic abuse. Additional information from David's Probation Officer/Prison Offender Manager at HMP Dartmoor in particular relating to his mental health assessments was also sought and has been included.

7.6 The Review Panel met on 5 occasions.

8.0 Review Panel Members

8.1 A Review Panel consisting of the Independent Chair and representatives of the following agencies was established. The panel members had the requisite knowledge, expertise, and seniority. All panel members were independent from the case and line management of practitioners involved.

Agency/Organisation	Role
Independent	Independent Chair
Avon and Somerset Constabulary	Neighbourhood Inspector (now Chief Inspector)
Bristol City Council	Safeguarding Lead
NHS England	Quality and Safety Manager
Public Health	Senior Public Health Specialist
Bristol Clinical Commissioning Group	Safeguarding Lead
Avon and Wiltshire Mental Health Trust	Safeguarding Lead
Bristol City Council	Equalities Team (advisory panel member)
NextLink (Domestic Abuse Service)	Safeguarding officer Team Leader-Outreach/IRIS (advisory panel member)

9.0 Chair and Author of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the Chair and author are the same person. Deborah Jeremiah is an independent Chair and author who has significant experience chairing and writing previous Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews and was judged to have the experience and skills for the task. Deborah has undertaken the Home Office DHR training and has also been involved with national domestic abuse initiatives and supports several organisations which work with families around domestic abuse. Deborah also has academic links with two universities researching in this field. Deborah is independent of the case and of all the agencies involved.

10.0 Parallel Reviews

10.1 Her Majesty's Coroner for Bristol opened and adjourned an inquest into Julia's death pending the outcome of the criminal trial. HM Coroner confirmed the inquest later concluded based on a suspension under Schedule 1 of the Coroners and Justice Act 2009 given the outcome of the criminal trial. Therefore, a full inquest was not necessary due to the evidence that was heard during the criminal proceedings. Avon and Somerset Constabulary completed a criminal investigation and prepared a case

for the Crown Prosecution Service and the court. David was convicted of the murder of Julia in April 2018. He is serving his sentence in the UK.

10.2 Following Julia's death in February, the matter was referred to the Independent Police Complaints Commission (IPCC) on the same day. The detail of the IPCC investigation was reported independently of this review process; however, it is felt important to report that the IPCC investigation levied no concern or criticism regarding the police involvement or actions taken at the time. The actions it concluded were in accordance with recognised training and guidance and were deemed to be reasonable and proportionate in the circumstances.

Criminal Trail – David's fitness to be detained

10.3 Given Julia's reported concerns and the GP's referral to AWP regarding David's mental health, the relevant police policy and procedure during investigations in circumstances when a person's mental health may be a factor, were considered. Police powers and procedures are governed by the Police and Criminal Evidence Act 1984 and supporting Codes of Practice (The Codes). The College of Policing also provides Approved Professional Practice (APP) on the matter of risk assessment in custody.

10.4 The Codes place duties on the Custody Officer but of relevance in this case Annex 'G' contains guidance for police officers and healthcare professionals (HCP) with regard to a detainee's fitness to be detained and interviewed.

10.5 The Codes state that it is essential healthcare professionals consider the functional ability of the detainee rather than simply relying on a medical diagnosis, e.g., it is possible for a person with severe mental illness to be fit for interview.

10.6 On this occasion David was examined by two health care professionals for this purpose. They concluded that David did not have any overt symptoms of mood disorder or psychosis.

10.7 The duty to ensure a person is fit to be detained and fit to be interviewed is ongoing for the whole period of a person's detention and were there to have been any information to indicate a further assessment should have taken place then this would have occurred. The custody officer would also be expected to report any concerns regarding a person suspected of such a serious allegation, particularly mental health concerns, to the senior investigating officer (SIO) in charge of the investigation. The SIO in this case confirmed that this happened.

10.8 Throughout David's detention, the circumstances were reviewed by officers of the rank of Inspector and at least Superintendent on set occasions as required by the Codes. These officers were required to satisfy themselves that David's ongoing detention was necessary and that he was being treated appropriately.

10.9 Having been charged with the offence of murder, David was remanded into custody at HMP Bristol. The following information was provided by His Majesty's Prison service record. On the day of Julia's death in February 2017, he was seen by a doctor when it was deemed he needed to be transferred to a mental health facility for examination under section 48 Mental Health Act 1983.

10.10 The record identifies that a week later, David was transferred to Fromeside Unit, Blackberry Hill Hospital (a medium secure inpatient unit) for assessment and treatment. The hospital was informed of the information that David's GP had queried whether he was psychotic and that he posed a potential risk to his wife. The initial assessment at the Fromeside unit was that there was no evidence of psychosis, but that David was assessed at being a high risk of self-harm and suicide.

10.11 In August 2017 as the trial date came closer David became distressed and panicky as a consequence of which his case was adjourned. He was subject to further psychology assessments supported by an interpreter. It was deemed that he was suffering from distress and anxiety, but not a major mental health disorder such as psychosis.

10.12 In December 2017 David again became distressed as he received a letter informing him of the new trial date, the date being his wife's birthday. In addition to this, David had also received a distressing phone call from his mother who lives in Brazil.

10.13 There then followed a period where it was recorded that David started to display 'challenging behaviour'. This manifested in him declining to engage, keeping his eyes shut even when walking around, refusing medication, taking little nutrition and displaying poor self-care and hygiene. He also lost a considerable amount of weight. By March 2018 his weight had stabilised, but he continued to decline to engage with staff.

10.14 An undated letter on the prison record identifies that ultimately a speciality psychiatrist diagnosed David as having a histrionic and dependent personality disorder. He was not diagnosed with a mental illness.

