*Cwm Taf*
**Partneriaeth Diogelwch Cymunedol**
**Community Safety Partnership**

CTSB
CWM TAF SAFEGUARDING BOARD

# Domestic Homicide Review
# Overview Report
# DHR 01

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## Report into the death of a 45 year old man


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


May 2019

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## 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 |

[11] As from 1st April 2017 NPT will be called HM Prison and Probation Service

# INTRODUCTION AND BACKGROUND

***The Chair/Author and Panel members in this review 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.***

## 1.1 Introduction

This Domestic Homicide Review concerns the death of the Victim (V), a 45 years old man, who was found dead in his home in 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 (from a previous relationship) 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.

1.1.1 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 MP1 (Male Perpetrator 1), and his partner is referred to as PP (Perpetrator's Partner).

1.1.2 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.

## 1.2 Purpose of a Domestic Homicide Review

1.2.1 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[2] on 13th April 2011 and reviewed in December 2016[3]. 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 violence, 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"*

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

[2] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[4], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*
>
> - *psychological*
> - *physical*
> - *sexual*
> - *financial*
> - *emotional*

1.2.5 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.

## 1.3 Process of the Review

1.3.1 South Wales Police notified Cwm Taf Community Safety Partnership (CSP) of the homicide on 3rd February 2016. Cwm Taf Community Safety Partnership with other agency representatives reviewed the circumstances of this case against the criteria set out in Government Guidance and recommended that a Domestic Homicide Review should be undertaken. The Chair ratified the decision.

1.3.2 The Home Office was notified of the intention to conduct a DHR 1st March 2016. An independent person was appointed to chair the DHR Panel and to write the Overview Report. At the first review panel terms of reference were drafted. On 17th November 2017 the Community Safety Partnership Board approved the final version of the Overview Report and its recommendations.

## 1.4 Independent Chair and Author

1.4.1 Home Office Guidance[5] requires that;

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on evidence the review panel decides is relevant," and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."*

[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.
[5] Home Office Guidance 2016 page 12

1.4.2 The CSP decided in this case to appoint both an independent chair and an independent author.

1.4.3 The Independent Author and Chair, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police. He has over 25 years' experience in writing over 90 Serious Case Reviews and chairing that process and, more recently, performing both functions in relation to over 28 Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies or the Local Authority. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it. Mr Ross is a consultant to Winston Limited, and works with Mr Martyn Jones who is also a DHR author and has worked alongside Mr Ross in this review.

## 1.5 DHR Panel

1.5.1 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, RCT
- Cheryl Emery – Housing – Homelessness and Supporting People Manager
- Sue Hurley – Independent Protecting Vulnerable Person Manager, South Wales Police
- Julie Clark - Head of Intensive Intervention, Children's Services, RCT
- Claire Williams – DCT, Service Manager
- Natalie Bevan – Wales Community Rehabilitation Company (CRC)
- Jane Randall – Head of Safeguarding, Cwm Taf University Health Board
- Jean Harrington – Director, TEDS
- Debbie Evans – Cwm Taf Regional Advisor for Domestic Abuse, Safer Merthyr Tydfil
- Paul Mee – Service Director, Public Health & Protection, RCT
- Nicola Kingham – CTSB Business Manager
- Fiona Davies – Safeguarding Specialist, WAST
- Rachel Lapham – CTSB Business Development Officer
- Elspeth Wynn – Cwm Taf YOS
- Sarah Watkins – RCT CBC
- Esther Thomas - RCT Education
- Jackie Neale - Adult Safeguarding Services Manager RCTCBC
- Nicola Jones - RCTSB Administration
- Martyn Jones, External Reviewer
- Malcolm Ross – Chair

1.5.2 None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

1.5.3 The Panel was supported by the Safeguarding Board Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

## 1.6 Parallel proceedings

1.6.1 The Panel were aware that the following parallel proceedings were being undertaken:

- The CSP advised HM Coroner by letter on 24th September 2016, that a DHR was being undertaken.
- The review was commenced in advance of criminal proceedings having been concluded and therefore preceded with awareness of the issues of disclosure that may arise.

## 1.7 Time Period

1.7.1 It was decided that the review should focus on the period from 1st July 2007 (V's first contact with the Police for domestic violence), until the time of death of V in October 2015, unless it became apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended if any agency had any significant relevant information.

## 1.8 Scoping the Review

1.8.1 The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the Cwm Taf CSP to identify agencies that had involvement with V, the Perpetrators and the family prior to the homicide. Where there was no involvement or insignificant involvement, agencies were advised accordingly.

## 1.9 Individual Management Review

1.9.1 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
- HM Prison & Probation Service Wales

1.9.2 In addition reports were received from:

- RCT Adult Services

1.9.3 Guidance[6] 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.

1.9.4 Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the reports. The recommendations are supported by the Overview Author and the Panel.

1.9.5 The IMR reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

## 1.10 The area

Rhondda Cynon Taf has a population of about 237,400 people (2015 census) and an almost equal split between men and women. 62% of those people are aged between 16 and 64 years. 72% of the resident population live in the most deprived half of Wales as shown by the Welsh Index of Multiple Deprivation. At present employment rate is growing and long term unemployment is reducing. However unemployment rates in the area remain higher than other areas of Wales. Unemployment and low income are drivers of child poverty.

1.10.1 5.4% of people were unemployed in RCT in the years September 2016 compared with 7.0% the previous year. However the figure is still higher than the national average of 4.7% for all Wales. Over 2,700 private sector dwellings in RCT have been vacant for over 6 months.

## 2. Terms of Reference for the Review

2.1 The aim of the DHR[7] 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;

[6] Home Office Guidance 2016 Page 20
[7] Home Office Guidance 2016 page 6

- 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**

2.2 Home Office Guidance[8] 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'*

2.3 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.

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

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

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

**Family Involvement**

2.7 Home Office Guidance[9] 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."*

2.8 The 2016 Guidance[10] illustrates the benefits of involving family members, friend and other support networks as:

[8] Home Office Guidance 2016 page 36
[9] Home Office Guidance 2016 page 18
[10] Home Office Guidance 2016 Pages 17 - 18

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 perpetrators in order to see the homicide through the eyes of V and/or perpetrators. This approach can help the panel understand the decisions and choices V and/or perpetrators 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.

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.

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

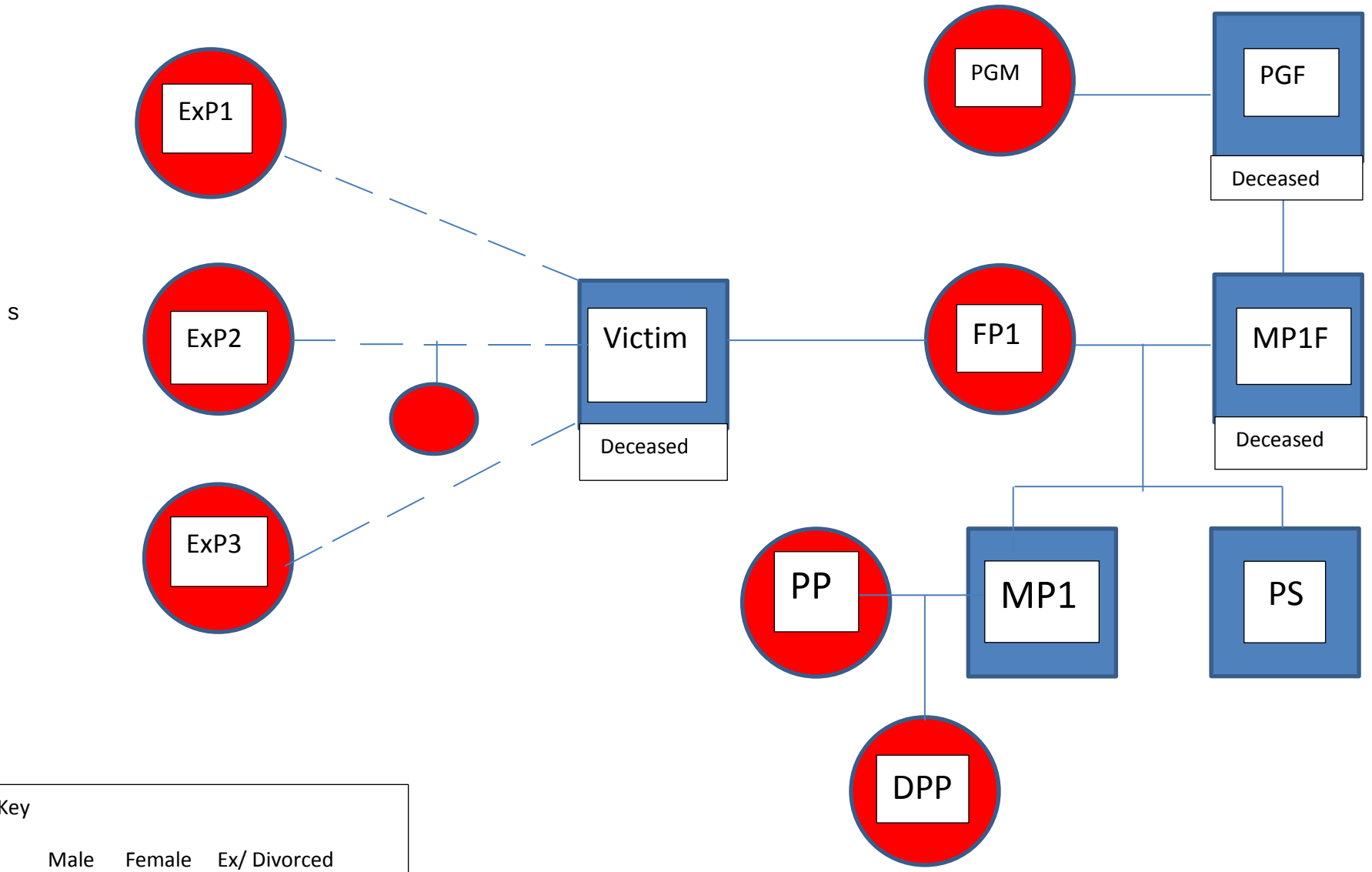
2.10 Letters have been sent to family members setting out the process of this review and inviting them to contribute to it, but there has been no reply from any family member. Similar letters have been sent to previous partners of V. Only one replied to say that she did not want to participate. There 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'.

