



Cwm Taf
Partneriaeth Diogelwch Cymunedol
Community Safety Partnership



Executive Summary

of

Domestic Homicide Review Overview Report DHR 01

Report into the death of a 45 year old man

**Report produced by Malcolm Ross M.Sc
Independent Chair and Author**

May 2019

List of Abbreviations

| | |
|---------|--|
| ADHD - | Attention Deficit/Hyperactive Disorder |
| ALS - | Alcohol Liaison Service |
| CAMHS - | Children and Adolescent Mental Health Services |
| CRC - | Community Rehabilitation Company |
| CSP - | Community Safety Partnership |
| CTSB - | Cwm Taf Safeguarding Board |
| DCT - | Disabled Children's Team |
| DHR - | Domestic Homicide Review |
| GP - | General Practitioner |
| IAT - | Initial Assessment Team |
| IDAP - | Intensive Domestic Abuse Programme |
| IDVA - | Independent Domestic Violence Advisor |
| IMR - | Individual Management Review |
| MARAC - | Multi-agency Risk Assessment Conference |
| MASH - | Multi-agency Safeguarding Hub |
| NPT - | National Probation Trust ¹ |
| PPD1 - | Public Protection Disclosure Form (Police) |
| PPU - | Public Protection Unit (Police) |
| PSR - | Pre sentence report |
| RCT - | Rhondda Cynon Taf |
| SEN - | Special Educational Needs |
| SIO - | Senior Investigating Officer (Police) |
| TEDS - | Treatment and Education Drugs Service |
| WAST - | Welsh Ambulance Services NHS Trust |
| WAVE - | Women Against Violence and Exploitation |
| YOS - | Youth Offending Service |

¹ As from 1st April 2017 NPT changed to HM Prison and Probation Service

Executive summary

of

Domestic Homicide Review Overview Report DHR 01

Introduction

This Domestic Homicide Review concerns the death of the Victim (V), a 45 years old man, who was found dead in his home on 3rd October 2015. Emergency Services were informed at 07.20 hours and responded to a man who it was believed was having a cardiac arrest. V's wife, her son and his partner were present and stated that V had been beaten up the night before. It was clear that V had suffered a serious assault and he was declared dead at the scene. Those present were treated as significant witnesses and conveyed to separate Police stations to obtain their accounts as the Police were unsure of what had happened. As the investigation unfolded it became clear that V had died from an unlawful act. All three people present were subsequently arrested, the partner (FP1) and her son (MP1) for murder and the son's partner (PP) for perverting the course of justice.

In this case there are three perpetrators, but for ease of understanding the wife of V is referred to as FP1, (Female Perpetrator 1) the step-son is referred to as MP 1 (Male Perpetrator 1), and his partner is referred to as PP (Perpetrator's Partner).

In 2016 all three appeared before the Crown Court. The FP1 was convicted of murder and was sentenced to 17 years imprisonment. Her son, MP1, was also convicted of murder and sentenced to 18 years imprisonment. The son's partner PP, was convicted of perverting the course of justice and was sentenced to 18 months imprisonment suspended for 2 years. She was electronically tagged.

The details of the Terms of Reference and the composition of the DHR Panel members are contained in an appendix at the rear of this Executive Summary.

The following genogram identifies the family members in this case, as represented by the following key:

| Identity | Relationship to Victim |
|----------|--|
| V | Deceased Husband of FP1 – step Father of MP1 and sibling |
| FP1 | Female Perpetrator - Wife of deceased, Mother of Male Perpetrator and his sibling. |
| MP1 | Male Perpetrator and step son of deceased |
| PS | Brother of Male Perpetrator 1 – step son of deceased |
| PP | Male Perpetrator's Partner (also a Perpetrator) |
| DPP | Daughter of PP and Male Perpetrator 1 |
| MP1F | Deceased Father of MP1 and PS and ex-husband of FP1 |
| PGM | Male Perpetrator's Grandmother – Mother of MP1F |
| PGF | Male Perpetrator Grandfather – Father of MP1F |
| ExP1 | Ex-partner of Victim |
| ExP2 | Ex-partner of Victim |
| ExP3 | Ex-Partner of Victim |

Summary of events.