10.15 In English law, under the Homicide Act 1957, diminished responsibility is one of the partial defences that reduce the offence from murder to manslaughter if successful. This allows the judge sentencing discretion, e.g., to impose a hospital order under section 37 of the Mental Health Act 1983 to ensure treatment rather than punishment in appropriate cases.

10.16 Under s.2(2) of the Homicide Act 1957 the burden of proof is on the defendant.

10.17 In this case David's defence solicitors commissioned MSS medico-legal a Bristol based firm specialising in the provision of psychiatry services (amongst others) to conduct an assessment of David. The assessments were conducted by two doctors.

10.18 The review did not seek to access the reports, as it is a fact that David's defence team did not seek to pursue a defence of diminished responsibility. Had they done so the police investigation team would have been informed and in turn the Crown Prosecution Service would have commissioned an assessment of David.

10.19 It therefore follows that David had been assessed by his own defence specialists and deemed 'fit for trial'.

10.20 It is acknowledged that the GP had referred David to mental health services as he was concerned David may be suffering from a mental illness. Paragraphs 2.6 – 2.17 above show that David was assessed on a number of occasions, including by the defence commissioned psychiatrists and was deemed fit to be detained and interviewed and at a later stage fit to stand trial. David was finally diagnosed with a histrionic and dependent personality disorder not a mental illness.

10.21 The review understood that the GP felt he would have been better to give evidence in person at the trial, rather than his evidence being adduced. The review therefore considered how the process of admitting evidence is governed by the Criminal Justice Act 1967. In practical terms this meant that the GP's statement was to be submitted in evidence by the prosecution and that the defence had accepted this. There was no need therefore for the GP to be called to the trial to present the evidence in person.

10.22 At trial David was convicted of murder.

NHSE Serious Incident Framework/ Mental Health Homicide Review

10.23 NHS England (NHSE) agreed that this case met the criteria for an Independent Investigation under the NHSE Serious Incident Framework (sometimes referred to as mental Health Homicide Reviews). NHSE's decision was that the DHR could serve the purpose of an Independent Investigation.

10.24 The mental health trust identified single agency recommendations via the process known as a Root Cause Analysis Report (RCA). NHSE have worked with the relevant mental health service following the production of their RCA report since 2018.The clinical commissioning group, now the Integrated Care Board, monitored the implementation of actions in support of these recommendations.

10.25 NHSE confirmed that to pursue a serious incident framework review was not appropriate given the passage of time.

11.0 Equality and Diversity

11.1 Julia was a white, 40-year-old woman who was a Brazilian national who had come to the UK to work and settle with her husband David. She had no children. Portuguese was her first language. As English was not Julia's first language this may have meant

that Julia was likely to have faced additional barriers to seeking and receiving support. Julia attended church and is reported to have had a strong faith.

11.2 David was 37 at the time of Julia's death. He is also a Brazilian national with Portuguese being his first language. AWP have David's ethnicity formally recorded as 'white – any other background'. David is divorced and has two children and an ex-wife in Brazil. David sometimes attended church with Julia.

11.3 Section 4 of the Equality Act 2010 defines protected characteristics as age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

11.4 There is no information to indicate that any act by David was motivated or aggravated by any factors relevant to the protected characteristics under the Equality Act 2010. However, one of the protected characteristics considered to have relevance to this DHR was Julia's gender, a female victim of domestic abuse. For the year ending March 2022, the Crime Survey for England and Wales (CSEW) estimated that 1.7 million women and 699,000 men aged 16 to 74 years experienced domestic abuse in the last year. This is a prevalence rate of approximately 7 in 100 women and 3 in 100 men.[1]

11.5 Julia informed David's GP that David had historic mental health problems, she also suspected that he was suffering with mental ill health, hence accompanying him to the appointment. However, there is no information to suggest David was disabled as a consequence of his mental health issues. Neither he nor Julia had physical health problems as far as can be ascertained.

11.6 Section 6 of the Equality Act defines 'disability' as:
[1] A person has a disability if: -
[a] they have a physical or mental impairment, and
[b] The impairment has a substantial and long-term adverse effect on the individual's ability to carry out normal day-to-day activities.

12.0 Dissemination of the Report

12.1 On final completion the report will be sent to the Keeping Bristol Safe Partnership. The following agencies will also receive copies of this report:

- Avon and Somerset Constabulary
- Bristol City Council
- Bristol Clinical Commissioning Group
- GP
- NHS England
- Next Link

[1] Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk)

12.2 The partnership will endeavour to share the report with Julia's sister.

13.0 Background Information and key events

13.1 David and Julia arrived in the UK as a couple in January 2016. This was a planned move. As far as the review was able to ascertain they were not married but referred to each other as husband and wife. It is unclear for how long they had been a couple, but it was for at least four years. Both arrived as Brazilian nationals from their home country. They stayed with Julia's sister, brother-in-law and children for a period, before moving to a private rented flat in a different part of Bristol in mid-2016. Julia's sister had moved and settled in the UK with her husband and children some years previously.

13.2 Julia and David's first language was Portuguese. At the time of her death Julia had applied to stay in the UK long term. David's immigration status was as an overstayer by the time of his trial. David and Julia's main family members reside in Brazil and some of Julia's also in Italy.

13.3 Julia and David's command of English is recorded differently in different places by services. It would be fair to reflect there may have been some level of a language barrier for David. It clearly states in AWP records that Julia spoke fluent English, although AWP still provided a translation service for her.

13.4 Both Julia and David were part of the "gig economy" working as car valets in the day and delivery drivers for fast-food companies in the evenings. They both drove and had vehicles, Julia a car and David a motorbike. Initially they worked at the same garage for car valeting in Bath but then Julia moved to a garage in Bristol. They worked most days and very long hours. Julia aspired to get a more permanent job to establish herself more in the UK.

