Cwm Taf
Partneriaeth Diogelwch Cymunedol
Community Safety Partnership

Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board

Domestic Homicide Review

Overview Report

DHR 02

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

Date of Death: December 2017

Completed by Alexandra Beckham and Jackie Neale
Independent Authors

Version	Date	
1	June 2019	First submitted to Home Office
2	December 2020	Resubmitted to Home Office following PQAA
3	**June 2021**	**This version resubmitted following further Home Office QA**

Contents

1.0 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'.

2.0 THE AUTHORS

2.1 The Authors of the report are Alexandra Beckham, Head of Service, and Jacqueline Neale, Adult Safeguarding Service Manager, both of whom are employed by Rhondda Cynon Taf County Borough Council's Adult Social Care Service.

2.2 Alexandra Beckham is a registered social worker with 20 years' experience in a range of services. At the commencement of the Review, Alexandra Beckham was the Safeguarding Lead for Merthyr Tydfil Social Services for Children, Adults and Domestic Abuse and previously sat on the Cwm Taf Safeguarding Board. At present, Alexandra is Head of Service for Rhondda Cynon Taf County Borough Council with responsibilities for learning disability, mental health and substance misuse. Alexandra acted as an advisor to Gwent police in a significant investigation into care homes and undertook a range of Reviews regarding care delivery. Alexandra has a range of experience in Safeguarding work and has undertaken Adult and Child Practice Reviews on behalf of the Cwm Taf Safeguarding Board, also undertaking the role of Chair in such Reviews. She has also contributed significantly to the management and development of responses to Domestic Abuse via the Multi Agency Safeguarding Hub (MASH) in the Cwm Taf Area.

2.3 Jackie Neale is the Adult Safeguarding Service Manager for Rhondda Cynon Taf County Borough Council and is the Local Authority Designated Officer for adults at risk and domestic abuse for Adult Social Care. She has considerable experience of undertaking Adult and Child Practice Reviews as both a Reviewer and Panel member, Case Reviews for quality assurance purposes for Rhondda Cynon Taf County Borough Council and the Cwm Taf Safeguarding Board and has been a Panel member on several DHRs. Jackie is a Registered Social Worker, Approved Mental Health Professional and Deprivation of Liberty Safeguards Best Interests Assessor. She has extensive practice, managerial and leadership experience in adult social care over a 30-year period.

2.4 The authors are independent of the Community Safety Partnership and their agencies have had no involvement with any of the parties involved in the case. Both authors have undergone training in respect of undertaking Adult and Child Practice Reviews and DHRs which, together with their experience and knowledge, fully equips them to author DHRs.

3.0 SUMMARY

3.1 This DHR report examines agency responses and support given to Howard, a resident of Cwm Taf, prior to the point of his death in December 2017

3.2 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.

3.3 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.

3.4 In addition to agency involvement, the Review also explored Howard's history to identify any relevant background or history of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the Review sought to identify appropriate learning for all to inform future practice.

3.5 A DHR Panel was convened on the 20th June 2018 following the conclusion of criminal proceedings where the perpetrator pleaded guilty to manslaughter by way of stabbing her husband and she received an eight-year prison sentence.

3.6 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.

3.5 Given that there was no information about Howard or the perpetrator and only limited information relating to Child 1, the Panel for this DHR, with support from the Home Office, agreed that it would be a proportionate Review to identify any areas of learning. As a result, the opportunity for any further investigation and analysis was recognised to be limited.

4.0 TIMESCALES

4.1 This Review began on the 20th June 2018 (the date of the first Panel) and was concluded on the 28th June 2019 where all Panel members had the opportunity to review the final report and offer any suggested amendments. The Review was subject to some delay to ensure that the Authors were able to carry out effective consultation with all family members should they wish to engage in the process.

