Cwm Taf Partneriaeth Diogelwch Cymunedol
Community Safety Partnership

Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board

Domestic Homicide Review

Overview Report

DHR 05

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 Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 46 year old white Welsh woman in her home in December 2018.

1.2 The report was commissioned by the Cwm Taf Community Safety Partnership in conjunction with the Cwm Taf Safeguarding Board (known as the Cwm Taf Morgannwg Safeguarding Board from April 2019).

1.3 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.

1.4 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 AUTHORS:

2.1 The Authors/Reviewers of the report are Ann Batley, Director of Children's Services, and Louise Davies, Director - Public Health, Protection and Community Services, both of whom were employed by Rhondda Cynon Taf County Borough Council at the time of the review. Neither the authors or the Council services they are responsible for have been involved with any parties within this case and they are therefore considered by the Cwm Taf Community Safety Partnership to be independent.

2.2 Ann Batley is a registered social worker with over 30 years' experience as a practitioner, senior manager and leader of a range of services, including adult social care, substance misuse services and child protection. She has extensive experience of leading on Child Practice Reviews. Ann has also been a Panel member on a number of Child and Adult Practice Reviews and DHR previously. Ann retired from Rhondda Cynon Taf County Borough Council at the end of 2020.

2.3 Louise Davies is registered as a Chartered Environmental Health Practitioner and has worked in Local Government Public Health, Protection and Community Services for over 25 years. She has significant practice, managerial and leadership experience. She has extensive experience of undertaking criminal investigations in the field of regulatory services and has contributed to a diverse range of service and case reviews during her career. Her current, senior management role has a diverse remit of services including community safety, environmental health, homelessness and trading standards. She has had strategic and operational responsibility for domestic abuse, substance misuse and community safety services for over 8 years.

3. SUMMARY:

3.1 This report of a DHR examines agency responses and support given to LJ, a resident of Cwm Taf, prior to the point of her death in December 2018.

3.2 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.

3.3 The DHR was established under Section 9(3) of the Domestic Violence, Crime and Victims Act 2004. The purpose for undertaking DHRs is to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b) Identify cleanly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
c) Apply those lessons to service responses including changes to policies and procedures as appropriate.
d) Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
e) Contribute to a better understanding of the nature of domestic violence and abuse
f) Highlight good practice.

3.4 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.

4. TIMESCALES:

4.1 A Domestic Homicide Review Panel was convened on 4th February 2019 where a briefing was provided by the Senior Investigating Officer. The Panel was notified that due to the circumstances of the case, family members would be significant witnesses in any trial so it was agreed that the DHR would be 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. As there were no further reasons to delay, the Panel was reconvened in September 2019.

4.2 It was agreed by the Review Panel that the review would focus 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.

4.3 Having re-commenced the Review in September 2019, it was concluded on 18th December 2020. The Panel met 7 times and was Chaired by Ann Batley until the first report was completed in December 2020 whereupon Mrs Batley retired. Further to the Report being submitted to the Home Office Quality Assurance Panels in 2021 and 2022 for consideration, the Review Panel undertook further work on the Review in response to feedback received. Between 2021 and 2023, two Panel Meetings were Chaired by Mrs Davies. The Authors would like to apologise to the family and friends of LJ for the time taken to complete the Final Report.

5. CONFIDENTIALITY:

5.1 The agency information provided as part of the review was treated as confidential. Information was only made available to participating officers/professionals and their line managers.

6. METHODOLOGY:

6.1 The Review Panel consisted of multi-agency partners who agreed that the incident met the criteria for a DHR.

6.2 Agencies were asked to ascertain whether they were involved with the victim and/or the perpetrator and whether an Individual Management Review (IMR) of their involvement was required. The IMR allows agencies:

- To look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training).
- To see whether the homicide indicated that practice needs to change or improved to support professionals to carry out their work to the highest standards.
- To identify how and when those changes or improvement will be brought about.
- To identify examples of good practice within agencies.

6.3 A senior officer, independent of the management of the case, completed the IMR on behalf of their agency. The process also required the Reviewers to meet and consult with family members. 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.

6.4 The Reviewers based this report upon information provided by the IMRs, 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.

6.5 The Terms of Reference of the Panel are attached as Appendix 1 and the Panel kept these under review during the course of its work.

7. EQUALITY AND DIVERSITY:

7.1 The Panel considered whether the nine protected characteristics, as defined by the Equality Act 2010, were relevant to this review. These are age, disability, sex, sexual orientation, gender reassignment, race, religion or belief, marriage and civil partnership, pregnancy and maternity. To that end, the Panel noted that LJ was a 46 year old, white, Welsh female whom the Panel understands was heterosexual. LJ was in a long-standing relationship with Adult A at the time of her death. The Panel was not able to establish any specific religion or beliefs held by LJ. The Reviewers did identify that LJ was awarded a Personal Independence Payment and subsequently a bus pass. On her bus pass application, she states she had epilepsy, anxiety and depression, an under-active thyroid and nerve problems in her legs. LJ continued to receive treatment for illicit drug use and was using the heroin substitute methadone up to the time of her death. The Panel's view is that, taking this information into consideration, she should be considered as having a 'disability' within the meaning of the Equality Act 2010 (i.e. a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on a person's ability to do normal daily activities).