## Subjects of the Review

2.11 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 |

**Genogram**

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ed in order to protect the identity of the individuals concerned and where necessary some information has been edited to ensure the report is in a form suitable for publication.

## 3. Summary of events

3.1 Through this review, which is complex in nature, reference is made to two separate families and two separate households.

3.2 The first consisting of V and his relationship with two partners, ExP1 and ExP2. ExP2 has a child with V. Events within this family structure are explained.

3.3 The second family consists of MP1, his Mother FP1 and natural Father MP1F and also MP1's partner PP. PP has a child with MP1.

3.4 V finished his relationships with ExP1 and ExP2 and the two families become one as a result of FP1 marrying V meaning that V became the step-Father of MP1.

3.5 In order to illustrate what life was like within the two families and explain the events in a chronological order, the author will make it clear which family is being described at any one time.

3.6 Whilst the time period for the review commences from 1st July 2007, there are significant events prior to the 1st July 2007, especially regarding the history of the families that are worthy of note.

**A summary of events for both families prior to the Perpetrator's and Victim's families merging in 2009**

3.7 MP1 first came to notice of the Disabled Children's Team in 1993. It is recorded that both of his parents, FP1 and MP1F had learning difficulties.

3.8 In March 2001, MP1 was referred to Disabled Children's Team for cruelty to animals, bullying his brother and displaying sexualised behaviour. The first Child Protection referral was made regarding MP1 in 2002 and an assessment indicated a suggestion of underlying emotional stress.

3.9 In 2003, MP1's behaviour in school deteriorated. His cruelty to pets continued. He had threatened his parents and another boy with a knife. He was being defiant to school staff and an urgent referral was made to CAMHS and also to the Miskin Project, an intensive support project for children at risk. By October 2003, CAMHS had decided that MP1 did not meet their eligibility criteria.

3.10 In July 2007 MP1 and his brother PS were arrested and charged with criminal damage to a local school. In February 2008, MP1 appeared before the Magistrates Court and was sentenced to a 12 months Referral Order and given 30 hours of reparation and additionally he had to work with YOS on his offending behaviour.

3.11 In relation to V, in July 2007, Police were called to the family home of ExP1 responding to a domestic incident. She alleged that her ex-partner, V had assaulted her. Both were intoxicated and neither made any complaint to the Police. A PPD 1 form was submitted and no further Police action taken.

3.12 There were a further four similar incidents involving both V and ExP1 throughout 2007 and into 2008. Each time Police responded and no formal complaint was made by either party. Each time one or both of them was under the influence of alcohol.

## 2009

3.13 In January 2009, V called the Police to report that he had been assaulted by ExP1 and her then current boy-friend. It appears that V had gone to the flat of ExP1's boy-friend and had fallen asleep on a couch. He had been woken by the flat owner punching him causing bleeding to his face. He did not leave the flat but fell back to sleep. He left the flat in the morning and reported the matter to the Police.

3.14 There were several witnesses to the incident but none of them would give a written statement. The owner of the flat was arrested but denied the offence. Those present said that V was drunk and unsteady when he left the flat and he could have met others that caused the injury. The Crown Prosecution Service was consulted and decided that there was insufficient evidence to justify any charges and no further action was taken.

3.15 In January 2009, a Social Worker made a home visit to MP1's parents and found them to be anxious and unable to manage their finances. The Social Worker suggested that FP1 should seek help from her GP regarding her anxiety, which demonstrated a supportive stance by the Social Worker. It is not recorded if the GP was visited. A referral was made to Supporting People.

3.16 Another home visit was made by Social Services to the grandparents. It was reported to the Social Worker that MP1 and his Father, MP1F had been involved in an altercation and MP1 had been thrown out of the house by MP1F. MP1 had bruising to his face. During this discussion it was noted that MP1 and his younger brother PS had found pornographic paraphernalia in their parent's bedroom. It was also alleged that PS watched pornographic films. The grandfather stated that he was concerned that the parents spent a lot of time out of the house and the boys were often left on their own. MP1 apparently wanted to return home to live. This matter was discussed with the Team Manager and did not proceed to a section 47 investigation.

3.17 In January 2009, V attended the GP surgery with head and chest injuries with a history of an assault.

3.18 A home visit took place in February 2009 to deal with the allegation that MP1F had hit MP1. He denied hitting his son and causing his nose to bleed. The Social Worker gave the parents advice about acting more responsibly towards the boys and pointed out the consequences of the allegations of assault. They were also advised about locking away any pornographic material they may have. Both parents agreed to work on managing their behaviour and reducing tensions within the home, and both agreed that MP1 could return home. By February 2009, MP1 told the Social Worker things appeared calmer at home. It appeared that the incident was dealt with just by negotiation with parents and the boys to consider behaving differently towards each other. There is no suggestion that the Police were involved or informed, although other agencies were updated on events.

3.19 The ambulance service responded to a call from FP1 in February 2009, asking for assistance as she was short of breath and having a panic attack. There had been an argument with the family. She calmed down and there was no need to take her to hospital. There is no more information as to what the argument entailed. WAST did not have a Domestic Abuse policy at that time so no referral was made.

3.20 In March 2009, the PGM rang Children's Services stating that there had been another fight between MP1F and MP1, again over MP1 watching pornography on his (MP1F's) computer. MP1 had run from the family home to his grandparent's house. A Social Worker attended and found MP1 at his grandparent's house. There were no signs of injury despite his being allegedly punched by MP1F. MP1F admitted losing his temper with his son. It was agreed that MP1 would stay at his grandparent's house. No referral made to the Police or any consideration of a strategy meeting with regard to the risk MP1 was in from his Father.

3.21 The Social Worker's records that MP1F and FP1 were saying they could not look after MP1 and they were concerned that MP1 would hurt MP1F. MP1 has been discharged from all behavioural services that were available and whilst MP1 had been accommodated with his grandparents, he was still free to go between his parent's and grandparents' houses.

3.22 In March 2009, the YOS Education Training and Employment (ETE) Officer went to visit MP1 but he was not at home. The ETE Officer was made aware of the fight the previous day and stated that she would inform the Children's Services Social Worker. There is no record of this being done, although the social worker was clearly aware of the incident. It is also worthy of note that at this time YOS was working with MP1 on a voluntary basis, but it may have been appropriate for an assessment to have been completed particularly in relation to the risk of harm being updated.

3.23 In March 2009, Social Workers spoke to FP1 and MP1F and advised them about the safe storage of any pornography. A Child Protection referral was raised by the Disabled Children's Team Manager, but the Intake Team Manager decided that the circumstances did not warrant child protection. This was not escalated by the Disabled Children's Team Manager.

3.24 In May 2009, Children's Services were advised that the Adult Disability Service Panel met to discuss MP1's suitability for Adult Team input when he reached 18 years of age. The decision was made that he did not fit the criteria for Adult Learning Disability Services where the IQ of 70+ was accepted, albeit, MP1's IQ at that time was 66.[11] The criteria for adult LD services are based on the WHO (World Health Organisation) definition of LD, which includes IQ and functional ability.

3.25 In May 2009, a Children's Social Services home visit found that home life for MP1 had improved considerably, but there is nothing to indicate that this triggered a discussion about his eligibility for transitional support from the Adult Learning Disability Team. He continued to receive ongoing support from the Children's Disabled Team.

3.26 In June 2009, MP1 threatened MP1F with a knife. A Housing Support Worker from a Housing Association reported the matter to Children's Social Services and suggested that MP1 required some sort of supported accommodation. MPF1 had been advised to take MP1 to see his GP. There is no record of a visit to the GP or that the suggestion of supported accommodation was considered. MP1 moved back in with his grandparents. The Police were informed and a PPD1 was submitted to Social Services. The Police recorded that, according to FP1, the threat was not taken seriously and it was believed to be a matter of 'teenager attitude'.

[11] This issue has now changed with the new Care Act

3.27 Children's Services shared the information and MP1's social worker followed up the matter. However, following that incident, there is no record of MP1 visiting his GP, or that the accommodation recommendation was taken any further. The Children's Service IMR Author is of the opinion that this was a significant incident and there is nothing to suggest that a Team Manager had been made aware of the circumstances. MP1 should have been supported to find accommodation.