13.5 Julia and David attended church where she got to know the pastor. The pastor is the father of one of their friends.

13.6 At some point in late 2016, Julia was concerned that David had started to behave strangely. He had become paranoid and fearful that she would leave him. She later reported this to David's GP and then later during conversations with AWP.

13.7 Julia was not registered with a GP practice as when she tried to do so she was deemed to be outside the catchment area for the particular practice she had approached. It may have been that she tried using her sister's address, but this remains unclear. She would have been given details of other GP surgeries in her catchment area but there is no record of her registering elsewhere. David, however, was registered with a GP.

Events of 24th January 2017

13.8 Given her concern about David's mental health and paranoia, Julia took David to see his GP on the morning of 24th January 2017. This attendance was the only time David was seen by the GP and Julia was present throughout. The GP used a telephone interpreter to assist with the consultation. David explained to the GP that he had two jobs and was stressed and that he was paranoid that Julia was having an affair.

13.9 Julia reported to David's GP that David had a history of mental health problems and was experiencing stress from work, financial pressures from a previous relationship and a skin pigmentation issue which appears to have impacted upon his self-esteem.

13.10 David was referred to secondary mental health services by his GP on 24th January 2017. The referral was marked as emergency, meaning that it requested face-to-face input within a four-hour period. The GP was concerned that David may be experiencing psychosis and that he could pose a risk of violence, especially to Julia. David's GP was concerned that David was experiencing paranoid delusions about his wife having an affair. His wife reported that David had a knife to protect himself and she reported that David had been verbally aggressive and, in the past, violent. The GP referral to AWP also contained the following information:

- David reported a 2–4-month history of feeling stressed, low and withdrawn, and had reported this to be getting worse.
- David had been working very hard with two jobs 07.00-23.00.
- David believed people were talking about him all the time, felt intimidated and thought people wanted to harm him.
- David had reportedly bought a big knife to protect himself but couldn't say why. Julia was said to be afraid he may get violent.
- Julia said David was convinced she was having an affair and that he had recorded her on his phone to try and prove this.
- She thought he was hearing voices telling him she was having an affair.
- She said he had used his phone to record evidence that she was having an affair. He claimed to hear them when playing back the recording.
- His wife stated that David had been going around to her sister's house behaving strangely, imagining things, and had been paranoid and aggressive.
- Julia reported fearing for her safety saying he was verbally aggressive to her, and she reported in the past he had been physically violent (although the context here was unclear).
- She reported to the GP that he had a similar episode two years ago in Brazil, stating that he had seen a psychiatrist and was offered treatment, but didn't take it. It has not been possible to verify or otherwise during this review process.
- No reported history of drugs or alcohol.
- Julia presented as anxious and stressed.

13.10 On 24th January 2017, initial contact was made by the Triage Nurse with David who was supported by an interpreter. It is unclear how long this assessment/triage lasted. David reported that he had a cleaning and delivery job, and that he worked

long hours. He stated that he was 'convinced his wife was having an affair with her brother-in-law as he has a recording of their voices'. Both his wife and his sister-in-law have listened to the 'recordings' and have 'dismissed them'. During the assessment, he denied having thoughts to harm himself or others and stated that he 'did not have any concerns about his safety or that of others'. He denied that he ever bought a knife 'to attack his wife or others'. He described having a skin pigmentation problem which affected his self-confidence, and which 'becomes worse due to stress'. David reported not hearing voices, but he was 'keen' to access mental health services, 'especially medication', and described being 'tearful and feeling increasingly anxious lately'.

13.11 At the end of the assessment, David agreed for the Triage Nurse to contact his wife and his friend. To triangulate the findings from the assessment, the Triage nurse then contacted David's friend with the aid of an interpreter. His friend stated that he was unaware of any problems David was experiencing and was unaware of issues between David and Julia, and that he himself has no concerns. The Triage Nurse gave David's friend the number for the Crisis Line.

13.12 To complete the triangulation of information, the Triage Nurse contacted Julia with the help of an interpreter. Julia was described as speaking 'fluent English'. She reported a 'noticeable' change in her partner's presentation, citing the examples of 'arrogance, self-isolation, verbal aggression, and paranoia', and that was why she took him to the GP.

13.13 She identified his problems at the time were related to his skin pigmentation, a 'court case in Brazil with his ex-wife' which was related to debts that had now been cleared, and to a 'general inferiority complex'. Julia stated that David played the 'recordings' to both herself and her sister, but that they denied the 'recordings' were of them. Julia advised that she was 'not worried about her own safety because she was able to stay with her sister', but that she wanted David to be able to access treatment.

13.14 She reported intentions to remain at her sisters until that happened. The Triage Nurse advised Julia of the follow up assessment on 26th January and Julia confirmed that she would be able to take him to this. The Triage Nurse provided Julia with the contact number for the Crisis Line.

13.15 Following the conversations with David, Julia and his friend, and a team discussion with colleagues, the referral was downgraded to urgent, which meant that David needed to be seen for a face-to-face assessment within 72 hours. This was based on the initial contact identifying no immediate risk of harm to David or others. The assessment would have utilised the Triage Trigger Tool to support the rationale to downgrade the assessment. The Triage Trigger Tool provides a structured framework for screening and categorising levels of risk and acuity for individuals newly referred to mental health services. It helps to underpin the clinical decision-making process following referral.

13.16 The triage nurse booked an appointment with the Recovery Team for 26th January, when he was due to be seen by the recovery nurse.

13.17 David did not attend the scheduled appointment with the recovery nurse on 26th January. That same day in response to the non-attendance, attempts were made by various members of the Recovery Team to speak to David's GP regarding additional information and to advise of the non-attendance. A message was left regarding the non-attendance. This is in line with the Access to Primary Care Liaison Services Standard Operating Procedure which would have been in place at the time of the referral. This procedure suggests that on a non-attendance a conversation should take place regarding the management and what further action should take place, in partnership with the referrer. The team also attempted to contact David, Julia, and a family friend, in order to book a further appointment. These attempts were not successful, and messages were left on their phones asking them to make contact to rearrange.