7.2 Adult A was a 51 year old, white, Welsh male whom the Panel understands was heterosexual. Adult A had been married previously and was in a long-standing relationship with LJ at the time of the homicide. Adult A had been receiving treatment including use of methadone for a number of years for illicit drug use, but this treatment stopped in the weeks before the victim's death because both Adult A and his treating psychiatrist felt he no longer needed it. Adult A appeared to have no level of impairment used to define the meaning of 'disabled' under the Act nor did the Reviewers identify any other protected characteristic that required specific consideration as part of this Review. The Panel did consider Adult A's bowel cancer diagnosis although this was not confirmed until after LJ's death, when Adult A was in prison awaiting trial. The Panel have considered the impact Adult A's deteriorating health may have had on his mental health as a material consideration in the analysis.

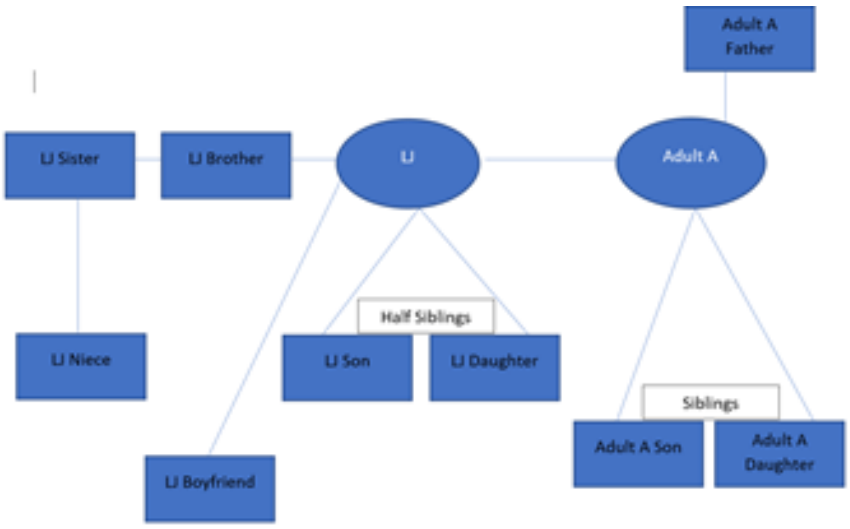
7.3 LJ's disability, notably her anxiety and depression, are taken into consideration by the Panel in the analysis of the Review information. Sex is also a material consideration in this Review given the evidence that intimate partner homicides are disproportionately perpetrated by men upon women. Both LJ and Adult A had access to services in particular Substance Misuse Services for many years, and there is no evidence that services discriminated against them. The panel did not identify any barriers to accessing services.

8. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY:

8.1 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. The Genogram (Figure A) illustrates the relationships and relatives of LJ and Adult A.

Figure A- Genogram



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8.2 The Panel identified family members and associates of both the victim and perpetrator to contact to ask them to contribute to the review. The family members were initially contacted by the Police Family Liaison Officer who explained the purpose of the DHR and how they could contribute. This was followed up with letters and information about a DHR (including the Home Office DHR Information Leaflet) being sent from the Reviewers, again inviting them to contribute. The Reviewers also followed this up with telephone calls to the victim's daughter, son and Adult A's son. The person with whom LJ had started having a relationship prior to her death (her boyfriend) was contacted by letter. LJ was not employed at the time of her death and at the outset of the review, no close friends were named to the reviewers as having been identified during the course of the police investigation into the homicide.

8.3 Those individuals contacted to contribute to the DHR therefore were:

- Victim's son.
- Victim's daughter.
- Victim's sister.
- Victim's niece.
- Victim's boyfriend.
- Adult A's father.
- Adult A's son.

8.4 LJ's sister agreed to contribute to the review and to be interviewed. She also agreed to ask LJ's daughter and son to contribute and to ask her own daughter (LJ's niece) if she wanted to be interviewed. LJ's sister told the Reviewers that all of these family members understood that the DHR was being undertaken and why it was being done but none of these individuals wanted to be involved

and meet the Reviewers or Panel. LJ's sister told the Reviewers that they were accepting of her speaking to the Reviewers as a family member.

8.5 Due to the lack of response from the other family members and the victim's boyfriend the Reviewers and the Panel concluded that they did not wish to be involved or contribute and agreed to proceed with interviewing LJ's sister only. The Reviewers were able to consider evidence given by individuals to the Inquest into LJ's death and statements provided to the Police during their investigation. This included information provided to police by a friend of LJ's whose connection to LJ was made known to the reviewers when the final report was being prepared. It was a decision of the Panel that due to the significant time that had elapsed since the Review was started that this person's account to police should be considered but they should not be contacted to participate in the Review. The late identification of this person to the Review has been acknowledged by the relevant Agency as an oversight. The need to ensure all persons of interest to a review are identified at the outset has been noted as a learning point from this review.