The Victim in this review (V) is known to have had three previous partners before his association with FP1. It is known that there was domestic violence coupled with alcohol abuse by V towards some, if not all of his previous partners.

FP1 was married before she met V. She and her husband had two male children, MP1 and his younger brother. It is known that the relationship between FP1 and her first husband was volatile and again fuelled by alcohol abuse. It is also known that during this relationship FP1 was a victim of domestic violence. However she also perpetrated violence towards her husband, but was often treated as a victim rather than a perpetrator when police were called to intervene.

MP1 met his partner PP while they were at school. PP was convicted of Perverting the Course of Justice in this case. It is her parents' view that her involvement in the death of V was a result of the coercive and controlling behaviour of MP1. PP's parents told the Review Author that MP1 controlled almost everything PP and their female child did.

There are a series of significant events prior to the merging of the families that are worthy of mention.

In 2001, MP1 was referred to Children's Services due to disruptive behaviour and cruelty to animals. He was bullying his younger brother and by 2003 he had threatened a school pupil with a knife.

In 2007, MP1 had been convicted of causing damage to school property and was sentenced to a 12 months Referral Order and given 30 hours of reparation. He also had to work with YOS on his offending behaviour.

In January 2009, V reported that he had been attacked by one of his former partners and her boyfriend. There was no formal complaint to the police by anyone involved although V did attend to his GP's surgery complaining of head and chest injuries as a result of the attack.

There were a series of agency intervention with MP1 and his father relating to allegations of assault on MP1 by his father and his father watching pornography in the presence of MP1 and his younger brother. These incidents were dealt with by Children's Services, but not under a Section 47 investigation.

In June 2009, MP1 threatened his father with a knife. A referral to Children's Services was made by a Housing Support Worker. It was advised that MP1 should be taken to see his GP, but there is nothing to suggest that he was taken to his GP or that a suggestion from Housing that MP1 needed separate accommodation was pursued.

In August 2009, police were called to an altercation between MP1's parents. His mother had threatened his father with a knife and had smashed a vase over his father's head. There was no complaint from either party and apart from a PPD1 form being submitted, no further action was taken.

During September 2009, Children's Services were involved with MP1. His grandparents had significant input into his safeguarding but in September 2009 police responded to a call that a man had been hit with a hammer whilst at the grandparents' house. The identity of the man or the assailant is not known, but it is an indication of the violence occurring in the life of MP1 even at accommodation which was deemed to be a safe environment for MP1.

Although a child protection referral was appropriately raised again the Intake Team Manager did not progress the referral and advised that the police were to be informed of the underage drinking and that the worker obtain more information about FP1 propositioning the friend.

Again in January 2010, concerns were raised by the grandparents about the amount of alcohol that was being used by V and FP1. Again the Intake Manager considered that there was nothing that could be done on the basis that MP1 could stay with his grandparents or FP1 even if child protection plans were in place. This has to be considered a missed opportunity to escalate to Child Protection.

On 30th July 2010, Children's Service received information from MP1's father that FP1, had moved out of the family home and left the boys on their own. The father had visited the house to find the fridge and freezer unplugged and there was no food. It appears that the mother had not actually moved out of the house but she expressed her intention to do so in the near future.

On eight occasions in 2011 and 2012, V attended hospital with alcohol withdrawal symptoms. In September 2012 the hospital reviewed the pattern of recent admissions. No social concerns were identified.

In January 2012, PP and MP1 were living together. PP's parents reported to the author that within months most of her savings had been withdrawn and spent. It is her parents' view that MP1 was behind the money being spent.

In October 2012, a domestic incident between FP1 and V was recorded by police. She had been locked out of her house with all of her belongings. Police calmed the situation down. There were no complaints made by FP1.

PP was confirmed as being pregnant in January 2013. Concerns were expressed about PP having been diagnosed with ADHD and the fact that MP1 had been known to Children's Services for some time and had attended the same school as PP.

There were two incidents of domestic disputes in November 2012 between V and his wife, FP1. The first was a verbal argument which resulted in a PPD1 being submitted. The second incident involved FP1 being arrested and cautioned by the police for assaulting V. This incident was recorded as a standard risk which is seen as a missed opportunity to consider the vulnerability of V.