5.0 CONFIDENTIALITY

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

6.0 METHODOLOGY

6.1 The Review Panel was made up of relevant multi-agency partners who agreed that the death met the criteria for a DHR.

6.2 Agencies were asked to review their involvement to ascertain whether an Individual Management Review (IMR) was required. This IMR would be completed by a senior officer, independent of the management of the case. The process also required the Authors to meet and consult with family members of both Howard and Adult 1. All close relatives and the perpetrator were contacted, as well as Howard's work colleagues. However, only three of Howard's relatives wished to be involved. Neither the perpetrator nor her relatives, including her parents who lived next door, wished to be involved. Consideration was given to the Authors speaking with Child 1, but neither grandparents, who had care of the child, nor the child's social worker felt that this would be in the child's best interests at that time.

6.3 All those contacted as part of the Review were given Home Office leaflets about DHRs but were not offered specialist support for advocacy around the DHR. This has been recognised as a missed opportunity because neither the Authors nor the Panel were aware that specialist advocacy was available at the time. The Authors and the Panel have learned from this experience that such a service exists and can be accessed.

6.4 The Review and this Report are based upon information provided by the police from the criminal investigation following the incident and two interviews with members of Howard's family. It was not felt necessary to liaise with HM Coroner because of the criminal proceedings.

6.5 The Terms of Reference of the Panel are attached as Appendix 1.

7.0 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

7.1 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.

7.2 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.

7.3 They were provided with the opportunity to read the report prior to submission to the Home Office. They raised no queries in relation to its content.

8.0 CONTRIBUTORS TO THE REVIEW

8.1 In order to establish any previous involvement with the family, the following agencies were contacted and were requested to provide any relevant information:

- 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

8.2 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.

9.0 THE REVIEW PANEL MEMBERS

9.1 The following professionals attended the Review Panel:

Alexandra Beckham (Independent Chair/Author)
Principal Manager Safeguarding, Merthyr Tydfil County Borough Council

Jackie Neale (Co-Author)
Service Manager, Adult Safeguarding, Rhondda Cynon Taf County Borough Council

Deborah Evans (Independent Domestic Abuse Specialist)
Regional Advisor for Violence Against Women, Domestic Abuse and Sexual Violence

Jane Randall, Head of Safeguarding, Cwm Taf University Health Board

Paul Mee, Service Director, Public Health Protection and Community Services, Rhondda Cynon Taf County Borough Council

Sue Hurley, Independent Protecting Vulnerable Person Manager, South Wales Police

Natalie Bevan, Team Manager, Wales Community Rehabilitation Company

Julie Clark, Head of Safeguarding (Children) Rhondda Cynon Taf County Borough Council

Gaynor Davies, Director of Education and Inclusion Services, Rhondda Cynon Taf County Borough Council

Katie Price, Team Manager National Probation Service

Rachel Gronow, Independent Domestic Violence Advisor (IDVA) Manager

9.2 The Panel met five times throughout the course of the Review and no Panel member had direct involvement with anyone involved.

10.0 EQUALITY AND DIVERSITY

10.1 A previous Cwm Taf DHR highlighted that agencies might have unconscious gender-based assumptions about victims and perpetrators of domestic abuse and a recommendation from that DHR was for agencies to Review their policies and procedures to ensure that there is no gender bias when responding to victims of domestic abuse. This work was completed and, as part of the Action Plan from that Review, all agencies now recognise that men can be victims of domestic abuse, and, at the same time, that women can be perpetrators. On

some occasions, individuals can be simultaneously victim and perpetrator of abuse irrespective of gender.

10.2 However, rather than institutional gender bias, this Review found that that domestic abuse of men by women might be more difficult to recognise within the wider community, because men are more usually perpetrators, rather than victims, of domestic abuse. Therefore, there was a potential reluctance within Howard's community to identify him as a victim of domestic abuse perpetrated by Adult 1 and there was certainly a suggestion from the his brother, sister in law and his daughter, who were interviewed by the Authors, that there are barriers, associated with cultural and social expectations, to men seeking and accessing support.

10.3 Under the Equality Act 2010, there are three protected characteristics for both the victim and perpetrator relevant to this case: sex, marriage and age. They were married, sex was a factor as was the 20-year age difference between them. The Authors and Panel carefully considered this age difference and, although theoretically, age could have been presumed to be factor, as Howard and Adult 1 were at different stages in their lifecycle (for example, Howard had an adult daughter who was around the same age as Adult 1 and Adult 1 had a much younger child), there was no objective evidence to determine this, other than the testimony of Howard's daughter, who had a difficult relationship at times with adult 1.