9. CONTRIBUTORS TO THE REVIEW:

9.1 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.

9.2 Agency Summary Reports were received from:

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

10. THE REVIEW PANEL MEMBERS

- Ann Batley, Director Children's Services, Rhondda Cynon Taf County Borough Council (Chair and Reviewer)(Retired 2020).
- Louise Davies, Director Public Health, Protection and Community Services, Rhondda Cynon Taf County Borough Council (Reviewer).
- Deborah Evans, Regional Advisor for Violence Against Women Domestic Abuse and Sexual Violence, Safer Merthyr Tydfil (Third Sector provider).
- Bev Brooks, Deputy Head of Safeguarding Cwm Taf Morgannwg University Health Board.
- Beth Aynsley, Independent Protecting Vulnerable Person Manager, South Wales Police.
- Jackie Neale, Service Manager, Adult Safeguarding, Rhondda Cynon Taf County Borough Council.
- Fiona Davies, Safeguarding Specialist Welsh Ambulance Service.

- Rachel Gronow, Oasis Centre Manager, Rhondda Cynon Taf County Borough Council.
- Cheryl Emery, Supporting People and Housing Options Service Manager, Rhondda Cynon Taf County Borough Council.

10.1 The Panel met seven times throughout the course of the primary review to prepare the first Report and a further two times when finalising this Report. No Panel member had any direct involvement with either the victim or the perpetrator.

11. DISSEMINATION:

11.1 Prior to publication, the Panel members will receive a copy of the report along with the family member who contributed to the review. The family member was consulted during the drafting of the Review and asked that the victim be referred to as LJ in the report. The Chair of the Review visited LJ's sister in January 2021 to discuss the report and its findings. She accepted the findings of the report and its content. A further meeting was held with LJ's sister in April 2023 to go through the revised report.

12. BACKGROUND INFORMATION (THE FACTS)

12.1 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. As a young adult, LJ had a history of illicit drug use and there was an offending history linked to her drug dependency at that time. There were reported difficulties within the family linked to LJ's lifestyle and LJ's children went to live with her parents for a time. LJ's daughter subsequently went to live with LJ and Adult A when they set up home together. LJ's son remained with his grandparents although he maintained regular contact with LJ.

12.2 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. Adult A had a history of illicit drug use that was also linked to an offending history.

12.3 LJ and Adult A had been in a relationship for 15-16 years. When they met, LJ and Adult A had chaotic lifestyles, linked to both being illicit drug users. It appears that when they met, they were a stabilizing influence on each other and LJ and Adult A's criminal activity stopped when they became established in a relationship. Both engaged with and maintained support from substance misuse services and their GPs over a number of years. They both started receiving treatment which continued throughout most of 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 while LJ continued to receive limited prescribed medication and support from TEDS and her GP. The private rented property where the homicide occurred had been their home for the majority of the time that they were together and LJ's family members described

them as having a happy relationship. LJ was very close to her father and helped her mother to care for him at the family home when his health deteriorated before he then passed away.

12.4 In June 2017, LJ is referred to Ambulatory Emergency Care Unit (AECU) by her General Practitioner (GP) due to complaints of pain. Investigations led to LJ being an inpatient at University Hospital of Wales for Neurological investigations in December 2017.

12.5 During January 2018, LJ had on-going counselling with TEDS, with a total of six appointments attended out of sixteen offered (nine appts cancelled by LJ & one fail to attend). In February 2018, LJ didn't attend Primary Care Drug & Alcohol Service Clinic (PCDAS) as planned. LJ did attend PCDAS Clinic in April 2018 and records say she was very positive about her future and was requesting to reduce Methadone dosage.

12.6 LJ's mother died suddenly and unexpectedly in May 2018 and this was a significant shock to the family. In July 2018 when LJ attended PCDAS Clinic records state that she is coping with death of her mother, requesting 2ml reduction in current dose of methadone. LJ said she was also now attending classes at the gym. It appears however that LJ struggled to come to terms with her mother's death as time passed and in August 2018 sought help from her GP for anxiety and depression as a result. Arrangements were made for her to see the practice nurse in September 2018 but LJ did not attend that appointment. There was no reason given in the records. LJ also attended a PCDAS Clinic in September 2018 and says she is using Diazepam since the death of her mother. There is no record of this being prescribed by a doctor for her.

12.7 It appears that around this time, (circa August 2018) that LJ started a relationship with a local man who she had known and who lived near her family for a number of years. At this time, the brother of the person who later became LJ's boyfriend was caring for a person whom LJ also knew and did shopping for. When that brother became ill, it appears that LJ's boyfriend began helping out. The person being cared for then passed away and LJ and the person who later became her boyfriend were sorting through the probate and therefore were spending time together 3 to 4 times a week.