During the early months of 2013, domestic incidents involving alcohol use continued between V and FP1. A PPD1 was submitted with a medium risk assessment and a 'Domestic Abuse Warning Marker' placed on police systems for the home address together with a 'Violent' marker for V. It was clear however that on occasions FP1 was the aggressor but she was treated as the victim.

In April 2013, as a result of FP1 withdrawing her complaint against V, a MARAC referral was made and the risk to her was recorded as high. Safety measures were put in place at FP1's house as she was deemed to be in danger of abuse from V. Again FP1 was seen as the victim.

During 2013 there were incidents of V failing to comply with bail conditions imposed by the police that sometimes resulted in him appearing before the Magistrate's Court. More often than not he was re-bailed by the Courts. It was not until May 2013, that he was arrested again for failing to comply with his bail conditions and he was remanded in custody. V however, wrote to FP1 asking her to change her mind and withdraw the complaint so he could again be released from custody.

FP1 explained this to her IDVA worker, who contacted the police. Arrangements were made for her to attend the Crown Court and although there was evidence of significant domestic abuse on FP1 by V, he was given a 24 month Community Order with a requirement that he completed the Integrated Domestic Abuse Programme (IDAP). There was no restraining order issued.

During July 2013, FP1 reported to her IDVA worker that V had stopped drinking alcohol. V repeatedly failed to attend his Probation appointments. There was no assertive action taken by Probation to 'breach' V and prosecute him for not complying with his Community Order.

During September and October 2013, V made several attendances to the Emergency Department of the local hospital with various head injuries associated with alcohol use. In September 2013, IDVA closed the case on FP1.

On 15th October 2013, V was arrested again for assaulting FP1. He was released on bail with a condition that he did not approach FP1. The following day he breached his bail again by approaching her at the railway station. He was arrested, appeared before the Magistrates and despite police objections he was again bailed.

A few days later FP1 went to V's house where he made an allegation of theft of his wallet. The wallet was found in the house but as she left, FP1 smashed a neighbour's window. She was arrested and charged with criminal damage.

In November 2013, V failed to attend another Probation appointment and again no enforcement action was taken. Later that month he was found at FP1's house in breach of his bail conditions. He was arrested and despite police objections, he was bailed by the Magistrate's Court the following day.

In December 2013, FP1's case with the IDVA Service was closed as she was, by now being supported by Women's Aid.

During 2014, V continued to breach his bail conditions and failing to attend his Probation appointments. He was also attending the Emergency Department of the local hospital for alcohol related injuries.

In June 2014, V attended for his IDAP. In a group session he stated that he had been abusing FP1 and described it as a 'one off' incident and played down the significance of the abuse on FP1. However, V blamed FP1 for the abusive times in their relationship as it was her that got intoxicated not him.

At subsequent IDAP meetings it was clear to those running the meeting that V had no concept of understanding the issues around disrespecting women and even wore a T shirt to one meeting with an offensive comment about women printed on it.

In October 2014, V was summoned to Court for failing to regularly keep his IDAP appointments. He was sentenced to 12 months imprisonment.

In December 2014, domestic violence incidents between MP1 and PP began to be reported and Children's Services were involved for safeguarding considerations with regard to the child.

MP1 was reported to have made threats to PP's father during January 2015 and the police issued MP1 with a Police Information Notice.

An ambulance was called to the home address of V just after 0700 hours on 3rd October 2015 to a report that a man had been beaten up the previous evening. Paramedics found V on the floor having been badly beaten. He was dead.

Police officers attended and initially interviewed those present, MP1, FP1 and PP as witnesses. However, due to discrepancies in their witness statements, they were all later arrested and interviewed under caution.

It was determined that V had been subjected to a significant assault. The house showed signs of being cleaned and the three people arrested had changed their clothes before the arrival of the police officers.

MP1 and FP1 were charged with murder. PP was charged with Perverting the Course of Justice.

At the Crown Court subsequently, PP pleaded guilty to Perverting the Course of Justice and received 18 months imprisonment suspended for 2 years. She was also electronically tagged.

MP1 was convicted of murder and was sentenced to 18 years imprisonment.

FP1 was convicted of murder and received 17 years imprisonment.

PP's child was placed with the maternal grandparents and subsequently made subject to a Special Guardianship Order.