13.18 A further attempt to contact David and reschedule the appointment was made by administrators on 27th January. He answered the phone and was unable to comprehend the administrator very well, but appeared to understand that she would send him an appointment letter. The letter was sent to David in both English and Portuguese offering him an appointment on 6th February and an interpreter was booked.

13.19 On the 2nd of February, an administrator sent David a text message reminder regarding his appointment. David replied via text: 'Hello good day! My name David. I'm very well. I'm working and I cannot miss. I'm very well with my wife. Thank you for all your attention!'.

13.20 On the 6th of February, David was assessed by a recovery practitioner, with an interpreter present. He described the anxiety he was experiencing was a result of his wife cheating on him. He stated that she went to live with her sister for two weeks but had returned to live with him again. David spoke of the audio recordings as proof of the affair. David stated that he made an audio recording of his wife so that he had proof she was having an affair and that he had seen her sister's husband entering their home during the daytime. David said that Julia had apologised and that he had forgiven her and that she had suggested couples counselling. He denied having any thoughts of harming himself or others. At the time of the assessment, David was not taking any medication but expressed interest in starting medication to help with his anxiety.

13.21 Following the assessment, the recovery practitioner left a telephone message with David's GP, requesting a call-back as their assessment indicated that David did not appear psychotic. They wanted to discuss why the original referral had been marked as emergency in case the GP had further information which AWP had not been made aware of, in effect to triangulate their findings with the concerns of the GP.

13.22 A telephone conversation was scheduled with the GP for 10th February to discuss the referral and the recent assessment. However, the GP Surgery's practice manager telephoned the recovery practitioner to inform them that the GP would not be available to talk the following day and stated that all the information needed was 'on the referral'. The recovery practitioner explained that it would be helpful to talk directly to the referrer, but records on RiO, (AWP case recording system), state that 'this was not heard'.

13.23 After not being able to discuss the case with the GP, the recovery practitioner telephoned the AWP Safeguarding Team for advice.

13.24 The team advised to further assess David, to contact Julia again regarding her concerns and to review her view of the risks, to further attempt to contact the GP to discuss the case, to consider requesting a 'police marker' on the address given the details on the referral and reported risks to Julia, and to consider reviewing lone working with David if able to carry out a face-to-face assessment.

13.25 After this discussion, the recovery practitioner attempted to call David, Julia and the family friend for a further time. However, none of them answered the telephone. The practitioner did however leave messages asking them to return the call. After not being able to make contact, the practitioner spoke to the senior practitioner to provide an update.

13.26 A further attempt was made by the recovery practitioner to telephone David, Julia and the family friend, but again without any of them answering. The recovery practitioner requested 'admin' sent text messages to David and Julia requesting a call-back. A further update was given to the senior practitioner and the decision was made to contact the Police. They requested a 'marker' be put on the address in light of the risks identified on the referral. A further contact was made after this with the GP to advise them of this.

13.27 Now 14 days after David was seen by the GP, at 2.43pm the police received the call from the recovery practitioner in mental health services. The recovery practitioner told the police that they were ringing because of the mention of a knife and possible historic problems about David becoming mentally unwell and being violent. They asked for the call to be logged and the address marked. However, mental health services gave Julia's sister's address, not the flat where Julia and David lived. The recovery practitioner told the police there were no injuries, nor any incidents known in the past. They said he had presented well mentally when recently assessed. The recovery practitioner explained to the police call handler that they had been unable to obtain any further information from the GP but there were no restraining orders or alcohol involved. They wanted the police to be aware.

13.28 The police initially graded this referral as requiring an immediate response. The police systems were checked at 2.57pm and neither Julia or David, nor the address were known to the police.

13.29 At 6.47pm, the incident was reviewed by police and a decision made that a welfare check should be conducted. The police also wanted more information to consider a safeguarding referral.

13.30 At 10.13pm, two officers attended Julia's sister's address (believing this was the address for David and Julia), but no one was visibly in. Nothing untoward appeared and neighbours had not heard any signs or noises of a domestic argument. It was marked for an officer to make contact later.

2 days before Julia's murder in February 2017

13.31 At 10.10am, the incident was considered for allocation by the police but at 12.50pm there were no available officers to deal with this. This was still the position at 8.38pm.

The day before Julia's murder in February 2017

13.32 The police attended Julia's sister's address again at 1.55pm and were advised by Julia's sister that Julia was staying with her, but that Julia was at work. This is contrary to what David told AWP staff on assessment on the 6th of February 2017 when he said she had returned to live with David.

13.33 Julia's sister said she did not know Julia's address with David. Julia's sister said she had no concerns about the couple. The police officer left that address. Julia's sister informed Julia that the police were looking for her and David. Julia was anxious and asked David if he had done anything. The couple then returned to their flat. At 3pm, a neighbour of Julia and David's heard an argument from their flat. The neighbour said the shouting was in another language and lasted around 15 minutes. The neighbour was not sufficiently concerned to call the police.

13.34 Both the couple were seen at their delivery jobs that evening and they travelled in convoy back to their flat at 10.54pm. The last message from Julia's phone was at 11.07pm to the work group to say goodnight. There was later phone activity on Julia's phone to David's relatives in Brazil. Those messages are believed to have been from David.

13.35 During the night, David travelled to his friend's house and was agitated. He said he and Julia had fought and he had left the house. His friend was unable to accommodate him, and David travelled back to Bristol and parked in the car park of the mental health recovery base at 6am. This is the same place at which he had been assessed on 6th February.