3.28 On the same day during a supervision session between the DCT Social Worker and their Team Manager it was highlighted that neither MP1 nor his brother, PS, was eligible for CST support as an adult. It was nevertheless agreed that due to the circumstances the case would remain open to DCT with any necessary input being arranged as and when required. This was a positive service user led response.

3.29 The following day, in June 2009, a Children's Service home visit was made where MP1 suggested that his Father had put pubic hair into his breakfast. The MP1F said that MP1 had punched a hole in a door as a result of this allegation. The MP1F stated that he was finding it difficult to deal with MP1 and he thought there was something wrong with his son. The Intake Team Manager decided that there was insufficient evidence to warrant child protection procedures.

3.30 In July 2009, a discussion took place between Team Managers from Rhondda Intake and DCT. There was a suggestion that someone from the In Take Team had worked with another child regarding an alleged sexual offence and the child had stated that they had been watching explicit DVDs at MP1F's house. The Police Child Protection Unit (CPU) was contacted the next day. It appears that the CPU had already been involved with the family and did not intend re-visiting the family concerning the incident that they had previously dealt with. There is no information held on Police records with regard to what if any further action was required by the Police to assist in this matter. There was no multi-agency holistic view of the whole family situation.

3.31 In August 2009, the paternal grandmother (PGM) contacted Children's Services to say that FP1 and MP1F had been involved in an altercation where FP1 had threatened MP1F with a knife and had smashed a vase over his head. All this had happened in front of the children. The Intake Manager was notified. Police officers also attended at the home. There was no mention of the knife to the Police and the matter was recorded as a verbal argument. There was no complaint made by either party. A PPD1 form was submitted for the attention of other agencies. This is an incident where FP1 is the perpetrator of violence.

3.32 Children's Services action was to ensure MP1 was located at and kept safe at the grandparent's house. Both FP1 and MP1F signed a written statement confirming their commitment towards avoiding future incidents of domestic violence and it was deemed by the Intake Team Manager that MP1 was old enough and resilient enough to be able to keep himself safe. The Children's Services IMR author considers that Child Protection procedures should have been instigated and that the resilience levels of the brothers was assumed by the Team Manager rather than properly assessed.

3.33 In August 2009, in the early hours of the morning, V was admitted to A&E with a history of being assaulted on his way home from a funeral. He sustained a laceration to his nose which required stitches and a right wrist fracture. He attended several follow-up appointments at both the hospital and with his GP. On one occasion the GP noted a

strong smell of alcohol which V reported was due to him drinking 'two cans' to decrease the pain.

3.34 In August FP1 attended her GP. She reported that she had separated from her husband three weeks previously.

3.35 in September 2009, the DCT Social Worker reviewed the chronology of this family over a number of years and considered that there were no grounds for child protection procedures at this stage. However there is nothing to indicate that this decision was escalated to a senior manager for review and approval. It is recorded that MP1F had left the family home by this stage and he did not return, so it would have been difficult to raise Child Protection concerns, but the IMR author points out that a chronology of events highlighted some missed opportunities to take positive action.

3.36 In September 2009, an incident occurred at the home of PGM where an ambulance responded to a man who had been hit on the head with a hammer and punched in the face while he was lying on the sofa. The identity of the assailant was not disclosed. The IMR author felt that this incident was relevant to the review as this was the household where it had been deemed to be a safe environment for MP1, but it indicates that there was domestic violence within the household of the people concerned in this review.

3.37 There is evidence that during this month, V, who had finished his relationships with ExP1 and ExP2, had now formed a relationship with FP1.

3.38 Throughout 2009 FP1 had twelve contacts with GP services for matters unrelated to the DHR. No disclosure of domestic abuse or other social concerns were made.

3.39 From this point in the report there is no need to distinguish between the two separate families as V's family and MP1's family had come together.

## 2010

3.40 In January 2010, MP1's grandmother PGM contacted Children's Services concerned about the two boys. MP1 came onto the phone stating that FP1 was intoxicated all of the time and in bed with her boyfriend V. MP1 had stayed the last two nights at their grandparent's house but did not like to do so as PGM was strict and he did not get on with his uncle and aunt who visited the grandparent's home. He said on New Year's Eve FP1 was intoxicated and had said she wished that he would die. She had then torn up all of the photographs of MP1 as a baby.

3.41 The Intake Manager was of the opinion that there was nothing that could be done on the basis that he could stay with his grandparents or FP1 even if child protection plans were in place. Perhaps that was true regarding MP1. This has to be considered a missed opportunity to escalate to Child Protection.

3.42 In March 2010, MP1's case with DCT was closed as he was 18 years of age and not eligible for support from adult services.

3.43 In June 2010 V was admitted to hospital following an alcohol withdrawal seizure. He had recently stopped drinking after a history of harmful alcohol use for 6-7 years. V reported a pattern of not drinking for days or weeks and then binge drinking of up to 12 cans a night for several consecutive nights. A brain scan at that time was reported

as normal. He was seen by the Community Drug and Alcohol Team and a home follow-up visit was arranged.

3.44 In July 2010, Children's Services received information from MP1F that the Mother FP1 had moved out of the family home and left MP1 at the house. MP1F had visited the house to find the fridge and freezer unplugged and there was no food. MP1 went to his Father's house. It appears that the Mother had not actually moved out of the house but she had expressed her intention to do so in the near future. The social worker was to help MP1 in seeking permission to have the tenancy of his Mother's house.

3.45 In August 2010, the Police were called to a domestic incident where V had moved close to where ExP1 and their children lived. The Police advised him to seek legal advice. A PPD1 was submitted.

3.46 In August 2010, Police and ambulance services were called to MP1F's address. They found him deceased.

3.47 Following the news of MP1F's death, a social worker visited MP1 on a home visit. MP1 stated that he had gone to his Father's house intending to stay overnight. He could not gain entry but was able to see that the fridge door was open and all of the lights were on at 10.20pm. He was sure that he heard the sound of his Father laughing coming from the club next door to his Father's house. He did not go into the club. He waited for a long time and eventually left. It was clear that he felt guilt in not staying and waiting longer for his Father. He related a story about a man leaving the club, in circumstances that MP1 thought were suspicious. These facts were relayed to the CID.

3.48 In September 2010, FP1 was treated for a fracture of her right foot. She sustained the injury as the result of a fall whilst under the influence of alcohol.

3.49 In September 2010 during a GP review it was noted that FP1 had anxiety and depression for many years, currently well controlled on medication which needs to continue long term.

3.50 Throughout 2010, FP1 had eight further contacts with GP services for matters unrelated to the DHR. No disclosure or social concerns were made.

**2011**

3.50 In February 2011, V was admitted to hospital with seizures secondary to alcohol withdrawal.

3.51 In June 2011, V was admitted to hospital with seizures secondary to alcohol withdrawal. He sustained a dislocated shoulder.

3.52 In August 2011, V was again admitted to hospital with alcohol withdrawal symptoms.

3.53 In September 2011, FP1, V's partner, was arrested for causing criminal damage to the house of V's former partner. She was cautioned by the Police.

3.54 In September 2011, V was discharged from the Community Drug & Alcohol Team as he did not engage with the service.

3.55 In October 2011, V was seen at A&E with seizure secondary to alcohol withdrawal. He was seen by the Alcohol Liaison Team.

3.56 In October 2011, Police were called by neighbours of FP1 due to anti-social behaviour. They found FP1 to be intoxicated. An Anti-Social Behaviour Notice was submitted.

3.57 In December 2011, MP1's social worker recorded that MP1 had told her that his Mother had written to him, stating that she would not be able to buy him a Christmas present as she was buying for her 'boyfriend', V.

3.58 Throughout 2011, FP1 had 27 contacts with GP services for matters unrelated to the DHR. No disclosure or social concerns were made.

**2012**

3.59 In January 2012 V was admitted to hospital by ambulance with a dislocated shoulder. Over the next five months he was seen a number of times by the GP for analgesia and within outpatients for recurrent shoulder dislocation.

3.60 By January 2012, MP1 was living with PP. She had moved in with him. In January 2012, PP's Mother rang Children's Services concerned about the relationship between MP1 and PP. She said that PP had been diagnosed with ADHD and in the last month she had withdrawn and spent all of her savings. PP was not known to DCT and she was over 18 years of age, however she was still referred to the Detached Youth Team for support.

3.61 In February 2012, neighbours complained about anti-social behaviour. MP1 expressed his anger towards the neighbour but was advised to calm down and to speak to his GP in relation to this and his feelings following his Father's death.

3.62 In May 2012, June 2012, July 2012, & September 2012 V was admitted to A&E for seizures. In September 2012 the hospital reviewed the pattern of recent admissions. No social concerns were identified.

3.63 In October 2012, Police were called to a domestic incident involving V and FP1. She had been locked out of the house with all her belongings. Police managed to calm the situation and get her back into the house. She stated that she did not fear him and no longer wanted any Police action.

3.64 In October 2012 V was admitted to A&E with alcohol withdrawal seizure. He was noted to have 'carpet burn to left side of head'.

3.65 PP's pregnancy was confirmed 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.

3.66 In October 2012 V was admitted to A&E with alcohol withdrawal seizure. He was seen by the Community Drug & Alcohol Team liaison and agreed to have community follow-up.