12.8 During a further appointment in October 2018 to the PCDAS Clinic LJ discussed stresses at home and it was agreed that her methadone dose to remain at 12mls daily. During the month, LJ is also seen by her GP after complaining of "funny sensations" & fainting episodes. LJ is referred to Cardiology Consultant at the local general hospital and she is referred for a 24 hour Blood Pressure monitoring; LJ had complained of giddy spells, near faint episodes and one blackout.

12.9 It was around November 2018 when the friendship turned into a relationship. Adult A and LJ's boyfriend were not known to each other previously. LJ's boyfriend reported that 2 weeks prior to the murder, he and LJ were together most days.

12.10 By November 2018**,** PCDAS Clinic records that Adult A is now in full time employment, and LJs mood is recorded as very good. Her methadone dose was to remain at 12 mls daily.

12.11 LJ attended her GP this month complaining of further symptoms where her left arm goes heavy and weak, with a feeling of water trickling down her face. She was seen by a Consultant neurologist who concluded the "seizures" LJ reported were not epileptic attacks and medication for epilepsy was stopped. No underlying neurological problems were diagnosed at that time. LJ was however awaiting tests for Hypertrophic Cardiomyopathy which is a disease where the walls of the heart chambers have stretched, thickened or become stiff, this condition is hereditary and the risk was identified following the death of her mother.

12.12 It was in December 2018 that Adult A was reviewed by his GP regarding multiple loose stools per day over preceding 6 weeks. Adult A refused a rectal examination and a referral was made by GP to the Colo- Rectal Clinic at a local general hospital.

12.13 LJ subsequently presented to PCDAS as very tearful, concerned over health issues with Adult A who has been bleeding rectally, and is currently undergoing investigations. 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.

12.14 At the beginning of December 2018, some days preceding the incident, Adult A found out about the relationship. Information shared as part of the police investigation indicates that Adult A has heard LJ on the phone to LJ's boyfriend and then checked her phone and found messages between them. He confronted her and she told him about the relationship. Adult A asked her to stop seeing this person but she said she couldn't. It was reported that LJ's daughter became aware of LJ's new relationship around this time too, following a conversation with Adult A. LJ also disclosed the relationship to her friend. This friend of LJ's subsequently visited the house in December and speaks briefly to Adult A who said words to the effect of 'we've been through worse I'm sure we'll get through it'. She described him as being very calm which she found unusual given the situation. At the time the friend was there, she told Police that Adult A was going back and forth to an iPad. The friend said that she believed LJ's phone and the iPad were linked and Adult A was able to view messages between LJ and LJ's boyfriend. LJ's boyfriend told the Police that Adult A had sent him messages through LJ's account on this date. According to LJ's boyfriend, it was around this date that Adult A again asked LJ to stop seeing him.

12.15 In December, LJ spent the day with her boyfriend and stayed with him overnight. That night, 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. When posting the video, he also posted the comment 'This is what happens to a wedding dress when a bride lies to her long term partner'. LJ's niece, upon seeing the social media post, went to speak to Adult A about this. LJs boyfriend later stated to the Police that LJ and Adult A argued on the phone following the burning of the dress and LJ's boyfriend reported that LJ stated she had not seen this side of Adult A before. Adult A went to work as scheduled that night and returned to the family home at approximately 6am the following day. LJ's daughter arrived home about the same time from her night shift and she went straight to bed.

12.16 At around 11.20am in December, after spending a night at her boyfriend's address, LJ returned to have a discussion with Adult A about their relationship and her involvement with this other person. LJ's boyfriend drove her home and dropped her off just up the road from the house. LJ's boyfriend believed LJ was going into the house to ask Adult A to leave after he burned the dress the night before. LJ's boyfriend told Police he was not particularly concerned about LJ going into the house although he knew she was apprehensive about delivering her message. He said he and LJ planned to meet back up later that day.

12.17 The police received a call later that day, at 12.38 pm from Adult A saying that he had argued with LJ, that she was dead in the kitchen and that he had strangled her. He also telephoned a number of his and LJ's family members to tell them what he had done. There was very little detail provided in these phone calls other than to state what he had done 'I've killed [LJ]'. The reason he gave to his son was that LJ had been having an 'affair'. He also sent a text message to LJ's boyfriend from LJ's phone stating 'you won't be seeing [LJ] again she's dead'. 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. Police contact WAST requesting attendance at an address where a perpetrator has stated that he has strangled his girlfriend. WAST attend the property and LJ is found deceased.

LJ's daughter later told Police that she has heard an argument downstairs between LJ and Adult A but said it was not a long or almighty row, and when it went quiet, she went back to sleep.

12.18 Upon arrival in custody, Adult A became violent and assaulted two custody detention officers who were seeking to carry out a routine search of Adult A before he was detained. Adult A seen by doctor in custody and a history is given of recent weight loss (approximately 3 stones) and blood passed in stools. Adult A reports finding it difficult to maneuver due to bruised ribs. Before interview, Adult A 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". Adult A further states that he has no thoughts of self-harm or suicide.