The day of Julia's murder

13.36 While in the carpark, David contacted his pastor, and they agreed to meet at 6pm that day.

13.37 David walked into the Recovery Team base without an appointment at 9.30am distraught, crying and inconsolable. He had what looked like a seizure and a

paramedic was called. He was also seen by the same recovery practitioner who had assessed him before. Another member of staff who spoke some Portuguese assisted and they established that David was saying that Julia was dead. The police were called accordingly. Police initially attended the address they had for the couple (Julia's sister's address). The sister said again she did not know their address but was able to take the police there. At 10.21am, police entered by force to find Julia with multiple fatal stab wounds. David was arrested. The murder weapon has never been found.

13.38 Matters were then progressed through the criminal justice system and David was subsequently convicted of Julia's murder.

14.0 Analysis

14.1 It cannot be in doubt that David murdered Julia in February 2017 and he was in an intimate relationship with her. However, from the information gathered from family and friends, this was not a couple for whom they had concerns around domestic abuse or coercive control.

14.2 Latterly, Julia did report to the GP some indicators of concern e.g., jealousy/paranoia about an alleged affair, verbal aggression, presence of a weapon and some history in Brazil of an altercation and verbal abuse when mentally unwell.

14.3 Those community members or family inputting into the review who knew the couple state that they were very committed to each other and had come to the UK to start a new life together and settle here. David was never seen in any other way as positive towards Julia. When David became mentally unwell, the GP suspected psychosis and made a referral to AWP. He believed that Julia was betraying him but also, he feared for himself, and both he and Julia expressed to professionals the impact of David's mental health upon their relationship.

14.4 David reported to AWP that Julia had apologised to him for being unfaithful and had suggested couples counselling. Whether this was in fact the case, the review has been unable to establish.

14.5 It is known that Julia did spend some time at her sister's. Julia said it was for two weeks whilst David sought support for his mental health, whereas David stated she returned home once she had apologised for being unfaithful. The review has been unable to identify which account is accurate.

14.6 During the review, issues of faith were considered. Those that knew them at church were not concerned about the couple from a domestic abuse perspective, but Julia was encouraged to take David to the GP for help as he was considered to be mentally ill. At no time did Julia express she was fearful of David or that she was in a situation of domestic abuse. The focus was one of great concern around David's mental health.

14.7 The review sought to explore what information sharing would take place had Julia shared she was the victim of domestic abuse with the church ministry team. Information was requested from both the Church of England (C of E) and Catholic Diocese in Bristol. Given the passage of time with this review, the current position has been included.

14.8 The Bristol (C of E) Diocesan Safeguarding Adviser explained that the Church response to domestic abuse has evolved considerably since the case of Julia and David. In 2017, the Church of England issued practice guidance 'Responding Well to Domestic Abuse'. From 2017, all parishes are required to adopt and display a Domestic Abuse Policy Statement.

14.9 Prior to January 2022, Domestic Abuse training was more limited to Clergy. Since that date, Domestic Abuse training is delivered online and is now a requirement for all Parochial Church Council Members and all who hold the bishop's licence (Clergy, Licensed Lay Ministers, Churchwardens). An online safeguarding virtual library has been developed which is hosted on the Church of England Safeguarding Training Portal. In the Diocese of Bristol, there is also an offer of a Domestic Abuse workshop to augment the online training and supports those who do not feel able for any reasons to do the training online to access the training 1:1 or as part of a face-to-face group.

14.10 The safeguarding advisor explained that the Church would expect any disclosure of Domestic Abuse to be reported to the Safeguarding Team. This would include encouraging the victim to seek support from local domestic abuse support services. In addition, if the alleged perpetrator was a church officer or member of clergy, this would be referred to the Local Authority Designated Officer if there are children in the household. Locally the Church has recruited a safeguarding caseworker who has previously worked directly with victims of domestic abuse.

14.11 Within the Clifton Diocese, domestic abuse is a feature in training for parish safeguarding representatives, the clergy, and volunteers which is offered by face-to-face and online. Every parish is provided personalised safeguarding information which includes local sources of support, the relevant contacts for that area, and parishes are encouraged to display posters in key locations. The safeguarding advisor advises parishes on domestic abuse concerns but acknowledged that a relatively small number of parishes approach them for advice and further work could be done to ensure all parishes within the Diocese are contacting the safeguarding advisor.

14.12 Nationally, the Catholic Safeguarding Standards Agency (CCSA) was set up in early 2021. The CCSA is in the process of auditing every Diocese in England and Wales against eight standards, supporting victims is a key part of this audit. CCSA have developed national domestic abuse guidance and provide online training modules on domestic abuse.

14.13 The cultural dimension was also considered, and the Chair gained input from those who work with the Brazilian community. Mental health is not seen in the same way as in the UK in the sense that it carries more stigma in Brazil. Julia informed David's GP that he had not taken his medication whilst living in Brazil. Julia's sister supported them to find a GP for David. We were advised that domestic abuse in Brazil is culturally not addressed as robustly as in the UK, but we cannot say in any event that there was a history of domestic abuse between the couple.

14.14 The language barrier appeared greater for David than Julia, and Julia was described by others to have gained English more quickly. Both the GP and AWP displayed good practice by providing interpreters and information in both English and Portuguese to David and Julia. Where there are language barriers, access to services can of course be more challenging. It is known that Julia had not managed to register with a GP.

14.15 There was good evidence of use of interpreters by AWP for the majority of contact with David, and certainly for both assessments. There was also evidence of letters being sent in both English and Portuguese which is evidence of good practice.

