Cwm Taf Partneriaeth Diogelwch Cymunedol
Community Safety Partnership

Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board

Domestic Homicide Review

Executive Summary

DHR 05

Executive Summary of a Report into the death of a 46-year-old female in December 2018

LJ

Completed by Ann Batley and Louise Davies, December 2020

Report updated following Home Office feedback January 2022 and November 2022

1 INTRODUCTION:

1.1 This executive summary outlines the process undertaken by Cwm Taf Community Safety Partnership (CSP) in reviewing the circumstances of the death of LJ, a 46 year old white Welsh woman in her home in December 2018.

1.2 The Authors and Panel members in this review would like to express their sincere condolences to the family of the victim in this case and hope that the recommendations made herein go some way to preventing a similar set of circumstances arising again.

1.3 To protect the identity of the victim and her family, her real name has not been used and at the request of her family, throughout the course of the report the victim will be referred to as LJ. The perpetrator of this crime will be referred to as Adult A.

2. THE REVIEW PROCESS:

2.1 This DHR examines agency responses and support given to LJ, a resident of Cwm Taf, prior to the point of her death in December 2018. The purpose of this specific review was to consider agencies' contact and involvement with LJ and Adult A, to consider whether behaviour was recognised as domestic abuse, whether there were any barriers to reporting domestic abuse, and whether appropriate support was available to the individuals.

2.2 On 4th January 2019, the Chair of the Community Safety Partnership received formal notification via South Wales Police of a domestic homicide within the Cwm Taf area. The victim LJ was a white Welsh female aged 46 at the time of her death. Her partner, who was also white and Welsh, committed the offence and was aged 51 at the time of the homicide.

2.3 A Domestic Homicide Review Panel was convened on 4th February 2019 where a briefing was provided by the Senior Investigating Officer. The Review Panel consisted of multi-agency partners who agreed that the incident met the criteria for a DHR. Terms of Reference for the Review were agreed by the Panel at the outset. The Panel was put on hold pending the outcome of the criminal proceedings in order for the family members to have an opportunity to participate in the DHR. A trial was scheduled for June 2019. The Panel was notified in April 2019 of Adult A's death in custody, and criminal proceedings were therefore concluded. The Panel was reconvened in September 2019.

2.4 The review focused on the period from December 2017 to 15th March 2019. The 12 months prior to the death of LJ was chosen as a pragmatic timeframe following an initial review where evidence showed little or no contact had ever been made by LJ with relevant agencies. The extended period took the review beyond the date of death of the victim to include the time Adult A spent in prison, up to the date of his death. This allowed the review to include any relevant information that may have been disclosed whilst in custody.

2.5 LJ lived with Adult A and LJ's adult daughter from a previous relationship. LJ also had an adult son from another previous relationship. Adult A had two grown up children from a previous marriage. All close family members of the victim and the perpetrator were contacted, however only one of the victim's relatives wished to be involved and that was LJ's sister. LJ's sister told the Reviewers that all of LJ's family members understood that the DHR was being undertaken and why it was being done but none of these individuals wanted to be involved.

2.6 The Reviewers based this report upon information provided by Independent Management Reviews (IMR) prepared by Agencies, Agency Summary Reports, information from the police investigation, the Prison Ombudsman Report into Adult A's death, the Inquest Report into LJ's death and the interview with LJ's family member.

3. CONTRIBUTORS TO THE REVIEW:

- Rhondda Cynon Taf County Borough Council (Public Protection Services; Children's Services, Adult Safeguarding)
- Regional Advisor for Violence Against Women Domestic Abuse and Sexual Violence, Safer Merthyr Tydfil (Third Sector provider).
- Cwm Taf Morgannwg University Health Board.
- Independent Protecting Vulnerable Person Manager, South Wales Police.
- Welsh Ambulance Service.

IMR Reports were received from:

- Taff Ely Drug and Alcohol Service (TEDS) (third sector provider of substance misuse services in area during the relevant period).
- Welsh Ambulance Service Trust (WAST).
- South Wales Police.

Agency Summary Reports were received from:

- Cwm Taf University Health Board.
- HM Prison Cardiff.
- HM Prison Cardiff Health Services.
- General Practitioner.

4. BACKGROUND INFORMATION (THE FACTS):

4.1 LJ was a much loved mother, sister and friend who had lived in Cwm Taf all of her life. LJ grew up living with her parents and two siblings. LJ had two adult children (son and daughter) from two previous relationships before she met Adult A. Adult A had been married before he started a relationship with LJ. He had two children with his ex-wife and the children remained with their mother when they split up.

4.2 LJ and Adult A had been in a relationship for 15-16 years. LJ's adult daughter lived with LJ and Adult A at the same address. When they met, LJ and Adult A had chaotic lifestyles, and both being illicit drug users with an offending history. It appears that when they met, they were a stabilizing influence on each other

and they both started receiving treatment which continued throughout their relationship. They supported each other throughout the treatment and evidence shows they were settled, with Adult A recently starting a full-time permanent job, working night shifts and stopping all prescribed medication and LJ continuing to receive limited prescribed medication support. The private rented property where the homicide occurred had been their home for the majority of the time that they were together. LJ's family members described them as having a happy relationship.

4.3 LJ's mother died suddenly and unexpectedly in May 2018 and this was a significant shock to the family. LJ struggled to come to terms with her mother's death and sought help from her GP for anxiety as a result. It appears shortly after this, in November 2018, LJ started a relationship with a local man who she had known and had lived near her family for a number of years.