12.19 Following arrest, Adult A replied "no comment" to most questions asked.

12.20 In December, 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 (the fast-track process being due to the Christmas period) and being remanded in custody.

12.21 During Adult A's time on remand, his mood is reported to be "up and down" over the past weeks prior to the murder. Adult A reports to feeling suicidal but said he would not go through with this at present as he feels that both himself and his victim's children need "justice".

12.22 In January 2019, HMP Cardiff contacted Adult A's GP who confirmed that Adult A was a patient at the practice. HMP then arranged further investigations regarding Adult A rectal bleeding. Adult A was seen by Psychiatrist for primary mental health review who found nil evidence of major mental illness.

12.23 Adult A is then seen by Doctor following referral by Psychiatrist who was concerned about Adult A's worrying history of change of bowel habits. Rectal examination and blood test preformed, and Ultrasound Scan arranged due to weight loss.

12.24 When seen by the Psychiatrist during a follow up appointment, Adult A presents as "very flat" on interview talking about his relationship with the victim. Adult A reported he feels that the children need to see justice happen and then he plans to take his own life when into his sentence.

12.25 In February, Adult A is admitted to hospital and HMP informed that Adult A has a diagnosis of bowel cancer and liver metastases. Adult A chose to be discharged from hospital back to HMP for "thinking time" and reported that he looks well and is talking positively about treatment. Adult A was seen by hospital consultant who says that he has approximately 10-12 weeks to live without treatment, could be a couple of months with Chemotherapy/Radiotherapy. Adult A declined treatment. Adult A had already made advanced decisions regarding his care and a 'Not for attempted CPR' (Cardiopulmonary resuscitation) form has been completed.

12.26 In March 2019, Adult A appeared in Cardiff Crown Court but there was no requirement at that stage for him to make a plea. The trial was listed for 17th June 2019.

12.27 Following his diagnosis, Adult A received inpatient clinical care at HMP and was referred to palliative care nurses. He was regularly reviewed and supported by both healthcare and mental health in-reach team and by hospital medical staff according to his needs. He was admitted to hospital later in March following a deterioration of his health. Adult A died in March 2019 of colorectal cancer in hospital whilst a prisoner at HMP Cardiff and his family were informed.

12.28 The inquest held in relation to LJ in June 2019, recorded a conclusion of unlawful killing. The cause of death was by sustained application of forceful pressure to her neck. The inquest was told the only object in the house fitting the marks on LJ's body was a lava lamp cable but forensic tests on the cable were inconclusive.

12.29 In view of Adult A's death in custody, an independent investigation into his death while in HMP Cardiff was conducted by the Prison and Probation Ombudsman and the report was published in August 2019. This report considered the medical and other care received by Adult A while a prisoner at HMP Cardiff. Its findings were considered as part of this review but it did not provide any additional insight to Adult A's actions or the relationship between LJ and Adult A prior to the homicide.

13. ANALYSIS

13.1 This analysis has been based upon the evidence and information available to the Reviewers and Panel. It was noted by the Panel however that there was limited information available, and this analysis is proportionate to the facts and insight the Reviewers and Panel were able to obtain.

13.2 **1. Were agencies:**

- **Sensitive to LJ's and Adult A's needs?**
- **Knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?**

13.3 Agencies had in place policies and procedures which identified what action was expected of them if they had concerns that someone was a victim or a perpetrator of domestic abuse; however, there is no evidence to suggest that LJ and Adult A displayed any indicators that would cause agencies to enquire about domestic abuse. There is reference to "stress at home" in the record of PCDAS contact in October 2018, however there is no indication from corroborating information at the time that this was due to her relationship with Adult A. Prior and future engagement with PDCAS identifies Adult A's illness and the continued anxiety related to LJ's mother's death as the stated cause.

13.4 Professionals within Cwm Taf are required to attend the Ask & Act Training to upskill them to identify indicators of violence against women, domestic abuse and sexual violence and ask appropriate questions to enable disclosures. They would be expected to use the Cwm Taf "Ask & Ask Pathway" to refer for support if indicators are identified. If indicators had been present and a disclosure made, PCDAS professionals should have used this pathway but there is no record that they had cause to.

13.5 The local surgery at which LJ was registered had received 'Identification & Referral to Improve Safety' (IRIS) training in 2016 and therefore staff were trained to identify and respond effectively to potential domestic abuse in patients.

13.6 In early December 2018, during a routine visit to the Primary Care Community Drug and Alcohol Service, LJ presented as being very tearful and said she was struggling, putting this down to not coping following the death of her mother earlier in the year and concern over health issues that Adult A was experiencing. At the time, Adult A had recently visited his own GP reporting

rapid weight loss, persistent diarrhea and blood in his faeces. He was referred to a Hospital Consultant, but he never responded to either appointments or follow up reminders sent. While this disclosure adds to the "stress at home" in disclosure in October 2018, there are no indications that there should have been further enquiry of her relationship with Adult A although on reflection, the review considers this may have been a missed opportunity for professionals.