Analysis and Recommendations

There are several areas in particular that the DHR Panel thought were pertinent and worthy of comment.

The decisions around Adult Social Care Services.

It is clear that adherence to the rigid eligibility criteria for services for Adult Learning Disability Services at that time, prevented a wider holistic view of MP1's needs being recognised and therefore a missed opportunity to provide him with support when he reached adulthood.

In line with the ethos of the Social Services & Well Being Act (Wales) 2014, eligibility for Adult Social Care Services is now based on needs for care and support, rather than on criteria that includes rigid adherence to factors such as IQ and the approach to transition between the Children's and Adults' Services is now also more flexible.

If MP1's situation were considered now, he might still not be accepted by the Specialist Learning Disability Service, but he would be accepted at least for assessment by the generic Adult Social Care Service.

Children's Services

In 2008, MP1 was said to have assaulted PS which should have triggered child protection procedures but did not and there is a lack of detail on file as to how that decision was reached.

In respect of the child DPP, authorities were made aware of concerns through a pre-birth referral from the midwife. This was followed by a number of contacts from Health, the maternal grandparents and two PPN's from the Police. Despite all of this information no initial assessment was conducted and no one from Children's Services visited the child or spoke to her mother, PP. The Children's Services IMR author states:

'There was an over reliance on information received over the telephone and at no point was a home visit made. On the information contained in the chronology, an Initial Assessment should have been undertaken. On the 7th January 2015, the information received should have triggered a S.47 enquiry.'

The Children's Services IMR make several recommendations that adequately address these shortcomings.

The Children's Services IMR points out that there were five instances where MP1's case was appropriately referred to the Intake Team Manager to initiate child protection procedures but no child protection enquiries were undertaken and therefore there were no investigations or periods of registration with regard to MP1.

The Children's Services IMR author considered that there were questionably high thresholds for child protection intervention and an over reliance on informal and alternative family arrangements that history should have indicated were unlikely to be sustainable. The evidence suggests individual management failings to follow child protection procedures that were in place at that time

In view of those findings the following recommendation is made:

Recommendation No 1

Cwm Taf Safeguarding Board satisfies itself that changes to current practices and procedures have addressed the historical issues identified.

V's reluctance to engage with agencies

Between October 2007 and May 2008, V was supported by both TEDS & Community Drug and Alcohol Team but his attendance and willingness to engage with both services was sporadic. He always dropped out of the service with an unplanned closure and failing to engage or keep appointments. He did not seek support to find employment or to deal with his binge drinking. He had a total of 13 appointments arranged at his home address of which he failed to keep 6 and a further appointment was abandoned by the worker due to V's intoxication. V showed no desire to change his alcohol intake. Finally after numerous times of failing to attend appointments and not responding to follow up letters and telephone calls the support from TEDS ended.

No contact was made by V until 5 years later in 2013, when following an admission to hospital he began to receive support from the Alcohol Liaison Scheme. Over the next 2 years his pattern of failing to attend appointments and responding to letters and telephone calls remained the same. Due to the fact of V's poor attendance and reluctance to engage with TEDS a holistic picture of his lifestyle was not fully obtained.

V had numerous offers of help. He chose not to engage. He had little motivation to help himself and it is difficult to engage with someone in those circumstances, knowing he cannot be forced into receiving support.

Recommendation No 2

Cwm Taf Substance Misuse Area Planning Board consider the role of alcohol as an enabler for violence and determine what practical measures substance misuse services can take to support victims of domestic abuse where alcohol is identified as a factor.

HM Prison & Probation Service

During the period of time that V was supposed to be engaging with HM Prison and Probation Service, the relationship between V and FP1 continued to be abusive. It is clear that due to V's lack of engagement there was no opportunity to undertake any offence focused cognitive intervention.

HM Prison and Probation Service, make several IMR recommendations that go a long way towards remedying those issues in record keeping and assessments that were identified by the IMR author.

Recommendation No 3

Cwm Taf Community Safety Partnership Board requests that HM Prison and Probation Service & CRC review their policies and procedures in light of the findings of this review to ensure they are robust.

South Wales Police

Between July 2007 and January 2015, the South Wales Police dealt with 32 incidents that involved one or more of V and FP1 and previous partners. The majority of the incidents were 'domestic' related and occurred after one or both parties had been consuming alcohol.