4.4 It was in December 2018 that Adult A was reviewed by his GP regarding multiple loose stools per day over preceding 6 weeks and a referral was made by GP to the local general hospital. LJ subsequently presented to PCDAS as very tearful, concerned over health issues with Adult A. Cancer was mentioned as a possible diagnosis. LJ stated that she would not cope should Adult A be diagnosed with bowel cancer added to the recent death of her mother. LJ stated that they were saving to get married.

4.5 At the beginning of December 2018, preceding the incident, Adult A found out about LJ's new relationship and the night before LJ's death, there was an incident where Adult A sent a video message to LJ and placed it on social media detailing him burning in their back garden a wedding dress that LJ had bought a few years previously, with the intention of marrying Adult A.

4.6 In December, after spending a night away from the family home, LJ returned to have a discussion with Adult A about their relationship and her involvement with another person. The police received a call later that morning from Adult A saying that he had argued with LJ, that she was dead in the kitchen and that he had killed her. He also telephoned a number of his and LJ's family members to tell them what he had done. The Police arrived within a matter of minutes to find LJ dead in the kitchen and Adult A is arrested at the house and taken into custody.

4.7 Upon arrival in custody, Adult A became violent and assaulted two custody detention officers. Adult A was seen by doctor in custody and underwent an assessment to determine if he was mentally fit to be questioned. During that examination, he stated "When I did what I did my mind was clear. I found out last Friday my partner was having an affair". Following arrest, Adult A replied "no comment" to most questions asked.

4.8 In December 2018, Adult A was charged with murder and 2 assaults under the Assaults on Emergency Workers Offences Act. The following day, he was taken to Merthyr Magistrates Court before being taken straight to Cardiff Crown Court that afternoon and being remanded in custody. In March 2019, Adult A

appeared in Cardiff Crown Court and the trial was listed for 17th June 2019. Adult A died in March 2019 of colorectal cancer whilst a prisoner at HMP Cardiff.

4.9 The inquest held in relation to LJ in June 2019, recorded a conclusion of unlawful killing.

5. **ANALYSIS**:

5.1 There was no indication given by LJ or Adult A that there were any issues with their relationship, the only concerns being verbalised by them during contact with agencies were concerns about LJ's mental health following the death of her mother and Adult A's physical health. The facts of the case indicate that friends and family believed the relationship was positive until days before LJ's death when the disclosure of her relationship with her boyfriend shows Adult A's behaviour changed. There is no indication that LJ engaged with agencies around this time however. The Review found no indications that would have caused further enquiry by professionals LJ was engaged with, such as PCDAS or her GP, of her relationship with Adult A.

5.2 As LJ and Adult A were not identified as either a victim or perpetrator of domestic abuse, no referrals in respect of domestic abuse were made. There was no evidence that LJ had any contact with any domestic abuse agencies.

5.3 The police records did, however, show that there had been a domestic abuse incident that Adult A had been involved in with his previous partner in 2002. This information was considered by the Panel in the context of the wedding dress burning incident. The Reviewers were not however presented with any additional insight or information from other sources which could be explored to determine if this behaviour was repeated in the long-term relationship between LJ and Adult A.

5.4 Adult A's violent behaviour in custody after arrest was considered in this review and indicates that Adult A demonstrated impulse control issues although there is no information to demonstrate that this lack of control was shown previously during his relationship with LJ.

5.5 While the views of this being a positive relationship are fairly consistent, the review has considered that LJ stated a view that Adult A's enquiries about her day-to-day activities were "controlling". The Review Panel found that Adult A may have exhibited behaviour that was controlling and that Adult A's desire to control LJ may have been escalating as a result of their relationship breaking down. The Panel however sought not to speculate beyond the evidence they had available, although it was accepted by the Panel that further insight could have been achieved during the review if other information was available.

5.6 There appears to be no direct learning for agencies as the involvement of agencies with LJ appears appropriate and whenever LJ asked for support, the support was provided. However, there were indications that LJ was beginning to struggle within the relationship; she had met someone else and wanted to end the relationship with Adult A. The Reviewers found there was no evidence

to suggest that by taking these steps LJ would be a victim of a domestic homicide. It is also difficult, in this case, to establish what impact Adult A's illness had on his actions but it is clear that both LJ and Adult A were of the opinion that his illness was serious and would have a huge impact on both their lives.

6. CONCLUSION:

6.1 The Reviewers concluded that this was a tragic case, triggered by a breakdown in LJ and Adult A's long-standing relationship at a time when Adult A was experiencing significant health problems, which were subsequently diagnosed as terminal. The Reviewers have concluded that no agencies or family members were aware of any difficulties in LJ and Adult A's relationship prior to LJ's death nor were there indicators that caused them reason to investigate further. The Panel however considered that further work should be done to improve public understanding of domestic abuse and coercive control, although the Panel were unable to substantiate whether this was a factor in this relationship.

6.2 Although there appears to be very little information gained through this review on the effect of Adult A's illness on both LJ and Adult A and any part this played in the homicide, the Panel felt that mention needed to be made of the potential impact major life events such as illness could have on relationships and the need for this to be reflected in any recommendations made.

7. RECOMMENDATIONS:

7.1 While it was difficult to identify any specific learning from this incident the case highlights opportunities for wider learning in raising awareness of domestic abuse in all forms, given the broader potential for coercive control to exist in relationships others would consider 'healthy'. The Panel would reiterate the need to continue to have a consistent approach to the Healthy Relationship learning with future generations and to raising awareness of the signs and indicators of domestic abuse with professionals and the general population. The raising of awareness must not only start at an early age but be reinforced at different times and in different environments to ensure that all generations are aware of what is acceptable and what is not and the support available. Awareness raising within the region must include:

- The definition and impact of coercive control.
- The need to understand the impact of major life events on relationships.
- The need to continue to up skill professionals in asking questions about domestic abuse (Ask & Ask Training).