10.4 It is widely understood that the majority of domestic abuse victims are female and, although Adult A alleged in her police interviews that she had been a victim of domestic abuse, other than her testimony made at a time that she was likely to be charged with murder, there was no evidence that she had been a victim of domestic abuse by Howard's. However, the reviewers have considered the typology of domestic abuse and violence as identified by Johnson (2008) in particular, that is, violent resistance, described as being perpetrated by a victim of intimate terrorism which identifies that the partner (usually a women) murdering an abusive partner (usually a man) in the context of being attacked or an imminent attack on her or her children. Adult A described in her statement to the police that she felt threatened by Howard and that an ashtray had been thrown at her. Coupled with Child 1 running to her parents' house next door, there could be some merit in this typology. However, the Authors were unable to explore this further, not least because Adult A did not wish to speak with the Authors and it was not in Child 1's best interests to speak with him. None of Howard's family members supported Adult 1's contention that she was a victim of domestic abuse herself.

10.4 Other protected characteristics were considered but were not relevant to the case. There is no evidence of any discrimination by any agency in relation to these protected characteristics.

11.0 DISSEMINATION

11.1 Prior to publication, the Panel members will receive a copy of the report along with Howard's brother, his sister in law and his daughter who contributed to the Review.

12.0 BACKGROUND INFORMATION (THE FACTS)

12.1 The village in which the homicide occurred has a small population with approximately 3000 people living within the area. It has an area of social housing and is described as a close-knit community. There are areas of social deprivation and some previous concerns with drug issues and anti-social behaviour. However, a joined-up response between the police, local authority and the community has resulted in developing the community as a whole, with benefits also being provided from European Union funding. The village has a relatively stable population, often with residents having an awareness of one another's lives. This became a particular issue in the aftermath of the homicide that will be discussed in greater detail.

12.2 All of Adult 1's family lived in close proximity to each other, with her relatives living on the same street as her and her mother and father living next door. Howard's family also live within the same area. Howard and his wife began their relationship in 2009 and were married in 2011. Adult 1's child (Child 1) lived with both the child's mother and step-father.

12.3 Howard was born and brought up in the local area and had been married previously. He had one adult daughter, who had recently had a child. Howard's daughter described him as being a "doting" grandfather and they had recently become much closer. Howard's brother described him as being outgoing and very sociable and the family was described by the bother as close. Howard was employed as a drayman for a local brewery company: this was a physically demanding job which Howard appeared to enjoy according to reports made by his brother and daughter.

12.3 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.

12.4 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.

12.5 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.

12.6 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.

12.7 As part of the investigation, blood was taken from both Adult 1 and Howard to measure the level of alcohol. Howard's results were 1.5 times over the legal limit for driving and Adult 1's at nearly twice over the legal limit for driving.

12.8 In December 2017, Adult 1 was formally charged with the murder of her husband, Howard. The knife concerned was a bread knife approximately 33.3cm in length, with the length of the blade approximately 20.3cm.

12.9 The cause of death was determined via a post-mortem and was found to be a single stab wound to the chest. An inquest was opened and then adjourned in December 2018 and formally closed in February 2019 due to the criminal outcome.

12.10 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.

13.0 ANALYSIS

13.1 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.

13.2 It has already been noted that there was a significant age gap between Howard and Adult 1 and that Howard's daughter was of a similar age to Adult 1. Howard's daughter reported that it appeared to her that, at times, Adult 1 was jealous of her and her relationship with her father. It was not possible, given the lack of corroborating reports, to make any further hypotheses in relation to the impact of the age difference between the victim and perpetrator, but it is possible that the closeness in age of Howard's wife and daughter and his increased closeness to his daughter after she had her baby caused adult 1 to feel less in control and insecure.

13.3 At separate interviews, both relatives were consistent in their observations and their understanding of Howard and Adult 1's relationship, although it is to be noted that, as information has only been sourced from Howard's family, the Authors have been unable to qualify this information or gain a perspective from Adult 1 or her family that might have provided a different perspective.