3.67 There were two incidents in November 2012 concerning V and his wife FP1, both of which concerned domestic upheaval and an assault on V by FP1. He had no visible signs of being assaulted and no injury. The first incident was a verbal argument and was dealt with by the Police submitting a PPD1 form which would be considered to be good practice because of the history of violence.

3.68 The second incident resulted in FP1 being arrested and cautioned by the Police for common assault on V. FP1 was assessed as Standard Risk following the verbal

argument; however the subsequent incident of physical violence against V was also mentioned on the PPD1 which was not good practice.

3.69 Since this time procedures have changed and a far more robust process is in place whereby the form which is now referred to as a PPN must be submitted prior to the end of the officer's tour of duty and it is subject to scrutiny by supervisors. The officer attending, risk assessed the incident that involved a verbal dispute as "standard risk", however when the PPN was not subject of a further holistic risk assessment.

3.70 Throughout 2012 FP1 had eleven contacts with GP services for matters unrelated to the DHR. No disclosures of domestic abuse or social concerns were made.

**2013**

3.71 In January 2013 PP attended her first antenatal appointment. There is no evidence in the records that the Routine Enquiry into Domestic Abuse was completed.

3.72 In March 2013, FP1 complained to the Police that she had been punched in the face and kicked whilst on the floor by V. Both were seen to be intoxicated on arrival of the Police. V was arrested, charged and bailed. 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.

3.73 In March 2013, V contacted the Police asking for a record to be made of the fact that FP1 had approached him in the street and hit him with a carrier bag with items inside. He stated that his bail condition was that he had no contact with her but she had approached him. However, in March 2013, Police attended at FP1's house and found V there in breach of his bail. Both were intoxicated. He was arrested but she intimated that she intended to make a statement withdrawing the allegation of assault. V was later released on bail by the court. There was concern that FP1 was being pressurised by V to withdraw her complaint.

3.74 It appears that V was being treated as the aggressor. There was a 'Violent Marker' on Police systems in relation to his name, but not in relation to FP1.

3.75 In March 2013, the IDVA service spoke to FP1 and advised her to keep herself safe. She said that she would like support from the IDVA service. The risk to her was measured as a medium risk.

3.76 In April 2013, Police made enquiries at the bail address of V and they found that he was not living there. He was located and arrested again. He was later again, released on bail by a court. As a result of FP1 withdrawing her complaint the PPD1 form was re-considered by the Public Protection Department and the risk amended to 'high'. This should be seen as good practice. Details were shared with Pontypridd Safety Unit. Warning markers were placed on FP1's address. A MARAC referral had been made and the Police command and control was endorsed with a 'Police watch' and a number of safety measures were put into place for FP1's address. She was deemed to be in danger of domestic abuse from her husband, V.

3.77 FP1 was offered alternative accommodation by RCT Housing but she declined the offer stating that she wished to remain in the current area.

3.78 On 8th April 2013 the Police contacted the GP for information. FP1 had reported to the Police that she had been assaulted in March 2013 and had attended the surgery for

analgesia for bruising sustained. She had not attended hospital. The surgery had no record of attendance.

3.79 In April 2013 PP attended an antenatal appointment with the Consultant Obstetrician. He discussed how PP was coping and documented that she lived with her partner, and had no concerns regarding coping with the pregnancy or the baby. PP was positive in her outlook.

3.80 In May 2013, V failed to report to the Police as per his bail conditions. He was arrested and remanded in custody

3.81 The following day FP1 was visited by the IDVA service. She gave an account of recent events with V, how he would become violent, throw her out of the house and take control of all of the finances and benefits and preventing her having access to his bank account. She had told no one in the family about him assaulting her, but nonetheless she still intended to go to court and give evidence withdrawing the complaint against him.

3.82 In June 2013, FP1 was seen by an IDVA worker. She showed the IDVA worker a letter that she had been sent from V whilst he was in prison, asking her to change her statement regarding the assault charges. FP1 explained to the IDVA worker how V had chased her with a shovel and had hit her in the face causing an injury, albeit she said this was an accident. FP1 appreciated the consequence of changing her statement and being untruthful and she agreed to speak to the Police.

3.83 The IDVA worker contacted the Police and in her presence the officer spoke to FP1. She described V's behaviour, the damage he caused to her property and the threats he has made to her in the past. Arrangements were made for her to attend the Crown Court to give evidence. This was a good example of the IDVA worker acknowledging the need to share information regarding the serious risk that FP1 was facing from V, albeit he was in prison at the time. Furthermore this was good multi agency working between Police and IDVA Service.

3.84 In June 2013, V appeared before Merthyr Tydfil Crown Court and was sentenced to a 24 month Community Order with a requirement that he completed the Integrated Domestic Abuse Programme (IDAP). There was no restraining order issued. The Wales Probation Trust organised his IDAP starting in July 2013.

3.85 In July 2013 V was admitted to A&E with alcohol withdrawal seizure. Bruising was noted on right chest wall from a fall.

3.86 In July 2013, the IDVA service saw FP1 again. She described how things had improved since V had come out of prison. He had stopped drinking and appeared more tolerant to her wishes. She was feeling more confident in herself and had started to work at a charity shop.

3.87 However,in July 2013, V failed to attend his Probation appointment. There was no evidence of any enforcement or any warning letter being sent to him regarding the breach.

3.88 In July 2013, the IDVA worker again saw FP1. She stated that V had not consumed alcohol but he did think he needed help with his abstention and had arranged an appointment with TEDS. She was sure that if V showed any signs of aggression towards her she would go to the Police.

3.89 In July 2013, V again failed to attend his Probation appointment. There was no enforcement and his failure meant that he no longer qualified to attend the IDAP. On the same day the IDVA service recorded that as there seemed to be reconciliation between V and FP1, the IDAP case should be closed after the next meeting. It was decided that if he attended the next 3 meetings he could be considered for another IDAP in Merthyr Tydfil, which he did at the end of August 2013.

3.90 In August 2013 V was admitted to A&E with alcohol withdrawal seizure. He sustained a head injury which required suturing.

3.91 On the same day, MP1's girlfriend, PP delivered a healthy baby. There were no concerns and MP1 was present at the time of the birth.

3.92 In September 2013 V was admitted to A&E with alcohol withdrawal seizure. A laceration was noted but no bruising. V stated that his wife had had as much to drink as him.

3.93 In September 2013 V was admitted to A&E with alcohol withdrawal seizure. An abrasion was noted to his right knee sustained from a seizure whilst out walking.

3.94 In September 2013, V failed to attend at his appointment with Probation and failed to attend for an assessment for the IDAP. He was sent a letter excluding him from the IDAP on 9th September and a final warning letter regarding his failure to attend his appointment was sent to him. However, later in September he did attend his appointment explaining the he had been ill on the missed dates. He also attended a further IDAP in September. He however again failed to attend an appointment and a breach letter was sent to him. This could have been treated as an escalation of concern and measures could have been considered.

3.95 In September 2013, FP1 called an ambulance for V who, she believed, had had a fit after drinking alcohol for the previous 5 days. The 999 call was assessed by a Registered Nurse and FP1 was told that V needed to go and see his GP.

3.96 V attended at the IDAP on 27th September 2013, but left half the way through the session. He went to the Probation appointment in September 2013, and stated the reason for missing the previous appointment was that his Mother-in-law had been taken ill.

3.97 In October 2013, the IDVA Service closed FP1's case.

3.98 In October 2013 V was admitted to A&E with alcohol withdrawal seizure noted to have occurred in the presence of his wife.

3.99 V attended the next two Probation appointments, but in October 2013, FP1 reported to the Police that she had been assaulted by V. He had dragged her round the living room with his hands around her throat and kicked her legs. A neighbour witnessed V punching FP1 in her ribs. Police arrested V and charged him with assaulting FP1. He was released on conditional bail to appear before the Magistrates Court in November. His conditions were that he kept away from FP1 and reside at an alternative address provided to the Police. A PPD1 was submitted and a warning marker attached to FP1's address on Police systems. FP1 also agreed to a Police 'walk by' as a precautionary action by the Police. As a result of this incident the IDVA Service re-opened the case on FP1.

3.100 However the following day at the train station, V reported that FP1 had been abusive towards him. Officers attended and FP1 said that the previous day V had sent her an abusive text, which constituted a breach of his bail conditions. He was arrested and appeared before the Magistrates, but despite the Police objecting to bail, V was again bailed with the same conditions.

3.101 In October 2013, V attended at his Probation appointment but did not mention being arrested for breaching his bail conditions the previous day. The case was adjourned by the Magistrates until December 2013.

3.102 In October 2013, a neighbour reported to the Police that a number of people, including FP1, had gone to V's house and he was reporting that his wallet had been stolen. In fact the wallet was recovered in the house and the people were asked to leave. As she left, it was alleged that FP1 smashed a window in the neighbour's house in retribution for making the allegation about the wallet. She was arrested and charged with criminal damage for which she was later conditionally discharged for 12 months.

3.103 In October 2013, V presented at the housing offices stating that he was on bail with conditions to keep away from FP1 and the relationship had broken down. He was given housing options but not declared homeless because he could stay with his Mother. His housing case was closed in October 2013.

3.104 On the same day, FP1 met with an IDVA worker and described the incident in October. She subsequently indicated that she did not wish for support from the Women's Aid Worker as she was content with the support she was getting from the IDVA Service.

