Domestic Homicide Review
Executive Summary

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

Review Panel Chair and Report Author:
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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.

1.8 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 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.

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

1.10 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.

1.11 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.

1.12 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.

1.13 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.

2.0 Contributors to the Review

2.1 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

2.2 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 IMRs had management of the case or direct managerial responsibility for the staff involved.

2.3 No Domestic Abuse service were involved with Julia or David, however one panel member from NextLink, a local domestic abuse organisation, had expertise in domestic abuse and victim support. 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.

2.4 There were additional contributions from NHS England, Church of England Diocesan, Clifton Diocese (the Catholic Diocese covering the West of England) and David's Probation Officer/Prison Offender Manager at HMP Dartmoor.

2.5 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. Julia's sister and work friends of Julia and David have offered information to the review via their Avon and Somerset Police family liaison officer. It is collectively understood that no-one was aware of any abusive element to the relationship.

3.0 Review Panel Members

3.1 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. They are 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)

3.2 The Review Panel met on 5 occasions.

4.0 Chair and Author of the Overview Report

4.1 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 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.

5.0 The Terms of Reference

5.1 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.

5.2 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

5.3 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.

6.0 Summary Chronology

6.1 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 to agencies 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.

6.2 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.

6.3 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.

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

6.5 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.

6.6 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.

24th January 2017

6.7 Julia took David to visit his GP to discuss concerns about David's mental health. 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. Julia reported 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. Julia reported that David had a knife to protect himself and had been verbally aggressive and violent in the past.

6.8 David's GP referred him to secondary mental health services. 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.

6.9 Initial contact was made by the Triage Nurse with David who was supported by an interpreter. During the assessment, he denied having thoughts to harm himself or others. He denied that he ever bought a knife 'to attack his wife or others'. 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'. 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.

6.10 The Triage nurse 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.

6.11 The Triage Nurse contacted Julia with the help of an interpreter. She reported a 'noticeable' change in her partner's presentation, citing the examples of 'arrogance, self-isolation, verbal aggression, and paranoia'. 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 '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. She reported intentions to remain

at her sister's 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.

6.12 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.

26th January 2017

6.13 David did not attend the scheduled appointment with the recovery nurse. A message was left with David's GP regarding the non-attendance. 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.

27th January 2017

6.14 A further attempt to contact David and reschedule the appointment was made. 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.

2nd February 2017

6.15 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!'.

6th February 2017

6.16 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.

6.17 Following the assessment, the recovery practitioner contacted David's GP to discuss why the original referral had been marked as emergency as their assessment indicated that David did not appear psychotic. They left a message, and a telephone conversation was scheduled for 10th February.

7th February 2017

6.18 The GP Surgery's practice manager telephoned the recovery practitioner to inform them that the GP would not be available to talk on 10th February and stated that all the information needed was 'on the referral'.

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

6.20 After this discussion, the recovery practitioner attempted to call David, Julia and the family friend twice more. None of them answered and messages requesting call-backs were left. Text messages were also sent to David and Julia requesting a call-back. The practitioner provided updates to the senior practitioner and the decision was made to contact the Police.

6.21 The recovery practitioner spoke to the police call handler at 2.43pm. They informed the police about the possible historic problems about David becoming mentally unwell and being violent and the mention of a knife. They informed the police that there were no injuries, nor any incidents known in the past. They said he had presented well mentally when recently assessed. They asked for the address to be marked, however gave Julia's sister's address, not the flat where Julia and David lived.

6.22 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.

6.23 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.

6.24 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

6.25 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

6.26 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 February 2017 when he said she had returned to live with David.

6.27 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.

6.28 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.

6.29 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

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

6.31 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.

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

7.0 Key Issues Arising from the Review

7.1 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.

7.2 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.

7.3 David believed that Julia was betraying him. Both David and Julia expressed to professionals the impact of David's mental health upon their relationship. 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.

7.4 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.

7.5 During the review, issues of faith were considered. 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. Both churches have shared that their response to domestic abuse has evolved considerably since the case of Julia and David and gave examples of the training and guidance now in place.

7.6 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.

7.7 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.

7.8 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. 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.

7.9 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.

7.10 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.

7.11 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. 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.

7.12 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.

7.13 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.

7.14 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.

7.15 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.

7.16 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 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.

7.17 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.

7.18 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 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.

7.19 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.

7.20 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.

7.21 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 user's carers, therefore this was met with the support offered to his wife and friend. All possible measures seem to have been taken to engage with Julia during this assessment process, however contact with Julia was unsuccessful beyond the triage process despite numerous attempts to contact her by phone. 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.

7.22 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.

8.0 Conclusions

8.1 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 for periods of time, but this cannot be ascertained definitively through this review. He was deemed fit to stand trial and was convicted of murder.

9.0 Lessons to be Learned

9.1 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.

10.0 Recommendations

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

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

10.3 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.