13.4 From discussions with Howard's daughter, his brother and sister-in-law, the relationship between Howard and Adult 1 could be described as unstable. The relationship appeared to be characterised by Adult 1's feelings of emotional insecurity. Adult 1 was described as being jealous and needy of attention. The use of alcohol would also contribute to situations often escalating: the couple were known to 'binge drink' at weekends and in social situations. Research[1] shows that alcohol reduces people's inhibitions and can result in reckless behaviour and a failure to consider consequences. Alcohol use was a relevant factor in the homicide in December. It was also identified as an enabler in a previous Cwm Taf DHR[2] where the victim was male.

13.5 The information received from Howard's brother, sister in law and his daughter, suggested to the Authors that Adult 1 might have struggled with regulating her emotions which manifested in poor impulse control, in which alcohol at times also played a role (this has not been qualified with Adult 1's family, Adult 1 or any health professional). This often reportedly resulted in inappropriate behaviour in social situations, often causing embarrassment to Howard, his immediate family and manifesting itself in verbal arguments with Howard.

13.6 It appeared to the Authors that, based upon descriptions by Howard's brother, sister in law and his daughter, Adult 1 had some deep rooted self-esteem and self-confidence issues, but also exhibited some behaviour that is typical of coercive control, for example, going through and checking Howard's phone after an argument with him and placing demands upon him to return home when he was out. Coercive control is much more frequently associated with gender-based privilege, but 15% of cases were found by the Office of National Statistics (ONS) to have female perpetrators[3]. The incidence of Adult 1's historical behaviours, which were described by Howard's brother, sister in law and his daughter, were understood by people who knew her to be part of her personality that needed to be managed by the people around her, rather than as domestic abuse, which, in fact, it was.

13.7 A common theme running through the Review, based upon interviews with Howard's brother, sister in law and his daughter, links to Howard's status as a step-parent: it was described how Howard would attempt to provide some discipline and boundaries to Adult 1's child. However, it was shared that he was

[1] Vengeliene, V, Bilbao, A, Molander A, and Spanagel, R. Neuropharmacology of alcohol addiction. British Journal of Pharmacology, 2008 May; 154(2): 299–315.

[2] Domestic Homicide Review – DHR 01 May 2019

3. ONS, Domestic abuse prevalence and trends, England and Wales: year ending March 2019, accessed at Domestic abuse prevalence and trends, England and Wales - Office for National Statistics (ons.gov.uk)

often met with resistance to this from Adult 1, who would not support Howard and would often state that he should not discipline her child. This issue was a source of arguments between the couple.

13.8 Howard's brother, sister in law and his daughter advised the Authors that there had been disclosures during the criminal investigation that Adult 1 herself was a victim of domestic abuse and Adult 1 herself described at her police interview that, on the night in question, that there was a domestic violence incident leading up to the homicide. A previous suspected domestic abuse issue was also referred to with Adult 1 being the victim, which led the Authors to consider family responses to this and whether this was a wider issue around accessing support. The Authors considered whether there was a view of "keeping it within the family". This could be reflected in light of the cultural issues within the family and them being fearful of the consequences if they were to address it, for example, whether they would make their relationship with Adult 1 worse. However, apart from this unreported incident, there was no further evidence of any previous domestic abuse by the victim against the perpetrator, apart from the allegations made by the perpetrator, which ultimately affected the outcome of the criminal proceedings (she was convicted of manslaughter by a guilty plea, rather than murder).

13.9 The Authors considered whether this had been a case of 'Violent Resistance' by the perpetrator (Violent Resistance involves primary victims trying to resist long term coercive and controlling behaviour, the motivator being survival and achieving safety, it usually results in injury to the primary perpetrator) but were not satisfied that this was the case. The Authors also considered whether there had been barriers to Adult 1 reporting domestic abuse incidents or seeking support, but this could not be further explored because neither Adult 1 nor her family wished to contribute to the Review. It was clear that the victim's brother, sister in law and his daughter did not believe this to be the situation for Adult 1.