3.105 In November 2013, V again failed to attend his Probation appointment. No enforcement action was taken.

3.106 In November 2013, a MARAC discussed V and FP1. It is recorded that FP1 was at high risk of domestic abuse.

3.107 In November 2013 V was admitted to A&E with alcohol withdrawal seizure. Bilateral orbital bruising was noted but it seemed to be an old injury. No clear history given by V as to how he had come by his injuries. He was seen by Community Drug & Alcohol Team liaison who noted V was well known to the team.

3.108 In November 2013, the IDVA worker met with FP1. She stated that V had made contact with her. He had apologised and promised not to abuse her again. If he did she would go to the Police. She indicated that she would like a restraining order put in place.

3.109 In November 2013, Police received information that V was at FP1's address in breach of his bail conditions. Officers attended and found him there and he was arrested. He was extremely intoxicated. He was charged with the bail offences and appeared before Magistrates the following day, 26th November 2013. Despite an application by the Police for him to be remanded in custody, he was granted conditional bail.

3.110 In November 2013 V was admitted to A&E with alcohol withdrawal seizure.

3.110 In November 2013, at 15:16 hours officers were despatched to a report of two people fighting in the street. Initially the officers were unable to locate those involved but it soon appeared that the call was regarding a medical episode where V had suffered some sort of medical emergency and an ambulance had been called. It also appeared that FP1 had been tending to him. Officers continued with enquiries and found V within the home of FP1. He was arrested for breaching his bail conditions and appeared

before the Magistrates in November 2013. He pleaded guilty to the bail offences and also to common assault on FP1. He was imprisoned for 12 weeks and a restraining order was made.

3.111 In December 2013, the IDVA Service agreed with FP1 that her case ought to be closed as she was now getting floating support from Women's Aid.

3.113 Throughout 2013, FP1 had ten contacts with GP services for matters unrelated to the DHR. No disclosures of domestic abuse or social concerns were made.

**2014**

3.114 In January 2014, V who was by this time out of prison, collapsed after binge drinking. An ambulance was summoned and he was taken to hospital.

3.115 Throughout the remainder of January and February 2014, V failed to keep his appointments with the Wales Probation Trust[12]. It was not until April 2014 that he started to attend although there were still occasions when he failed to go. Consideration should have been given to impose an enforcement notice at this stage.

3.116 In February 2014, V was admitted to A&E with alcohol withdrawal seizure. He was seen by the alcohol liaison service, who noted that he was well known to them but did not attend his appointments. He stated he wanted support so a home visit was arranged.

3.117 In May 2014 V was admitted to A&E with alcohol withdrawal seizure. He was seen by the Alcohol Liaison Service.

3.118 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.

3.119 In June 2014, V blamed FP1 for the abusive times in their relationship as it was her that got intoxicated not him. He was reluctant to accept any responsibility for his previous actions. He was not on the horizon of any alcohol support agency at this stage.

3.120 In June 2014, there were two calls to WAST regarding a man having a seizure. On the first occasion the man could not be located but all enquiries suggested that it was V. On the second occasion the caller was identified as V who declined assistance.

3.121 In June 2014, V attended at another IDAP session with cuts to his face. He explained that he had fallen in the garden suffering from sunstroke. He sought medical treatment regarding the fall, but there is no evidence that he had fallen. The session concerned 'accepting women's anger' but he did not contribute to any discussion. This was the case in the next two IDAP meetings.

3.122 In July 2014, he failed to attend an IDAP session which was to cover 'honesty and accountability'. The Offender Manager sent him an enforcement letter. He explained his absence at a subsequent meeting was due to illness but he had no money to call and inform the group. It is clear from the records from following IDAP meetings that V

[12] On 1st June 2014, the Wales Probation Trust was divided into two distinct companies, the Wales Probation Trust Service and the Community Rehabilitation Company (CRC). From 3rd June 2014 the Perpetrator was dealt with by the CRC. On 1st April 2017 the Probation Service became HM Prison and Probation Service

could not understand issues about disrespecting women and aggressive behaviour. Other people in the group challenged him. He failed to understand that the T shirt he had worn to one session with 'I Love Slags' printed on it could be seen as offensive towards women.

3.123 In September 2014, an ambulance responded to a call stating that V had fallen from the toilet whilst intoxicated and sustained a head injury which required suturing. He was treated and discharged.

3.124 In September 2014, V again failed to attend his IDAP session. He claimed he had a sore throat and he was told that he would be removed from the programme if he did not attend that day. He responded by saying that he did not care. He did not attend that day and was considered excluded from the programme.

3.125 In September 2014, he attended an IDAP session with a written note, purporting to be from his GP's nurse but clearly written by himself, explaining that he was too unwell to attend the last meeting. He was issued with a summons to attend court which he failed to do.

3.126 In October 2014, V appeared before Magistrates Court and he received 12 months custody.

3.127 In December 2014, Police received a call stating that MP1 and PP were arguing and he had threatened her with violence if she did not leave the house. Officers attended and spoke PP who did not mention the threats of violence. PP agreed to leave the house and take their 16 month old child to her Father's house. Police submitted a PPD1 form.

3.128 In December 2014, PP's Mother contacted Children's Services complaining that PP had been threatened with violence and was a victim of domestic abuse by MP1. She stated that PP and grandchild DPP would be staying with her for safety reasons. No action was taken by Children's Services, on the basis that the grandparents were providing an appropriate level of safeguarding support to PP and DPP. Whilst their input was clearly an identifiable strength and protective measure, the IMR author considers that the Mother of PP and PP should have been spoken to directly about the concerns raised, resulting in the possible completion of an Initial Assessment.

3.129 Throughout 2014, FP1 had seven contacts with GP services for matters unrelated to the DHR. No disclosures of domestic abuse or social concerns were made.

**2015**

3.130 In January 2015, a referral was received by Cynon IAT to the effect that the relationship between PP and MP1 had broken down and that there was a history of domestic abuse towards her from MP1. It was stated that MP1 also ignores DPP which was contrary to what PP had said. She had always suggested that MP1 had been helpful and caring towards the child. PP had also found material written by MP1 saying that he thought PP was a 'bitch' and the child was fat. There was also sexually explicit material found that had been written by MP1. The grandparents were supporting PP and DPP, and facilitating MP1's contact. There is nothing to suggest that an Initial Assessment or a section 47 investigation was considered in response to this, which, as already noted, should have happened and was likely influenced by the ongoing and proactive supportive involvement of the grandparents.

3.131 In January 2015, PP's Father contacted the Police saying that MP1 had made threats of physical violence towards him during an argument they had over access to the child. The Father wanted MP1 warned about his behaviour. Police saw MP1 and issued him with a Police Information Notice. No action was taken by Children's Services.

3.132 In May 2015, PP's parents advised Children's Services that PP and MP1 had resumed their relationship and they were living together. There is nothing to indicate an assessment was completed given the knowledge of domestic abuse and threats made to family members.

3.133 In June 2015, FP1 attended the GP surgery for medical review. She stated she was not able to work as she was now looking after her granddaughter. She was noted to be well dressed, chatty and no signs of depression.

3.134 In July 2015 V was admitted via Ambulance to A&E with alcohol withdrawal seizure. No injuries were noted. He was referred to Community Drug & Alcohol Team for relapse prevention.

3.135 In August 2015 V was admitted via Ambulance to A&E with alcohol withdrawal seizure. No injuries were noted.

3.136 In September 2015, FP1 attended GP surgery for review. No features of depression noted. Encouraged to get back into voluntary work to gain confidence and improve her mental health long term. FP1 agreed to look into this and she declined mindfulness.

3.137 At 07.09 hours on 3rd October 2015, an ambulance was called to the home address of V where it was reported that a 45 year old man was in a possible cardiac arrest and who had been assaulted the previous evening. Police officers also attended. Family members were in attendance some of whom suggested that V had been beaten in the town the previous night. V was found on the floor in the house and when paramedics arrived they found V to be deceased and badly injured. In the house at the time were, MP1, PP, their child DPP and FP1. At that time the officers were not sure of the facts and as a consequence all three adults present were treated as significant witnesses and conveyed to separate Police Stations where they provided their accounts to the Police. The scene was secured for further investigation. The child DPP was placed in the care of the grandparents.

3.138 In their witness statements, FP1 stated that she had returned home from work and found V injured in the back garden of the house. V was taken into the house where she witnessed MP1 punch V and hit him with a glass vase which broke on impact causing severe cuts to V. FP1 then stated that she dragged V off the sofa onto the floor and started to kick him and stamp on his head making comments indicating that she was acting in retribution for the years of abuse from V. FP1 admitted that all three people attempted to clean the house of evidence.

3.139 All three adults were subsequently arrested on suspicion of the murder of V. A post mortem showed that V had been subject to a significant assault. He had a damaged liver and a broken jaw. On examination of the house, forensic officers found signs that parts of the house had been cleaned. It was suspected that those arrested may have changed their clothes before the arrival of the Police and they were required to hand over their current clothing to the Police before leaving he house.

3.140 All parties were interviewed by the Police over a number of days and it transpires that V was assaulted at home the evening before during which he was badly cut. He was

taken into the garden and left there for some time and then returned to the sofa in the living room overnight. Although it was obvious that he was badly injured and bleeding he was left until the morning where at 07:00 hours they realised he had died.