V was involved in 8 domestic related incidents involving former partners. He was arrested on 3 occasions for assaulting ExP1 and twice for assaulting FP1. He was further arrested a total of 6 times for breach of bail without any significant consequences being imposed by the Courts.

FP1 was involved in 4 domestic related incidents involving MP1F and MP1. FP1 was also arrested for assaulting V and for damaging ExP3's window. FP1 was subject of a MARAC held after she was assaulted by V

MP1 was involved in 4 domestic related incidents, the latter being related to access to his child DPP.

Where allegations were made of violence against FP1, swift and positive action was taken and where the evidence existed, arrests were made. However when allegations were made of violence against V including on one occasion when FP1 was arrest for 'Common Assault', V was not recognised as a victim of domestic abuse, nor FP1 as a perpetrator. The Panel are of the view that there was an element of gender bias when dealing with these incidents.

Recommendation No. 4

All partner agencies review their policies and procedures to ensure that there is no gender bias when responding to victims of domestic violence. All agencies must recognise that men can be victims of domestic violence, and at the same time women can be perpetrators. On some occasions, individuals can be simultaneously victim and perpetrator of abuse irrespective of gender.

V's bail conditions

The Panel has expressed concern regarding the number of occasions that V was granted bail and despite committing further offences including breaching his bail, the Magistrate's Court continued to grant him further bail. The Panel are of the opinion and that there was no effective enforcement in response to the breaches of bail conditions.

Recommendation No 5

H.M. Courts and Tribunal Services considers the findings of this review in respect of the decisions of the Courts in relation to repeat offenders of domestic abuse and repeat bailing of offenders and determines whether there is a need for further awareness raising or training amongst magistrates, concerning domestic abuse.

Women's Aid, IDVA and Oasis

In addition to being supported by the IDVA Service, FP1 also sought support from Women's Aid. She attended the WAVE (Women Against Violence and Exploitation) group life skill programmes to overcome the effects of alleged domestic abuse from V.

She had the opportunity to discuss personal issues and disclose incidents of domestic abuse or sexual violence on a one to one basis, but there is no evidence to suggest that she did disclose any such behaviour.

Prior to receiving support from Women's Aid, both FP1 and PP were referred to the Oasis Centre. Records within Oasis indicate that FP1 was at high risk of domestic abuse from V. In March 2013 she accepted support and worked with Oasis until January 2014 when she began to receive long-term support from Women's Aid.

In October 2015, PP attended at an Oasis drop in centre following advice from Children's Services. She attended one meeting and received a follow up telephone call. She was at medium risk of domestic violence from MP1. It is thought that the continuity of support FP1 had from Women's Aid and Oasis was outstanding.

Disclosure of medical information of the Perpetrator

In the Home Office Guidance of December 2016, paragraphs 98 – 100 deal with disclosure of medical information when the patient does not give consent. The Local Health Board for Cwm Taf was initially reluctant to disclose the perpetrators' medical information without consent. The CSP sought legal advice regarding the interpretation of the guidance. The advice was that the guidance was part of a Statutory Instrument and should be complied with. This resulted in all relevant information regarding the Perpetrator's medical records being disclosed and considered by the Review Panel. Nonetheless, the panel was of the view that further guidance was required.

Recommendation No. 6

The Department of Health and UK Council of Caldicott Guardians issue guidance on the disclosure of health information in a Domestic Homicide Review, clarifying the criteria and principles on what information is relevant and what is not.

Recommendation No 7

The findings of this review and lessons learned are shared with practitioners through the Safeguarding Board Adult Review Group. Views of the family and of those concerned on this review.

At the commencement of this review, the author wrote to the three perpetrators, their legal representatives, the immediate family of the victim and the family of PP. For many months no-one replied. The author tried again with more letters and eventually received a response from the family of PP. No-one else has replied.

In March 2017, the author and a colleague Mr. Martyn Jones, visited PP's family at their home address. Details of a comprehensive meeting with the family are contained in the Overview Report but in summary PP's parents said that they felt that from the time their daughter, PP, met MP1 at school, he developed a controlling nature towards her. Mention has already been made of the money that was spent from PP's savings in a very short time, once she was with MP1. It appears that he ignored the child once it had been born and he became obsessed with his image, clothing and body building. They described his relationship with his mother, FP1 and stepfather, V, as a troubled one.