13.10 Throughout this Review, the huge impact of this homicide, the trauma that has been felt by Howard's family and the ripple effect that Howard's family reported to the authors as having on the community that they live in, was evident during their presentation at interview. According to Howard's brother, sister in law and his daughter, his homicide has had a powerful and long-lasting impact on community cohesion resulting in a split community and one in which they are still living. Social Media has contributed to this, with his daughter describing how she was singled out and targeted by individuals within the local community, but external to it as well. Howard's daughter described messages of anger being sent to her via social media, often citing that Howard must have provoked Adult 1, suggesting that there might be a wider issue about perceptions of the underlying causes of domestic abuse by female perpetrators. Howard's daughter described that it appeared people were trying to find a reason for the homicide occurring in the way that it did.

13.11 This led the Authors to question the underlying cultural expectations of men and social construction of masculinity: it also appeared to the Authors that our society can struggle to conceptualise women as being perpetrators of domestic abuse. When women are violent in an intimate relationship, there is an

underlying cultural belief that this must be in response to her being a victim in the first place, rather than as the primary perpetrator.

13.12 Male victims of domestic abuse need to be encouraged to report and seek support: agencies can learn well from mental health services who are changing our understanding of male mental health within the same cultural context, by encouraging more men to talk openly about their mental health and the experiences they have, in order to support their emotional well-being. This could be replicated in a campaign focusing upon male victims of domestic abuse both nationally and locally: this was echoed by Howard's brother, sister in law and his daughter who were strongly supportive of this. A previous local DHR[3] found that agencies might have an unconscious bias that made it less likely that men would be identified as victims of domestic abuse and offered services: this was not the case for this Review because no agencies had been involved at any point within the Review Timeframe.

14.0 CONCLUSIONS

14.1 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.

15.0 LESSONS TO BE LEARNT

15.1 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.

15.2 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,

[3] DHR 01 May 2019

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.

16.0 RECOMMENDATIONS

16.1 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.

Appendix 1

Terms of reference for case DHR - 02

16 July 2018

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[4] 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 house hold 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 the 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;
- 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.

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

- 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[5], South Wales Police notified the circumstances of the death of Howard in writing to the Chair of the RCT Community Safety Partnership on 8 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[6] 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 20 December 2018.

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 deemed necessary. The Panel will be supported by the Cwm Taf 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 an authorities will be requested to submit an Individual Management Review.

Independency

An independent Chair/Author has been appointed, Alex Beckham, Principal Manager for Safeguarding, Merthyr Tydfil County Borough Council. The Chair/Author will prepare a redacted Overview report and an Executive Summary. She will be supported by Jackie Neale, Service Manager for Adult, Rhondda Cynon Taf County Borough Council. The completed

[5] Home Office Guidance Page 8
[6] Home Office Guidance page 8

Overview Report and Action Plan will be presented to the Cwm Taf Community Safety Partnership and the Cwm Taf Safeguarding Board.

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

Scope of the Review

The scope of the review will be the 3 year period prior to the homicide on the 17 December 2017. The rationale for this is that Howard's daughter stated that his relationship with his partner had deteriorated over the last 3 years. Other relevant information may be considered outside of these parameters.

Individual Management Reviews

It has been determined that there was no involvement from any agencies in this case. The Panel has determined that Individual Management Reviews will not be required at this stage.

Circumstances of Concern

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

- The victim had no contact with agencies.
- Services were not available locally to support the victim

Questions to be Addressed

It has been determined that the victim had no known contact with agencies. The focus of the DHR will therefore be on the questions poses to the family, friends and colleagues of the deceased. In particular:

- Did they recognise Domestic Abuse or concerning behaviour and, if so, why didn't they tell someone?
- Why was there no contact with agencies?
- Were there any barriers to the victim accessing services?
- Were there particular reasons why local services were not appealing to the victim?
- Could more be done in the local area to raise awareness of services available to victims of domestic abuse?
- Did the victim make a disclosure at work? Does the organisation have a domestic violence policy?

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?
- Were the victim and perpetrator social housing tenants? If so, were there rent arrears or frequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? Does the social landlord carry out routine screening for domestic abuse? Are there policies in place which support and allow staff to identify and report suspected domestic abuse? Have the processes in place been reviewed to ensure that they remain effective?
- 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 enquiries.

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.