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

3.142 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.

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

3.144 FP1 was convicted of murder and received 17 years imprisonment.

3.145 The child was placed with the maternal grandparents and subsequently made subject to a Special Guardianship Order.

## 4. Contact with the family and their contributions

4.1 In accordance with the Home Office Guidance[13], letters were written to family members, the three perpetrators, MP1, FP1 and PP and their solicitors. Only PP and her family replied and have been engaged with the review process. Letters have also been sent to V's previous partners, of which one replied stating that she did not wish to become involved with the review process.

4.2 In addition, the letters to the perpetrators requested permission for their medical records to be disclosed for the purposes of the review. There has been no reply and therefore no consent given for the review to have access to any medical records.

4.3 Cwm Taf Community Safety Partnership sought legal advice regarding the interpretation of the Home Office Statutory Guidance for the Conduct of Domestic Homicide Reviews of December 2016, especially with regard to paragraphs 98 – 100, the disclosure of medical information when the person does not give consent, in this case being the perpetrator.

4.4 In light of the legal advice received, the health information relating to the three convicted perpetrators MP1, FP1 and PP was reviewed and information relevant to the DHR has been included in the report.

4.5 MP1 had no contact with secondary health care during the timescale of the review. PP's relevant contacts with maternity services have been included. FP1 had a significant number of contacts with secondary health care services for health concerns that are not relevant to the DHR and have therefore not been included. However at these contacts there is no record that FP1 ever made any disclosures of Domestic Abuse.

4.6 Letters were also sent to PP's parents who agreed to see the Author and Mr Jones at their home in March 2017. Whilst the discussions were taking place PP arrived at the family home and agreed to contribute to the conversation with her observations.

[13] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Home Office December 2016 Section 6 Pages 17 - 19

4.7 The parents of PP agreed to participate in the review and welcomed the opportunity to do so. What is recorded herein are the views of PP's parents and PP herself. In the absence of any views from the other parties involved, these opinions must be interpreted with caution to avoid the potential for bias.

4.8 Both parents stated that they did not know the deceased and had never met him. They had previously met his partner FP1 on a few occasions predominantly at the time that their daughter, PP was courting MP1. They explained that PP had learning difficulties and had attended specialist educational facilities for some time. PP was described as a friendly person who was very vulnerable. PP attended a school that provided bespoke educational facilities and it was at this location that she first met MP1.

4.9 PP's Mother commented that she was surprised that MP1 was attending the school due to his previous bad behaviour and not because he required specialist educational support. PP's Mother was aware that MP1 had been involved in an incident at a local school that resulted in court proceedings.

4.10 They stated PP was 14 years of age when she first met MP1 and he was 13 years old. MP1 left the school when he was 16 years old. PP remained in the school until the age of 19 years. They shared the same circle of friends.

4.11 PP's parents went on to say that in or around May 2010 MP1 and PP started a relationship. This was PP's first boyfriend; she was besotted with him.

4.12 According to the parents, MP1 would often visit PP's family. Both PP's Mother and Father found MP1 immature, he was difficult to communicate with.

4.13 They stated that MP1 told them that his Father, MP1F, had committed suicide. MP1 explained that he was not close to his dad. MP1 would never speak fondly of his Father. MP1 disclosed that his Mother FP1 was often violent to his Father. There was a Police investigation into his Father's death and he was interviewed by the Police. MP1 was very close to his paternal grandparents especially his grandfather.

4.14 PP is unable to visit the bank and withdraw money and she relied heavily on family members to accompany her to the bank to make various withdrawals. PP would have difficulty in understanding the bank / withdrawal process. PP's Mother soon discovered that during a very short period a large amount of money had been withdrawn from PP's bank account. PP's Mother believed that MP1 had benefitted from these withdrawals.

4.15 PP's Mother described how, in January 2012 PP moved in to live with MP1. This was a big step that both PP's parents reluctantly agreed with. PP's Mother would often visit the house to check that PP was being looked after. PP's Mother emphasised that she specifically asked MP1 to look after PP.

4.16 At the time PP's Mother found that PP was often bullied by MP1. This would involve verbal abuse although PP's Mother suspected that MP1 was also being physically abused. PP did not make any disclosures to her Mother.

4.17 The Parents are of the view that financial management within the home was difficult. PP's Mother stated that both PP and MP1 would spend money very quickly and often have no money to pay the bills or buy food. MP1 would regularly purchase football shirts and other items at the expense of providing for PP. This may be evidence of financial abuse.

4.18 Both PP's parents stated that they were unhappy with this situation although they found themselves "powerless" to intervene. MP1 had attempted to turn PP against them, which caused family disagreements. PP then increased her visits to her parent's home and complained of having no food or basic hygiene items. PP made no disclosure regarding any form of domestic abuse.

4.19 The parents considered that MP1 appeared to be oblivious to the situation. In December 2012, he changed his name to that of his favourite footballer but changed it back again on the birth of their child.

4.20 They said when PP found she was pregnant, MP1 showed no interest. PP's Mother stated she accompanied PP to various medical appointments. PP moved back in with her parents and lived with them for around 9 weeks. MP1 had difficulty in understanding pre-natal care.

4.21 Both PP's parents stated that they arranged for PP and MP1 to have rented accommodation close to their home. They cleared PP's and MP1's debts and her father became guarantor with the letting agent. PP's father used his own private bank account to ensure PP's and MP1's bills were paid.

4.22 MP1 and PP lived at PP's parent's home for a short period until March 2013 when they moved in together. On some occasions, they found him to be nasty and horrible to PP. MP1 had a temper and on one occasion PP's Mother threatened MP1 not to harm PP.

4.23 PP's parents stated that in August 2013, their grand child was born. They lived together as a family. PP's mother would visit them to check on the baby on a daily basis and on one such visit she saw that PP had facial bruising. PP refused to disclose how these injuries had been sustained.

4.24 The appointed Health Visitor was described as a "rock". She noticed that MP1 showed very little interest in the child. During Health Visitor's appointments MP1 would be the one to answer questions although he would then disappear to play football.

4.25 PP's mother explained that MP1 appeared fixated on being physically fit, he would trawl the internet for "magic potions" that would make him stronger and faster. MP1 would not drink alcohol excessively. No one identified if he used illicit drugs.

4.26 PP's father commented that he experienced violent behaviour from MP1. In December 2014 after a domestic dispute with PP, MP1 visited PP's father's home and threatened to hit her father. MP1 shouted abuse at PP's father but when confronted and challenged by the father, MP1 walked off. PP's father made it quite clear to MP1 that he would defend himself and his family. PP's father felt that MP1 did not want a confrontation when he saw that the father was not about to back down.

4.27 PP's father continued that later MP1 telephoned PP's father and threatened to re-visit him and slash his throat. The phone call was abusive and the Police were contacted.

4.28 Both PP's parents advised her to get out of the house and return to their home. They were concerned that MP1 may harm PP and the baby.

4.29 PP's father visited her and took both her and the baby home with him. The Police were present at the time and PP's father commented that MP1 was very impolite to the Police Officers.

4.30 PP's mother described how PP and the baby DPP then lived with her parents for a while. MP1 later moved out from the rented home and moved in with his grandmother.

4.31 According to PP's parents, it was then that PP disclosed that MP1 was physically abusive towards her. PP disclosed that MP1 had smashed her head up against the wall and was very demanding. PP's mother explained that PP's disclosures were brutal in nature and the violence was in the presence of the baby DPP. Both parents were horrified and sad that PP would make excuses for MP1 and try and hide the violence.

4.32 PP's mother stated that when MP1 moved out from the rented accommodation she decided to visit and try to redecorate the property. PP's mother found letters from MP1 to PP in PP's bedroom. The mother describes them as childlike in nature. The letters described PP as a bitch and the child as fat. The letters contained threats to PP. The mother found these threats horrific. She did not discuss the letters with MP1 but handed them to the health worker. Social Services become involved.

4.33 The mother went on to say that PP moved back into the rented property. She was safe, she lived close by. Her parents could keep an eye on both PP and the child. MP1 then wanted to see the child. They received threatening phone calls and on one occasion the Police were involved. They also received telephone calls from PGM who requested that MP1 have access to the child. Both parents were uncomfortable with this. They described MP1 as a dangerous person, especially after the letters he had written to PP.

4.34 MP1 took professional advice. There then followed a process of mediation where MP1 would have supervised access to the child. This occurred on a Saturday morning at a neutral location. PP would also attend these sessions. During these mediation sessions PP secretly saw MP1 and they rekindled their relationship.

4.35 PP's mother was unhappy with this as she believed that MP1 was controlling PP. PP and MP1 shared text messages. This was on-going during the mediation. PP's mother told the health worker what was going on and she believes that the health worker spoke with both PP and MP1. MP1 was then asked to leave his grand-mothers home.

4.36 PP started talking about moving in with MP1. PP started to challenge her parents who disagreed with this idea.

4.37 PP's father stated that as a compromise to protect both PP and the child, the parents agreed for MP1 to move back into the rented accommodation. PP's mother advised Children's Services what was going on. She was surprised that this was not picked up during the mediation sessions. She stated she advised Children's Services she was concerned about the safety of her PP and granddaughter DPP. She is unaware if there was any Children's Services case review of the circumstances. MP1, PP and DPP lived in the rental property. Both parents actively checked on PP's and the child's welfare.