14.16 During the review, a friend of the couple described the work arrangements in their fast-food delivery job as distant and lacking in any concerns as to the welfare of workers, be this health or abuse. The focus was simply getting the hours filled to business need. He confirmed the hours were long but that long hours were necessary to earn a basic living wage as the pay was so low. It is noticeable that David missed one of his medical appointments because of work pressures and that the couple were difficult to track down by phone or at their home. We know that David had money problems emanating from his divorce and the couple were renting in a private flat in Bristol where rents are high. Julia described David as having low esteem. The work colleague said that he thought the couple were happy together, but that David seemed very stressed. Julia did not disclose any domestic abuse issues to her work colleagues. Whilst Julia did not outwardly describe what was happening to her as domestic abuse, there were highly likely signs which would have indicated this given her presentation. It is doubtful however, given the description of the work environment and related pressures, that work colleagues would have had the time to explore these issues with Julia. Of interest, the work colleague did say that Julia's English was good but David less so.

15.0 Appraisal of agency and professional practice

15.1 This appraisal of practice and analysis is in reference to the Terms of Reference set out earlier in this report.

15.2 It is important to acknowledge that at the time, AWP conducted a root cause analysis of their involvement in the case which resulted in three recommendations. They are reported below but updated given the passage of time since the report was commissioned.

1. A review to be carried out of the Safeguarding Team's current use of RiO, (AWP's case recording system), including its capacity to access it as part of the process of giving advice and the impact on the quality/reliability of that advice of not doing so.

   Response
   The team now have full access to 'Rio'. They are able to review patient records and now input any contacts and subsequent safeguarding advice directly onto the recording system.

2. Guidance to be provided for practitioners in the escalation process to follow when they are unable to carry out direct communication with healthcare professionals outside the Trust.

   Response
   There is now an organisational expectation and process for such a concern to be escalated to someone senior.

3. Recovery Team: Responding to non-attendance (DNAs)/cancellations of assessment by service user.

   Response
   There is now a requirement for the assessor to be clear about urgency of when next appointment should be offered. DNAs/cancellations of 72-hour referrals are now discussed in the assessment meeting and plan agreed regarding urgency of the next assessment. The assessor informs the assessment administrator of the time of the next appointment, for example within in 24/48 hours. The administrator is to escalate to a band 7 if no available assessment slot is available in that time frame. This guidance has been recirculated to assessment teams.

15.3 Given the passage of time since this review was originally commissioned and the delay in report completion, it is appropriate to report here the considerable additional progress made by AWP with regard to recognising and assessing domestic abuse which are included here:

- The advice on Trust procedure now is to complete a 'DASH' at any disclosure of domestic abuse or any new info indicative of domestic abuse.
- The Trust has developed support tools for staff to support in their response to domestic abuse - the first being a support tool for helping frontline staff complete the DASH, a Safety Planning tool for staff to complete with victims of abuse, and the Domestic Abuse Service Directory which outlines the domestic abuse support services by locality and the national support options.
- The Trust has also since employed a Domestic Abuse Lead to identify areas of service development in relation to domestic abuse and to have oversight into how the Trust interfaces with agencies in relation to domestic abuse e.g., Multi Agency Risk Assessment Conferencing (MARAC) and strategic meetings. The role also offers oversight Trust wide into themes of practice which

require improvement identified through audit, staff knowledge surveys, DHR oversight and training oversight for all staff in AWP in relation to domestic abuse.

- The Trust has also provided training to frontline staff on the DASH risk assessment, has developed a DASH risk assessment support tool to identify red flag indicators of serious harm based on evidence and has developed a safety planning toolkit for staff to support in advising victims on maintaining safety.
- The Trust also organised and facilitated a Domestic Abuse conference in 2021 based on high-risk cluster behaviours of harm, 8 steps to homicide research, perpetrator behaviour and victim risk factors. This was attended by over 300 individuals from a variety of voluntary and statutory agencies.
- AWP now also has an in-house training via e-learning platform for all practitioners who are required to complete level 2 safeguarding training. The module consists of details around how to complete a DASH, high risk cluster behaviours and recognising the signs of abuse and high-risk cluster behaviours amongst other topics.

15.4 Julia had little contact with services, but David had registered with a GP. Julia had tried to register with a GP but at the time was living outside the practice having moved to her own flat from her sister's where she and David first lived when they came to the UK. They both intended to settle in the UK, and both were applying to stay here long term.

15.5 David first accessed a service when he was taken to the GP by Julia on 24th January 2017. This was the only contact with primary care. The GP was sufficiently concerned to make an immediate and urgent referral to mental health services. The detail of the consultation and referral is included earlier in this report. The GP noted some tension between the couple.

15.6 The police say in their IMR that had they established that David was carrying a knife in a public place, he would have been subject to detention and investigation. This in turn may have included a Domestic Abuse Stalking and Harassment and Honour based Violence (DASH) risk assessment. This report outlines how the police went on to conduct a welfare check on Julia.

15.7 At the time of the review, the DASH form was designed to be used by any frontline professional, but it was mainly used by the police. Since that time, through updated policy and training, there is a broad understanding across agencies of both domestic abuse and specifically the DASH. As a minimum, agencies have dedicated professionals who can conduct the DASH. In some agencies, for example AWP, all frontline staff are expected to use the DASH.

15.8 The Royal College of General Practitioners endorse an approach known as "IRIS" which is a practice-based training, support and referral programme that IRIS provides domestic violence and abuse training for general practice teams and

specialist support for those experiencing Domestic abuse. The GP practice in this case was an IRIS practice and would therefore have been DVA aware.

15.9 AWP explained that the decision to downgrade the referral from 'emergency' to 'urgent' was commensurate with the level of risk captured by the conversations that took place, including in the Trigger Tool. The guidance from the Trigger Tool indicates that emergency referrals (i.e., 4 hours) would involve imminent risk to life such as a service-user being on top of a building or a railway line. In this case, Julia was not expressing immediate concerns, and David was willing to engage and denying immediate risk to self or others. A brief triage assessment is simply used to identify the need for assessment and the urgency. A more thorough assessment was required and was booked for within the 72-hour time frame.