PP's parents often saw marks and bruises on PP and suspected that there was domestic abuse between MP1 and PP, but, they suspect, through fear, PP never made any complaints about his being violent towards her. They are in no doubt that MP1 was a bully towards their daughter, who was herself a vulnerable person with learning disabilities. During the course of the meeting with PP's parents, PP arrived and contributed to the conversation, confirming all that had been said by her parents.

Conclusions.

It is not clear if FP1 was bullied and coerced by MP1 especially with regard to the violence that led to the death of V. What is known is that FP1 engaged in a degree of violence when V was in a desperate state during the evening before he died having been left alone overnight on a sofa, critically injured.

No professional had any knowledge of V's problems due to the non-engagement of him and his family with services. The agencies that did have contact with his family did so in isolation of each other, which today would be identified through the MASH information-sharing process.

V was not recognised as a victim but only as a perpetrator. He was also a vulnerable person, which was not recognised. Both FP1 and V repeatedly failed to engage positively with services or lacked the motivation to do so. V lived with an aggressive and violent woman, (FP1) and had a violent step-son, (MP1). Alcohol in the family surroundings added to his risk. The role of alcohol as enabler for violence was significant for both V and FP1 and the connection between alcohol misuse, violent behaviour and vulnerability was not made.

Conversely, FP1 is identified as a victim of domestic abuse and receives support and intervention but was not recognised as a perpetrator of domestic violence, despite multiple incidents indicating violence on her part towards V, and the review has learned, also to her former partner.

There is evidence to suggest that there exists a gender bias across organisations. Men were not recognised as victims.

There were many missed opportunities to intervene with MP1, both as a child and adult.

There are seven recommendations made in this review. The Panel are satisfied that policies and procedures in various agencies have improved so as to prevent similar mistakes being made in the future.

Recommendations

Recommendation No 1

Cwm Taf Safeguarding Board satisfied itself that changes to current practices and procedures have addressed the historical issues identified.

Recommendation No 2

Cwm Taf Substance Misuse Area Planning Board consider the role of alcohol as an enabler for violence and determine what practical measures substance misuse services can take to support victims of domestic abuse where alcohol is identified as a factor

Recommendation No 3

Cwm Taf Community Safety Partnership Board requests that HM Prison and Probation Service & CRC review their policies and procedures in light of the findings of this review to ensure they are robust.

Recommendation No 4

All partner agencies review their policies and procedures to ensure that there is no gender bias when responding to victims of domestic violence. All agencies must recognise that men can be victims of domestic violence and at the same time, women can be perpetrators. On some occasions, individuals can be simultaneously victim and perpetrator of abuse irrespective of gender.

Recommendation No 5

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Recommendation No 7

The findings of this review and lessons learned are shared with practitioners through the Safeguarding Board Adult/Child Practice Review Group.

Individual Management Reviews Recommendations

Children's Social Services

Recommendation No1.

Quality Assurance Framework and Audit Processes to be strengthened within the Local Authority to ensure recording policies and supervision audits are adhered to.

Recommendation No 2

Children's Services to proceed with implementing a risk assessment framework across the division that encourage consistent thresholds and supports evidenced based decision making and practice.

CRC

Recommendation No 1

Given the fact that BBR has superseded IDAP there are no formal interagency response. Staff have fully accredited training to deliver BBR which is endorsed by the Ministry of Justice, this is appropriate to ensure staff are adequately equipped with the skills to manage the scenarios raised above.

Treatment and Education Drugs Services

Recommendation No 1

Undertake review of all the assessments/risk assessments used by staff across all the projects within the organisation (including those that are run as a consortium).

Recommendation No 2

Make case recording/report writing training mandatory as part of staff induction.

Recommendation No 3

Undertake a review of how effectively different projects/consortia staff share information with their colleagues & how this can be improved in order to facilitate effective practice.

Cwm Taf Youth Offending Services

Recommendation No 1

A learning event be held with YOS case managers with regard to Risk of Serious Harm assessments to ensure that information from other agencies and previous behaviour informs the assessment and other aspects which have been identified within this case are fed back to staff.