4.38 The father stated MP1 enrolled on a college course although he did not continue with the course. He would appear co-operative to PP's parents and anyone else who visited them. PP's father describes this as "disguised compliance".

4.39 The father then said that DPP would stay at PP's parent's home at least for two nights a week. The father was aware from PP that V had an alcohol addiction.

4.40 PP stated that MP1 had beaten V previously and had taken photographs of his injuries which he kept on his mobile phone. MP1 knew he could get away with it. V was often helpless when he was drunk.

4.41 PP stated that MP1 was violent to her. He threatened to slit her throat once and on another occasion, threw a cake into her face. She described feeling bullied.

4.42 Both parents then discussed how disappointed they were that PP was charged and convicted for a serious criminal offence when it was obvious she was being threatened by MP1. They felt that PP had been treated too harshly.

## 5. Analysis and Recommendations

5.1 Children's Services were engaged with MP1 from 1993, well before the scoping dates of this review; however, some details of those contacts have been included in this report to illustrate the holistic picture of MP1's early years and his life circumstances at that time.

5.2 There are several themes that emerge from this review that are worthy of comment and some recommendation.

5.3 Altercations between MP1 and MP1F continued during the remainder of 2009 and into 2010. So too did domestic incidents between FP1 and MP1F. Both boys witnessed FP1 hit their Father over the head with a glass vase and as neither of the parents would make a formal complaint about the other, no further Police action was taken. No action was taken by Children's Services other than to request both parents sign a written agreement about their behaviour in the future. It was thought that MP1 was resilient enough to take care of himself.

5.4 Even though there was no complaint on either side, this was another example of the Mother not being seen as a perpetrator but rather as a victim when the evidence indicated it was she that she was often the aggressor.

5.5 The above paragraphs indicate several opportunities for agencies, particularly Children's Services and the Police to take appropriate action to safeguard either MP1 and PS or both of them. That however was in 2009 and the Panel are satisfied that procedures and policies have moved forward considerably since 2009 and that if similar circumstances arose today, positive action would be taken. The use of the multi-agency MASH[14] process, improved understanding of adverse childhood experiences, better training and awareness and better supervision would ensure that children and young people of that age are protected in an appropriate way. This negates the necessity for a recommendation about opportunities missed some 8 years ago.

### The decisions around Adult Disabilities Services.

5.6 In relation to the decision that the perpetrator MP1 did not meet the criteria for Adult Disability Services, the eligibility for Adult Social Services is now based on needs for care and support, rather than criteria that includes rigid adherence to factors such as IQ. The approach to transition between the Children's and Adults' Services now is also more flexible, based again on the requirements of the Social Services & Wellbeing

[14] MASH- Multi- Agency Safeguarding Hub - The goal of a MASH is to improve safeguarding and promote the welfare of children and young people through the timely exchange of proportionate and accurate information following an enquiry by any professional or member of the public.

(Wales) Act 2014, in that diagnostic criteria are less important than an assessed need for care & support that can only be met by the Adult Social Care Services.

5.7 It is clear that adherence to the rigid criteria for services prevented a wider holistic view of MP1's needs being recognised and therefore a missed opportunity to promote his well-being.

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

**Children's Services decision making.**

5.9 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 referral was ever raised and subsequently there were no investigations or periods of registration with regard to MP1.

5.10 The decision not to proceed with child protection procedures had a number of potential consequences. There is no written record of these instances being communicated to the Police. If this had happened it may have resulted in a Section 47 investigation being instigated with further issues being identified or further disclosures being made.

5.11 The Children's Services IMR author considered that the Intake Team Manager placed too much focus on the age and assumed resilience of both of the boys, which resulted in questionably high thresholds for child protection intervention and poor quality decision-making. There was 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.[15]

5.12 The use of written agreements concerning behaviour between parties has since been reviewed and discontinued. As part of its review the Safeguarding Board should satisfy itself that this historical practice has been discontinued.

5.13 Whilst it is appreciated that the issues occurred in 2009, as a matter of re-assurance the following recommendation is made;

[15] The Intake Team Manager referenced from 2009-2011 left the employment of RCT Children's Services Department in 2011; concerns having been raised about their practice with senior management which were investigated and upheld.

**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**

5.14 As far as support for V is concerned, between October 2007 and May 2008, he was supported by both TEDS & Community Drug and Alcohol Team. However his attendance and willingness to engage with both services was sporadic. V worked with several teams within TEDS but 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. An assessment conducted in 2007 noted that V may be vulnerable when intoxicated. 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. Records show that 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.

5.15 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, however over the next 2 years his pattern of failing to attend appointments and responding to letters and telephone calls remained the same.

5.16 The TEDS IMR author states:

> *'Workers involved with V appear to have made concerted efforts to contact V when he missed appointments, did not return calls or disengaged from the service. However, there is limit to these efforts and as an agency we also need to respect the fact that someone may choose to disengage & not wish to be contacted'*.

5.17 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. The TEDS IMR author states:

> *'There is nothing on the computer case recording system or the paper assessment forms for the ALS workers that show particular risks regarding V's pattern of alcohol consumption (either in terms of health risks directly from binge drinking or wider risks associated with his drinking behaviour rendering him potentially vulnerable from assaults or alcohol-related injuries/accidents)'.*

5.18 This is inconsistent with the chronology that indicates that V disclosed on at least two occasions that he had been assaulted. The TEDS IMR author does however make three IMR recommendations regarding record keeping, assessments and procedures.

5.19 During the time that V was subject of the IDAP Order he was supervised by the Wales Probation Trust.

> *'It is noted that enforcement should have been more robust with this behaviour and did not meet with expected practice'.*

5.20 Throughout this review there is little evidence of V being recognised as being a vulnerable person, or indeed as a victim of domestic abuse, until the incident surrounding his death.

5.21 V had numerous offers of help. However, he mainly 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**

5.22 It is noted that during the period of time that V was supposed to be engaging with the HM Prison & 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.

5.23 The HM Prison & Probation Service make several IMR recommendations that go a long way towards remedying those issues identified in record keeping and assessments.

**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.**

**Children's Services**

5.24 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".*

5.25 As noted previously the grandparents were providing a robust level of safeguarding support to their daughter and grandchild, and whilst their input was clearly an identifiable strength and protective measure, this appears to have been inappropriately

factored into the decision not to speak directly to PP or DPP about the concerns that were raised.

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

**South Wales Police**

5.27 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.

5.28 V was involved in 8 domestic related incidents involving former partners, ExP1 – on 6 occasions, ExP2 on one occasion and ExP3 on one occasion.

5.29 V 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.

5.30 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.

5.31 FP1 was subject of a MARAC held after she was assaulted by V.

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

5.33 Some of the earlier domestic related incidents did not meet the criteria for the submission of a PPD1 at that time. The Police at that time had a degree of flexibility due to the criteria of submission and any failing around this would be an individual failing on the part of the officer. This has now changed with the introduction of the PPN, which must be submitted in every domestic related incident or concern. A risk assessment is undertaken within the MASH.

5.34 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.

5.35 On one occasion FP1 hit V with a carrier bag. No injury was caused and V did not want any action taken. On another occasion FP1 hit V over his head with a vase. Policy now dictates that positive action must be taken in respect of allegation of domestic abuse regardless of the wishes of the victim. Positive action does not necessarily mean an arrest in every case and it is a matter for the officer to record the rationale for the action taken.

**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**

5.36 Following his arrest V was granted conditional bail. One of those conditions was not to have any contact with his wife FP1. In order to ascertain that he was abiding by the conditions of his bail officers conducted random visits to her home and found him present. Each time he was arrested and taken back before the court where an application was made to remand him in custody. Despite the court granting him bail officers persisted with this tactic and arrested him on six occasions.

5.37 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 continued to further grant him bail. The Panel members are of the view 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**

5.38 As well as 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. FP1 attended sessions held at local community facilities from September 2013 until September 2015. A support worker was always in attendance at all groups to provide an opportunity for client to discuss and personal issues or 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.

5.39 Prior to receiving support from Women's Aid, both FP1 and PP were referred to the Oasis Centre, a support organisation that provides safety measures, advice, advocacy and support and works closely with other agencies situated within RCT County Borough Council. Records within Oasis indicate that FP1 was at high risk of domestic abuse from V. She was referred by South Wales Police in March 2013. She accepted the support and worked with Oasis until January 2014 when she began to receive long-term support from Women's Aid.

5.40 Oasis also has a record of involvement with PP from October 2015, when PP attended at the drop in centre following advice from Children's Services. She is recorded as being of medium risk of domestic violence from MP1. PP attended just one meeting and received a follow up telephone call. It is thought that the continuity FP1 had from Women's Aid and Oasis was outstanding.

**Disclosure of medical information of the Perpetrator**

5.41 As stated in the introduction, (para 2.10) the DHR Chair wrote to MP1 and FP1 informing them of the existence of the review and its process and requesting gives written permission for the review to have access to relevant medical records in order that a balanced report could be submitted to the Home Office. The letter also invited them to participate in the review process. A letter was also sent to their Solicitors.

5.42 The Community Safety Partnership has not received any communication from the perpetrators or their legal advisors acknowledging the letters or giving permission for the release of medical information.