15.10 AWP also explained that there was no indication at this stage that intensive input would have better managed the situation. Given David's presentation, albeit over the phone, and denials of a mental health element to the ideas he was expressing, the IMR author states this could even have exacerbated the situation and his attitude toward those ideas and Julia. He was expressing willingness at this stage to work with the plan agreed with the Triage Nurse, which included a face-to-face assessment as well as consideration for the introduction of medication to help alleviate the anxiety he said he was experiencing.

15.11 From the moment David did not attend the appointment with mental health services on 26th January 2017, on-going attempts were made by mental health professionals to liaise with other agencies aware of David's referral to mental health services: the GP, Julia and their friend.

15.12 In addition, during this period, advice was sought from the Trust's safeguarding team, senior colleagues and latterly, the police. The assessment by a nurse that took place on 6th February 2017, found no evidence of psychosis and David presented as very different to what was portrayed in the referral submitted by the GP, in that he was plausible in his account of his situation, as well as appearing coherent, rational and emotionally balanced. The assessment was aided by the presence of an interpreter. The decision by the recovery practitioner to contact the GP was an indication that the information on the referral continued to be taken seriously and that additional information from the referrer could have helped build a different picture to that presented on the day.

15.13 When the GP did not provide further information, another recovery practitioner sought advice from the Trust's Safeguarding Team. Advice was provided by three adult safeguarding leads and was based on information given to them by the recovery practitioner during a teleconference.

15.14 Based on the information given to the safeguarding leads at the time, the advice they provided appears proportionate to the evidence of risk. However, during this review it has become apparent that information contained in the GP referral, regarding a possible history of domestic abuse, or David becoming violent when

mentally unwell, was not fully communicated to the safeguarding leads. The advice from the safeguarding leads was therefore based on sub optimal information. The safeguarding leads did suggest the police be contacted for a welfare check which is good practice. The mental health service initial appraisal was that risk was low, following contact with the wife and service user, efforts were then made to contact the GP to discuss the initial assessment from mental health services. Following the face-to-face assessment by mental health services, this led to further attempts to review the concerns with the GP given the continued low risk identified by mental health services in the context of the initial 4-hour emergency referral. Following the assessment on the 6th of February by mental health services, there was an absence of contact despite efforts with primary care, service user, wife or friend. Following further review with the AWP safeguarding team and the recovery team senior practitioner, a decision was made to request a welfare check by the police in respect of the initial concerns raised by the GP.

15.15 The AWP safeguarding professionals state that had they been aware of all of the information, they would have advised the completion of a DASH with potential consideration of a referral to MARAC.

15.16 Reaching out to those entering the UK for the first time who may be in need of agency support around actual or potential domestic abuse remains a challenge.

15.17 Evidence suggests that working closely with carers and/or significant relatives is both likely to produce better outcomes for patients and reduce the stress and often distress of caring for someone with mental health problems. In these circumstances the triangle of care commitment is to the service users carers, therefore this was met with the support offered to his wife and friend.

15.18 All possible measures seem to have been taken to engage with Julia during this assessment process i.e., during the triage process when staff spoke to her, and subsequent efforts were made to contact her on the phone. Beyond this point, numerous attempts were made to contact her by telephone, messages being left on every occasion but not all information from the GP referral appears to have been fully appreciated from the outset. The lack of further contact with Julia meant that there were no further opportunities to explore the initial information from the GP in further detail.

15.19 The police had no history on the couple or previous knowledge until they were contacted by mental health services some 14 days after David presented at his GP's. The police in their IMR say they did use the mobile number provided by mental health services to contact the couple.

15.20 The misunderstanding regarding Julia's actual address from the police perspective has been reported above. Arguably the police could have asked Julia's sister to take them to her address when they were trying to conduct the welfare check but in the event they were reassured by no concerns being expressed by the family member,

thereby the police would have felt the need for them to conduct a welfare check was no longer necessary.

16.0 Conclusion and Learning Points

16.1 This review has been unable to definitively conclude that domestic abuse was a current feature in the relationship in the lead up to Julia's death. David appeared to have ongoing issues around paranoia. His GP had concerns that David was exhibiting signs of psychosis which were referred to secondary mental health services. Julia believed David was hearing voices. At times, Julia went to stay with her sister for short periods. The review has worked on the assumption that this was for some sort of relief but has not been able to identify whether this was because of David's mental health and/or associated aggression, or in fact whether David was also responsible for domestic abuse. Those close to the couple highlighted David's stress and mental health challenges rather than concerns that David was abusing Julia, but we cannot say with total clarity what the dynamic of their relationship was in February 2017. The fact remains that David ultimately murdered Julia. David may have been mentally unwell at periods of time, but this cannot be ascertained definitively through this review. He was deemed fit to stand trial and was convicted of murder.

16.2 Both GP and secondary mental health services face challenges in terms of high volumes of service delivery required and tight resource. The grading of the urgency of referrals from GPs to mental health are of course a matter of interpretation. It is important therefore that where attempts are being made between primary and secondary care to 'triangulate' referral information against later assessment, that all professionals create the time and space to engage in dialogue.

16.3 During the review it was established that David had asked if he could be returned to his home country of Brazil to serve his prison sentence there as he has no family of friends in the UK. In Brazil, he has his mother, a sister, his grandfather and two sons. Enquiry was made with the Home Office but transferring David to his home country was not possible as they do not have an equivalent sentence to that he must serve under UK law.

16.4 Whilst in custody, David started to learn English, but it is described as basic. He continues to be supported by translation services.

16.5 There is a significant and therefore problematic time difference between the UK and Brazil. This is compounded by a severe lack of telephony facilities for serving inmates. Consequently, David gets little contact with his family, which given his situation would seem to be a matter of some concern to the UK criminal justice system.