13.7 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 and Adult A's physical health. The facts of the case indicate that friends and family believed the relationship was positive until days before LJs 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.

13.8 **2**. **Did agencies follow their own and any multi-agency, domestic abuse and safeguarding procedures; if not, why not and were any gaps identified?**

13.9 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. The only mention of what could be assumed to be domestic abuse was made during the murder investigation by the person with whom LJ had begun a relationship, this being that Adult A had been violent in the past. This person was contacted by the Reviewers but he did not respond and therefore, this could not be explored any further. There was no mention of this from any other source and no reports received at any time by the Police. During the police investigation, no close family members reported any concerns about the relationship between LJ and Adult A, the belief being that they had a loving relationship. At the inquest into LJs death, LJs son described their relationship as "excellent" and stated he had never witnessed any domestic incidents between then and this was why "what happened has come as a massive shock". He went on to say that "[Adult A] had helped turn [LJ's] life around". A friend of LJ reported Adult A appeared to be monitoring LJ's messages via the family iPad in the days immediately before her murder. His behaviour was also described as "calm" which the friend considered unusual given he had just found out about LJ's new relationship. Taking these reports into account, it is clear from this review that the relationship was breaking down.

13.10 LJ's sister said she had seen no signs of domestic abuse in the relationship between LJ and Adult A and LJ never acted as if anything was going on. She said she was surprised when she read about it in one of the witness statements. The Reviewers have been unable to quantify this perspective by speaking to family members or friends, or explore the report made by LJ's boyfriend after her murder. During the course of this review however information obtained during the murder investigation and disclosed during the inquest was considered and corroborates that close family members believed the relationship between LJ and Adult A was good. The opportunity to explore LJ's boyfriend's account was not available to the reviewers and it is accepted that it

might have provided a different perspective. The Panel was made aware of the incident when Adult A set fire to LJ's wedding dress and the Panel wanted to explore this further with LJ's niece who spoke to Adult A about the incident. The Reviewers were unable to get agreement from LJ's niece to be interviewed. The incident happened the night before LJ's death and was not known to agencies given it happened very close in time to the homicide. LJ's sister told the reviewers that at the time, the family thought the dress being set on fire was just an argument. She now wonders whether the dress fire was more significant as it was only just before the murder. Professionals acknowledged that this would have constituted a domestic abuse incident. The incident was not reported and the Panel noted that this was an important incident. Taken with the disclosure by a friend of LJs to the Police during the murder investigation that she believed Adult A was monitoring LJs phone via a remote device makes it likely that this would have prompted some further enquires, had it not been for LJ's death.

13.11 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. At the time, Adult A was charged and pleaded guilty to common assault and battery. This incident was considered by the Panel who discussed and noted that abusive behaviour can be a pattern that is repeated in subsequent relationships. 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, other than the above mentioned comment from the person with whom LJ had started a relationship, that suggested this behaviour was repeated in the long term relationship between LJ and Adult A.

13.12 Adult A's violent behaviour in custody after arrest does give an insight to his impulse control however. Police noted that the violence was spontaneous and nothing occurred to provoke the reaction. This behaviour 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 during his relationship with LJ. LJ was reported as saying, in response to the wedding dress burning incident, that 'she had never seen that side of Adult A before'.

13.13 **3. How did agencies take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to LJ and Adult A?**

13.14 The Panel agreed that there was no evidence to suggest that LJ's disability was not taken into account and there were no identified issues or barriers in respect of LJ and Adult A receiving services. Adult A's bowel cancer and physical symptoms appeared to have an adverse impact on his and LJs mental health in the weeks before the murder. It is clear that he was referred for further investigations but did not take up the appointments. LJs sister believed this was due to health issues with Adult A's father that occurred at that time but it is not possible to draw conclusions about why Adult A did not engage with medical services. The fact that LJ and Adult A both believed he had cancer, although it was not diagnosed at the time of LJs death, clearly had an impact on their

relationship based on statements LJ made to PCDAS and her GP indicating she felt unable to cope with Adult A having a cancer diagnosis.

13.15 **4. Did family, friends or the community have any concerns about domestic abuse in the relationship between LJ and Adult A, and did they know what to do with it?**

13.16 From the discussion with LJ's family member there was an acknowledgment that she and LJ were not close, but they did see each other often and she felt that if there were issues in LJ and Adult A's relationship that she or someone else within the family would have spotted it. Her description of the relationship between LJ and Adult A was that Adult A was LJ's "rock", "he kept her straight". She said Adult A loved LJ so much he "worshipped the ground she walked on." She said Adult A wanted LJ to "live like a queen" thus his resolve to get off all medication and secure a permanent job. She did say that LJ had once told her that she could not leave Adult A because she owed him too much. She also felt that LJ liked being treated this way. The notion of coercive control was explored with the family member but she did not believe this was an issue.

13.17 In a statement read to the inquest, LJ's boyfriend stated that LJ felt she "owed" [Adult A] for helping her "turn her life around". This view was also expressed by LJ's son to the inquest. LJ's boyfriend further stated that "[LJ] had tried to tell [Adult A] that their relationship was over but he just was not listening. [LJ] felt it was over because it had gone stale and she did not have feelings for him".

13.18 Adult A gave a 'no comment' interview to police after arrest, and there were no disclosures during his time on remand that assist in gaining an insight to his perspective on the relationship. The police report that the comments on their relationship from family/friends were positive. The investigation did not unearth evidence regarding domestic violence, other than the comment from LJ's boyfriend that LJ had briefly told him Adult A had been violent 'in the past' but had never stated that he hit her. He said she had also told him that Adult A made her and LJ's daughter tell him about their day, which she found controlling. Family on both sides (including those who had lived with them at different points) and a friend of LJ's, described the relationship in positive terms; they were described as being 'totally in love', 'close and affectionate' with each other with the relationship being 'excellent' and 'close to perfect'. A neighbour described them as always holding hands or cuddling.

13.19 Of course, these are not LJ's own words, they are the observations of others, but they do come from those who were close to her and in some cases in whom she confided about the affair. 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 also notes the information from her friend that Adult A appeared to be monitoring LJ's phone remotely in the days before the murder, although there is no corroborating information to support that view or indication that this was behaviour Adult A undertook over time. It does however indicate to the

Panel 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 LJ's affair.

13.20 Whether the comments made indicated that LJ felt trapped within the relationship and whether Adult A's behaviour contained elements that could be construed as coercive control is difficult for the Panel to determine. Nothing further appeared to support this hypothesis. However, the Panel acknowledged that coercive control is not always well understood by the general public and that the family may have had difficulty in recognising it. Action to improve awareness of domestic abuse and coercive control among the community and public is therefore important in the Panel's view.

13.21 LJ's niece was asked to participate as she was reported to be close to LJ and spoke to Adult A after the incident when he burnt LJ's wedding dress. The police investigation found that LJ's niece had gone to speak to Adult A after seeing the video on social media. The Panel wanted to explore this conversation further with LJ's niece however, as she and other family and friends chose not respond to the Reviewers' requests to participate, this incident and other aspects of LJ and Adult A's relationship could not be explored in more detail. The Panel therefore 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.

13.22 **5. Were there issues in relation to capacity or resources in agencies that impacted on their ability to provide services to LJ and Adult A, including management oversight and supervision or an agency's ability to work effectively with other agencies?**

13.23 LJ and Adult A had been in a stable relationship for the last 15-16 years. When they met they both had chaotic lifestyles, both being illicit drug users and the support they gave each other and they received from the Primary Care Community Drug and Alcohol Service and TEDS over a number of years appears to have helped them turn their lives around. They both accessed services regularly, over a number of years and when the need for interventions were identified they were made available. An example of this is that LJ was referred to a Mindfulness Course in April 2018 by TEDS after the death of her mother, but due to TEDS being disbanded it was not possible for the Reviewers to confirm if she attended.

13.24 They had, over a long period, both been prescribed methadone, which LJ continued to take at the time of her death, but Adult A had recently stopped, having taken up full time employment. Whilst vulnerability due to use of substances was considered by the Panel, LJ was a long-term user of services for substance misuse and was considered stable. There is no indication therefore that LJ's treatment and use of prescription medication for her addiction was a factor in this case.

13.25 The only other agency which LJ had contact with, prior to the incident was Health, through her GP. This related to a number of health issues she had

which, on occasions, needed further hospital exploration which were made available to her.

13.26 No agency identified any resourcing issues; nor did the Panel.

13.27 **6. What learning has emerged for agencies?**

13.28 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, it is clear that 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.

13.29 The Panel accepts that some information became available to the review after the initial review had been undertaken, reinforcing the need for agencies to ensure all relevant individuals are identified and contacted at the outset of a review. The late information provided some relevant information about the relationship between LJ and Adult A but did not provide any learning regarding agencies involvement with LJ or Adult A that assisted with the Panel's conclusions.

13.30 **7. Are there any examples of outstanding or innovative practice arising from this case?**

13.31 There were no examples of outstanding or innovative practice arising from this case identified by the DHR Panel. Nevertheless, the Panel acknowledged that the practitioners who worked with both LJ and Adult A did so with professionalism and care.

13.32 **8. Does the learning in this review appear in other domestic homicide reviews commissioned by Cwm Taf Morgannwg?**

13.33 The DHR Panel were content that the learning from this review does not appear in other domestic homicide reviews commissioned and published by Cwm Taf Morgannwg.

14. CONCLUSION

14.1 The Panel 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 although the days leading up to LJ's murder indicate that Adult A's behaviour was changing. There had also been no indication previously that this was an abusive

relationship or involved any form of domestic abuse, although the Panel took into consideration the disclosure that Adult A had been abusive to his ex-wife. The wedding dress incident on the night before the homicide is considered important as is the suggestion that Adult A was found to be monitoring LJ's phone remotely however the timing of these incidents relative to the homicide mean the opportunity for appropriate enquiries to be undertaken was not available to agencies. Adult A's violence in custody further indicates he had issues impulse control. The Reviewers have concluded that no agencies or family members were aware of any difficulties in LJ and Adult A's relationship prior to LJs death nor were there indicators that caused them reason to investigate further. The Panel note that LJ's boyfriend offered a different perspective on the relationship to the Police and the review may have benefited if he had participated in the review. 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.

14.2 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.

15. RECOMMENDATIONS

15.1 The Reviewers found it difficult to identify any specific learning from this incident but did consider that 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).

Appendix 1

Terms of reference for case DHR 05

Purpose of a Domestic Homicide Review

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011. Under this section, a 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 abuse, 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, held with a view to identifying the lessons to be learnt from the death"

Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and criminal courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 www.homeoffice.gov.uk/publications/crime/DHR-guidance

- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

Process of the Review

In compliance with Home Office Guidance[2], South Wales Police notified the circumstances of the death of LJ in writing to the Chair of the RCT Community Safety Partnership on 4 January 2018.

The Chair of the RCT Community Safety Partnership advised the Home Office that the circumstances did meet the criteria for a Domestic Homicide Review and as such a review should be conducted under Home Office Guidance.

Timescales

Home Office Guidance[3] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review. However, in this case, a decision was made to delay the commencement of the Review pending the outcome of criminal proceedings. The proposed completion date is December 2020.

Domestic Homicide Review Panel

In accordance with the statutory guidance, a DHR Panel has been established to oversee the process of the review. The Panel consists of professionals with significant experience in Domestic Abuse issues. The Panel may seek independent advice as

[2] Home Office Guidance Page 8
[3] Home Office Guidance page 8

deemed necessary. The Panel will be supported by the Cwm Taf Morgannwg Safeguarding Board Business Unit.

The Panel will consider if there is a need to involve agencies and professionals from other Local Authorities and if so identify which agencies and authorities will be requested to submit an Individual Management Review.

Independency

An independent Chair/Author has been appointed, Ann Batley, Service Director, Children Services Rhondda Cynon Taf County Borough Council and. The Chair/Author will prepare a redacted Overview report and an Executive Summary. She will be supported by Louise Davies, Service Director, Public Protection, Rhondda Cynon Taf County Borough Council. The completed Overview Report and Action Plan will be presented to the Cwm Taf Community Safety Partnership and the Cwm Taf Morgannwg Safeguarding Board.

Once the Home Office has assessed the Overview Report it will be published on the Cwm Taf Morgannwg Safeguarding Board website.

Scope of the Review

The scope of the review will be the 1 year period prior to the incident in December 2018 to the death of the perpetrator on the 15th March 2019. It was apparent that only universal health care services and substance misuse services had had involvement, so the initial scope is defined as the 12 months prior to the incident. The rationale for the scope to post date the homicide is to include any relevant information that may have been disclosed whilst the perpetrator was in custody. Other relevant information may be considered outside of these parameters.

Individual Management Reviews

It has been determined that there was no involvement from any domestic abuse agencies in this case, there was only involvement with universal health services, substance misuse services and the police in their response to the homicide. The Panel requested that Individual Management Reviews were submitted by only the agencies with known contact with the victim or perpetrator.

Circumstances of Concern

The following factors will be considered by the Panel undertaking this Review:

- The victim's only contact with services was with universal health services and substance misuse services, not domestic abuse services.
- Were services available locally to support the victim

Questions to be Addressed

It has been determined that the victim had contact with universal healthcare services and substance misuse services only prior to the incident. The victim never disclosed or alluded to any domestic abuse when using those services and had not had any contact with domestic abuse services. The focus of the DHR will therefore be on the questions posed to the family, friends of the deceased. In particular:

- Did they recognise Domestic Abuse including coercive control or concerning behaviour and, if so, why didn't they tell someone?
- Why was there no disclosure of domestic abuse including coercive control to agencies?
- Were there any barriers to the victim accessing services?
- Were there particular reasons why local services may not have appealed to the victim?
- Could more be done in the local area to raise awareness of services available to victims of domestic abuse?

The specific questions to be considered by the Panel in relation to this case are as follows:

- What appear to be the most important issues to address in identifying the learning from this specific homicide?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learnt from this case relating to the way in which agencies work to safeguard victims and promote their welfare, or the way risks posed by perpetrators are identified, assessed and managed? Where could practice be improved?
- Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and the perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?

Lessons Learned

The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as appropriate and relevant research.

Media

All media interest at any time during this review process will be directed to and dealt with by the Chair of the Community Safety Partnership.

Parallel Enquiries

There are no parallel enquires. The coroner's involvement ended in June 2019 (victim) and the Prisons and Probation Ombudsman's investigation ended in August 2019 (perpetrator).

Arrangements for Review

These Terms of Reference will be considered a standing item on Panel Meetings agendas and will be constantly reviewed and amended according as necessary.