5.43 As a result of that, the Cwm Taf University Health Board considered the Home Office Guidance of 2016 especially paragraphs 99 and 100. It also considered a written response from Mr. Birol Mehmet of the Public Protection Unit of the Home Office, that was sent to Northampton Community Safety Partnership on 3rd May 2017, (attached as an appendix) that was in response to a query raised by that CSP about the issue of disclosure of medical information when there is a refusal by the perpetrator or no response to requests.

5.44 The Cwm Taf University Health Board, although eager to assist with the review process, was initially not satisfied that the 2016 guidance gives enough justification to support disclosure of the perpetrator's medical records without their written permission. Cwm Taf Community Safety Partnership sought counsel opinion and on the basis of that advice in relation to the circumstances of this particular DHR, the UHB were satisfied that disclosure was appropriate and the information was subsequently made available to the review panel.

5.45 Whilst Cwm Taf CSP obtained legal advice in relation to the circumstances of the particular DHR, there is still a need for clear guidance in relation to disclosure of information without consent when there is no consent from the convicted perpetrators.

5.46 The Department of Health and the UK Council of Caldicott Guardians in 2012 issued "Striking the Balance"; Practical Guidance on the application of the Caldicott Guardian Principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences). Similar guidance in relation to Domestic Homicide Reviews is urgently required to remove the uncertainty that persists across the UK around the use of paragraphs 99 and 100 of the Home Office Guidance 2016.

**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.**

5.47 The Review Panel propose that the learning from this DHR is disseminated to practitioners through the exiting arrangements under the Cwm Taf Safeguarding Board.

**Recommendation No 7**

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

## 6. Conclusions

6.1 It is clear from what PP told the review, that it is her opinion that MP1 was a very domineering person who bullied her during the majority of their relationship. It is also her view that FP1 was prone to demonstrate episodes of violence towards her former husband and sometimes towards V. 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.

6.2 Because of his non engagement, V was not recognised as a victim of domestic abuse, only as a perpetrator. He was also a vulnerable person, which also 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 alcohol in the family surroundings added to his risk. The role of alcohol as an enabler for violence was significant for both V and FP1 and the connection between alcohol misuse, violent behaviour and vulnerability was not made.

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

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

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

6.6 There are seven recommendations made in this review. However there are several additional issues identified where things could have been carried out differently in years gone by. 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** Page 34

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

**Recommendation No 2** Page 35

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** Page 35

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** Page 37

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** Page 37

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

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**Recommendation No 6** Page 38

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** Page 39

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

## Bibliography

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

**Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews** – Home Office 2016

| No | Recommendation | Action Required by Agency | Implementation Lead | Target Date For Completion | Summary of Action Taken | Finalisation Date Signed Off |
|---|---|---|---|---|---|---|
| 1 | The Cwm Taf Safeguarding Board satisfies itself that changes to current practices and procedures have addressed the historical issues identified. | The MASH Quality Assurance Sub-Group is required to ensure that a robust quality assurance framework is in place. | Chair of the MASH Quality Assurance Sub-group | Completed | The Safeguarding Board has a robust quality assurance framework for the Multi Agency Safeguarding Hub where all threshold decisions around concerns are made. This is scrutinised on a quarterly basis. The Quality Assurance and Learning Framework includes amongst other things, supervision and recording standards and how and when these are to be audited.<br><br>Written agreements had previously been discontinued and this has been reinforced through Children Services Management Team<br><br>The Cwm Taf Multi-Agency Risk Assessment Framework (MARAF) was | January 2018<br><br>June 2018<br><br>June 2018 |

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| | | | | | developed and implemented within Children's Services in 2017 to encourage consistent thresholds and supports evidenced based decision making and practice. | |
| 2.1 | 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 | The APB to audit whether service providers are complying with the assessment requirement around domestic abuse and appropriate referrals are being made. | Cwm Taf Area Planning Board - Lead Officer | Completed | The overview report has been considered by the Cwm Taf APB and audit undertaken to determine levels of compliance with domestic abuse assessments. As a consequence it is now a requirement specified in each contract that these assessments are undertaken. | September 2018 |
| 2.2 | | Substance Misuse service providers to comply with the training requirements under the Violence against Women, Domestic Abuse & Sexual Violence (Wales) Act 2015, National Training Framework to ensure that staff are aware of domestic abuse issues | Cwm Taf Area Planning Board Chair | Completed | The overview report has been considered by the Cwm Taf APB and level 1 training under the VAWDASV (Wales) Act has been rolled out to the service providers. | September 2018 |

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| | | and act on information received. | | | | |
| 2.3 | | Develop and implement the Blue Light Alcohol Project in Cwm Taf to provide a multi-agency approach to actively engage with individuals who are not in treatment but whose alcohol issues cause them to frequently present to front line services. | Cwm Taf APB – Lead Officer | Completed | The Cwm Taf APB has commissioned Alcohol Concern to roll out the Blue Light Alcohol project in Cwm Taf | May 2018 |
| 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. | HM Prison and Probation Service & CRC to review current policies and procedures in relation to enforcement of court orders and confirm they are robust. | CSP Board Members for NPS & CRC | August 2019 | Report has been considered by the CSP Board and the Chair has asked the NPT & CRC representatives to respond to this action. | In progress. |
| 4.1 | 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 equally women can be perpetrators. On some occasions, individuals can be simultaneously | Statutory agencies to review their individual violence against women, domestic abuse and sexual violence polices and confirm compliance with the recommendation in relation to gender bias. | All statutory agencies | November 2019 | Cwm Taf UHB – completed<br>Merthyr Tydfil CBC – completed<br>Rhondda Cynon Taf CBC – *in progress*<br>SW Police - completed | November 2017<br>March 2018<br><br>In progress<br><br>October 2017 |

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|---|---|---|---|---|---|---|
| 4.2 | victim and perpetrator of abuse irrespective of gender. | VAWDASV Steering Group to request all other service providers and agencies to confirm polices comply with the recommendation in relation to gender bias. | Chair – VAWDASV Steering Group | March 2019 | Report has been considered in full by the VAWDASV Steering Group on 12th April 2018 and action is in progress. | In progress |
| 5 | H.M. Courts and Tribunal Service considers the findings of this review in respect of the decisions of the Courts in relation to repeat offenders of domestic abuse and determines whether there is a need for further awareness raising or training amongst magistrates, concerning domestic abuse. | Report to be sent to the All Wales Criminal Justice Board for consideration and action as appropriate. | Chair – CSP Board | November 2018 | Report has been sent to the All Wales Criminal Justice Board following consideration by the Safeguarding Board Executive Group. | In progress |
| 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. | The Review Panel seeks the advice of the Home Office in relation to this recommendation. | Home Office | Completed | In submitting the Overview Report to the Home Office Quality Assurance Panel, the Review Panel has sought their advice on how this recommendation may be progressed. | January 2019 |
| 7 | The findings of this review and lessons learned are shared with practitioners through the Safeguarding Board Adult/Child Practice Review Group. | To be included on the work programme for the training and learning sub- group of the Safeguarding Board. | Chair – training and learning sub-group. | March 2019 | The review and the lessons learned from the review have been placed on the training & learning work plan for 2018/19. | 11th March 2019 |

## Letter from Home Office

**Appendix No 1**

Copy of letter sent to Debbie Ferguson of Northampton Community Safeguarding Partnership, in response to an enquiry relating to the disclosure of medical information of the perpetrator when consent has not been forthcoming in the DHR process.

From:

*Birol Mehmet*
*Domestic Homicide Reviews*
*Public Protection Unit*

*Thanks for your email about the sharing of medical information relating to the perpetrator to inform a Domestic Homicide Review (DHR) that you are currently undertaking.*

*I should start by explaining that all national guidance and legislation on confidentiality and data protection supports sharing information to safeguard children and vulnerable people. The Data Protection Act 1998 (DPA) and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.*

*A perpetrator's medical records will be classed as "sensitive personal data" under the DPA because they represent personal data relating to a living individual and consisting of information relating to their physical or mental health or condition.*

*When medical records are shared with the Community Safety Partnership (CSP) in relation to a living perpetrator, they are being disclosed by dissemination, which counts as "processing" within the DPA. Therefore, the perpetrator's medical records can only be processed if that processing complies with the data protection principles in the DPA.*

*Principle 3 is the principle that personal data shall be "not excessive in relation to the purpose for which it is processed". Therefore, it is necessary to decide whether providing the full records, rather than a summary is excessive, or whether it is necessary to achieve the purpose behind the DHR. The question would, therefore, be: is it necessary to see the full medical records in order to understand the full history so as to*
*learn lessons from the death to avoid future domestic violence homicides, or can the same outcome be achieved by only sharing a summary?*

*It may be worth reiterating to health practitioners that DHRs are anonymised in order to protect the identities of V, perpetrator, family members and agency staff. However, if they remain unwilling to share information about the perpetrator, you will need to explain in the final report the efforts you undertook so that it is clear to anyone who reads the*
*report that you were unable to get the information requested.*

*The section on data protection in the revised statutory guidance has been considerably expanded. We keep the guidance under continuous review and will consider whether the data protection section can be further updated at the next available opportunity.*

*I hope this has provided a little more clarity on this issue.*

*Kind regards,*
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