17.0 Recommendations

17.1 KBSP to seek assurance that all agencies recognise the need and use DASH to assess risk in appropriate cases.

17.2 New residents, particularly for those for who English is not their first language, to be supported to register with a GP practice.

17.3 As part of the reform of Domestic Homicide Review Statutory Guidance, the Home Office should consider whether homicides involving acute mental health episode meet the criteria for a Domestic Homicide Review.

Appendix A: Action Plan

Recommendation	**Scope of recommendation** Local/ Regional/ National	**Action to take** *What specific actions will be taken to fulfil this recommendation? Ensure the actions are SMART: Specific, Measurable, Achievable, Realistic, and Timely*	**Lead Agency**	**Key milestones achieved in enacting recommendation** *What are the key milestones within the plan for completing these actions which can be measured for progress reporting?*	**Target Date** *When will these actions be completed?*	**Date of completion and Outcome** *To be completed upon completion of actions.*
1. KBSP to seek assurance that all agencies recognise the need and use DASH to assess risk in appropriate cases.	Local	1.1. Agencies to raise awareness to all staff about the need for a DASH and who is able to complete DASHs within and external to their service e.g., IDVAs, police.	KBSP	1.1. Refresher to all staff on the need for DASH and for all staff to be aware of who can conduct a DASH.	July 2024	*Completed.* *All agencies involved in this review have provided assurance that they raise awareness and offer training within their agencies about the need to complete a DASH.*
		1.2. Awareness of the need and who can complete a DASH to be included in the KBSP Multi-agency Domestic Abuse Training.	KBSP Training and Development Officer	1.2. KBSP Multi-agency Domestic Abuse and Safeguarding Training updated.	December 2022	*Completed.* *KBSP developed and has rolled out Multi-agency Domestic Abuse and Safeguarding Training since December 2022 this includes information about the need for DASH risk assessments, who can complete a DASH and how it feeds into MARAC referrals.*

2. New residents, particularly for those for who English is not their first language, to be supported to register with a GP practice.	Local	2.1. ICB to provide assurance that those who present to GPs from outside their catchment area will be signposted to the appropriate GP surgery that is local to their need. This is especially important for those whose first language is not English.	BNSSG Integrated Care Board	ICB to share their policy/guidance for signposting those who present to the GP that is outside their catchment area.	June 2024	*Completed.* *A GP bulletin was issued to all general practices across the BNSSG footprint to share guidance for staff to sign post service users who are outside their catchment area to other service users.*
		2.2. KBSP to promote a learning brief or other resource across the city the need for services to ensure clients who present to their service are signed up to a GP surgery or are provided with assistance to register. This is especially important for those whose first	KBSP	Learning brief created. Learning shared to professionals across Bristol.	July 2024	*Completed.* *The GP bulletin that was disseminated across the BNSSG footprint was also shared in the KBSP Newsletter in September 2024. The newsletter gets circulated to over 2000 professionals and members of the public.*

		language is not English.				
3. As part of the reform of Domestic Homicide Review Statutory Guidance, the Home Office should consider whether homicides involving acute mental health episode meet the criteria for a Domestic Homicide Review.	National	3.1. KBSP to write to the Home Office Review Panel to request that the new guidance includes information about when a DHR or Mental Health Homicide Review should take place following a homicide that involves an acute mental health episode.	Home Office	DHR Guidance to provide clarity around the distinction between Mental Health Homicide Reviews and Domestic Homicide Reviews. Guidance updated.	June 2024	*Completed.* *This recommendation has been incorporated into the feedback for the Home Office 2024 Consultation: updating the domestic homicide review statutory guidance.*

Appendix B: Home Office Feedback Letter

Home Office

Interpersonal Abuse Unit
Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848 2

www.homeoffice.gov.uk

Statutory Review Officer
Keeping Bristol Safe Partnership
KBSP Business Unit (City Hall), Bristol City Council
PO Box 3399
Bristol
BS1 9NE

24th June 2024

Dear Keeping Bristol Safe Partnership,

Thank you for submitting the Domestic Homicide Review (DHR) report (Julia) for Bristol Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 22nd May 2024. I apologise for the delay in responding to you.

The QA Panel felt there were good efforts made to involve Julia's family abroad, including utilising the Embassy and an interpreter. It was helpful to see specialist advice was sought to take into consideration culture and faith and there were good references to legislation relevant to the areas specified.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published. **Areas for final development:**

- Please obscure precise key dates, for example the date of death. Only the month and year is required.

- It would be helpful to set out how the pseudonyms were chosen and if Julia's family approved them.

- The report uses the term, wife, ex-wife and partner and is not always clear to whom they refer; the victim or the ex-wife. The report states the perpetrator was divorced previously and not married to the victim.
- The report was very delayed in coming to the Panel, with the victim being killed in early 2017. The reasons outlined for this in the report and currently somewhat and unclear and could be further clarified.
- It would be helpful to clarify why the perpetrator remaining in prison is a rationale for it not being possible to engage him in the DHR.
- Paragraph 7.3 appears to suggest that specialist domestic abuse service was not sought as none were involved with Julia and David. It would also be helpful here to state who the faith group and Brazilian culture experts were.
- The contributions of the Bristol City Council Equalities Officer should be specified and the source of advice on Brazilian culture disclosed.
- Independence statements for Panel members – including the Chair – should be included.
- The Chair's career history is currently somewhat brief; some specificity would be welcomed.
- The information around how Julia's sister and the couple's work friends were contacted and how she took part in the review is somewhat vague and could be expanded upon.
- Please review the equality and diversity section to ensure that all relevant protected characteristics are considered for both the victim and the perpetrator. The section currently only appears to consider how the protected characteristics apply to David, not Julia. There is no consideration of sex or of English not being Julia and David's first language.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates

and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel