Cwm Taf
Partneriaeth Diogelwch Cymunedol
Community Safety Partnership

Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board

Domestic Homicide Review

Executive Summary

DHR 02

Report into the death of Howard, a 52 year old man

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June 2019

1. INTRODUCTION

1.1 This Domestic Homicide Review (DHR) has been carried out in relation to a male victim of domestic abuse. The report was commissioned by the Cwm Taf Community Safety Partnership, in conjunction with the Cwm Taf Safeguarding Board (now Cwm Taf Morgannwg Safeguarding Board). Throughout the course of the report the victim will be referred to as Howard, which is a pseudonym agreed with his brother, sister in law and his daughter who contributed to the DHR. The perpetrator will be referred to as 'Adult 1' and her child will be referred to as 'Child 1'.

1.2 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and, most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

2. SUMMARY

2.1 On 8th January 2018 the Chair of the Community Safety Partnership received formal notification via South Wales Police of this domestic homicide within the Cwm Taf area. The victim, Howard, was a white Welsh male, aged 52 at the time of his death. His wife, who was also white and Welsh, was the perpetrator and was aged 32 at the time of the homicide. Adult 1's child, Child 1, was 13 years of age and lived with the couple.

2.2 On the day of the homicide, Adult 1 and Howard had attended a Christmas jumper party along with Adult 1's child (Child 1) at their local rugby club. They were taken home by Adult 1's brother. During the car journey home, Child 1 realised they had left their phone in the rugby club. Howard made a comment that Child 1 should look after their own phone. Reports were made that Adult 1 did not like the way Howard spoke to Child 1, which resulted in an argument breaking out between Adult 1 and Howard.

2.3 On arrival to the family home, the argument continued within the home. Child 1 went to their grandparents' house who lived next door. Adult 1 provided an account to the police that that both she and Howard were on the sofa arguing with her describing them as "both being as bad as each other". Adult 1 reported that both "went for each other's throats" and she "scrammed" Howard down the face.

2.4 Adult 1 then got up and told Howard that she was going to get a knife. Howard allegedly threw an ashtray at her as she left the room. Howard followed Adult 1 into the kitchen where they confronted each other, Adult 1 was holding a knife, Adult 1 claimed that Howard allegedly encouraged her to stab him before lunging for her throat, at which point she stabbed him to the left of his chest.

2.5 The coroner reported that this action would not have taken much force to penetrate his upper left-hand side of the chest. The blood then bubbled upwards towards his airway and out of his mouth causing him to choke. Adult 1 called for help from the neighbours who assisted to try and save Howard's life. Police were called at 21:32, emergency services attended, but despite extensive efforts to save Howard's life, he was declared deceased at 22:26 hours. Adult 1 was arrested on suspicion of murder.

2.6 Adult 1 pleaded guilty to manslaughter at Swansea Crown Court, by way of stabbing her husband, Howard, who was 52 years old at the time of his death. Adult 1 received an 8-year prison sentence.

3. METHODOLOGY AND INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES NEIGHBOURS AND WIDER COMMUNITY

3.1 The purpose of this specific Review was to consider agencies' contact and involvement with Howard and Adult 1, to consider whether there were any barriers to reporting domestic abuse, whether there was any previous behaviour that was recognised as domestic abuse and whether support was available to individuals. It was agreed by the Review Panel that a 3-year time span prior to the incident (December 2014 –December 2017) was reasonable to identify any learning. This time span was agreed due to the concerns shared by Howard's family when giving their statement to the police that they believed Howard and Adult 1's relationship had been observed to be deteriorating. There had been no reports of domestic abuse to any agencies during the 12-month period prior to Howard's death, so it was agreed that it would be appropriate to extend the timeframe identify any learning.

3.2 The Panel identified family members and work colleagues of both the victim and perpetrator to contact for interview. Following letters being sent with information about the DHR and the support of police family liaison officers, who shared information regarding the purpose of the Review, three members of the victim's family agreed to be interviewed. Family members of adult 1 declined and her parents, who also had parental responsibility for child 1, declined for themselves but also for Child 1, citing the impact this could have on them all. Adult 1 also declined to be involved in the process.

3.3 The Authors also made direct contact with Howard's family members and his manager at his place of work in order to provide further information and support to assist them to engage. Despite this, they continued to decline. The Authors and the Panel concluded that they did not wish to cause any further distress to family members of Howard and Adult 1 and agreed to proceed with interviewing Howard's close relatives namely his brother, sister in law and his daughter.

4. CONTRIBUTORS TO THE REVIEW

4.1 Information was requested from the following agencies:

Cwm Taf University Health Board
Rhondda Cynon Taf County Borough Council Social Services (Adults and Children Services)
Rhondda Cynon Taf County Borough Council Education Department
South Wales Police
Wales Community Rehabilitation Company
National Probation Service
Domestic Abuse Services, Oasis Centre, RCT
Welsh Ambulance Service Trust

4.2 However, all agencies confirmed there had been no involvement with the family prior to the homicide, apart from Child 1's school and his primary health care service and there were no concerns or significant incidents reported by either agency in relation to Child 1. In addition, neither Howard nor the perpetrator had any relevant contact with their GP, in fact Howard did not have contact with his GP for a number of years prior to his death. As such, no individual IMRs were completed.

5. CONCLUSIONS

5.1 The authors' ability to analyse and identify learning has been impacted upon by the lack of agency involvement and the limited interviews able to be undertaken. Therefore, the authors were wary about drawing conclusions based upon only 3 people's views.

5.2 However there are some key areas to consider and some learning identified. Whilst There were no reports of alleged domestic abuse by either party to any agencies: this does not mean, of course, that no domestic abuse took place prior to the incident that resulted in Howard's death. It is likely that there were barriers to reporting witnessed incidents to police, partly because of the conceptualisation by Howard and Adult 1's friends and family that Adult 1's behaviour was challenging, particularly when they had both been drinking, but also because of a culture that struggles still to recognise that domestic abuse can be perpetrated by a woman against a man and clings to some extent to traditional notions of male pride and strength. Neither Howard nor Adult 1 sought help with their relationship difficulties as far as can be ascertained: the Authors were unable to uncover any potential reasons for this.

6. LESSONS TO BE LEARNT

6.1 There is no direct learning for agencies as there was no involvement with either Howard or Adult 1 prior to the homicide. However, it is clear that there were indicators that their relationship was troubled and that there was a potential for escalation of negative behaviour, including violence. There appears to be a need for public services generally to raise public awareness of what constitutes

domestic abuse, but also to raise awareness that men can be victims of domestic abuse.

6.2 The family may have benefitted from accessing support services, and it has led the authors to consider whether there were any barriers to this rather than choosing not to seek help. This might be attributable to their understating of what support services can offer and provide and that they could be fearful of any potential consequences should they have sought support. However, this cannot be verified, as there were no police contacts, no mental health contacts, no contacts to domestic abuse agencies and no contacts to Children's Services throughout the Review period that could have alerted agencies to problems in family relationships, which could have led to the provision of advice and assistance.

7. RECOMMENDATIONS

7.2 The Authors have identified the following recommendations in relation to this case:

1. There should be a consistent approach to Healthy Relationship work to be undertaken across all schools, to include the impact of domestic abuse, in order to educate future generations and reduce the likelihood of harm, including:
    - What is a Healthy relationship?
    - The inter-relationship between mental health issues, substance misuse on the incidence of domestic abuse
    - Support for Emotional Wellbeing.
    - This approach may encourage children to disclose domestic abuse to a trusted adult in school

2. Agencies should consider how to support a community in relation to the aftermath of trauma, both in the short term and in the longer term.

3. There should be a national and local communication strategy developed to raise awareness that men can be victims of domestic abuse and the support available to them.