Terms of Reference for the Review

The aim of the DHR² is to:

- 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;
- Identify clearly what the 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;
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working,
- Contribute to a better understanding of the nature of domestic violence and abuse : and
- Highlight good practice.

Individual Needs

Home Office Guidance³ requires consideration of individual needs and specifically:

‘Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted’

Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The review gave due consideration to all of the Protected Characteristics under the Act.

² Home Office Guidance 2016 page 6

³ Home Office Guidance 2016 page 36

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- 2.5 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

There was nothing to indicate that there was any discrimination in this case that was contrary to the Act.

Family Involvement

Home Office Guidance⁴ requires that:

“Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related Police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.”

The 2016 Guidance⁵ illustrates the benefits of involving family members, friend and other support networks as:

- a) assisting V's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide;
- b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on Vs and perpetrator's perspectives rather than just agency views.
- c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.
- d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of V and/or perpetrator in order to see the homicide through the eyes of V and/or perpetrator. This approach can help the panel understand the decisions and choices V and/or perpetrator made.
- e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

⁴ Home Office Guidance 2016 page 18

⁵ Home Office Guidance 2016 Pages 17 - 18

f) revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) enabling families to choose, if they wish, a suitable pseudonym for V to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

In this case the Overview Report Author made contact with the Senior Investigating Officer (SIO) from South Wales Police at an early stage.

Letters have been sent to family members setting out the process of this review and inviting them to contribute to it, but there has been no reply from any family member. Similar letters have been sent to previous partners of V. Only one replied to say that she did not want to participate. There has been no reply from either MP1 or FP1 consenting to their medical records being disclosed. However, PP was seen at the same time as her parents and all three people made some helpful comments about this case. Please see section 'Views of the Family'.

DHR Panel

In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Mr Ross chaired the panel. Other members of the panel and their professional responsibilities were:

- Debbie Osowicz – Deputy LDU Head, Wales Probation Trust
- Charlie Arthur – Chief Executive Officer, Women's Aid, Rhondda Cynon Taf
- Cheryl Emery – Homelessness and Supporting People Manager, Rhondda Cynon Taf
- Sue Hurley – Independent Protecting Vulnerable Person Manager, South Wales Police
- Julie Clark - Head of Intensive Intervention, Children's Services, Rhondda Cynon Taf
- Claire Williams – Service Manager, Disabled Childrens Team, Rhondda Cynon Taf
- Natalie Bevan – Team Manager, Wales Community Rehabilitation Company
- Jane Randall – Head of Safeguarding, Cwm Taf University Health Board
- Jean Harrington – Director, Treatment Education Drug Service
- Debbie Evans – Cwm Taf Regional Advisor for Domestic Abuse, Safer Merthyr Tydfil
- Paul Mee – Service Director, Public Health & Protection, Rhondda Cynon Taf
- Nicola Kingham – Cwm Taf Safeguarding Board Business Manager
- Fiona Davies – Safeguarding Specialist, Welsh Ambulance Service NHS Trust
- Rachel Lapham – Cwm Taf Safeguarding Board Business Development Officer
- Elspeth Wynn – Cwm Taf Youth Offending Service

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- Sarah Watkins – Secretary to Service Director, Rhondda Cynon Taf
 - Esther Thomas - Temporary Director Of Education And Lifelong Learning, Rhondda Cynon Taf
 - Jackie Neale - Adult Safeguarding Service Manager, Rhondda Cynon Taf
 - Nicola Jones - Cwm Taf Safeguarding Board Administrator
 - Martyn Jones - External Reviewer
 - Malcolm Ross – Chair

Individual Management Review

An Individual Management Review (IMR) and comprehensive chronology was received from the following organisations:

- Oasis Centre (Independent Domestic Violence Advisors)
- South Wales Police
- Women's Aid RCT
- TEDS (Treatment and Education Drug Service)
- Wales Community Rehabilitation Company (WCRC)
- RCT Children's Services including Youth Offending Services (YOS)
- RCT Education Services
- Welsh Ambulance Services Trust (WAST)
- RCT Community Housing Services
- Cwm Taf University Health Board
- National Probation Service Wales

In addition reports were received from:

- RCT Adult Services

Guidance⁶ was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

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

⁶ Home Office Guidance 2016 Page 20