# FLINTSHIRE COMMUNITY SAFETY PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

Relating to the homicide of
'Julie'
in October 2018


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## 1. Acknowledgement

1.1 At the outset of this report, it is important to acknowledge that it relates to the life of a person that was valued and loved by her family.

1.2 Her murder, and the circumstances of it, represents a tragic loss to her three children and her wider family, all of whom miss her greatly. We can only hope that our efforts to learn from her murder have not added to their trauma and distress.

1.3 To enable this Domestic Homicide Review to be conducted effectively the various agencies involved have all gathered and shared personal and sensitive information, under conditions of strict confidentiality; balancing the need to maintain the privacy of the family and the need for the agencies to learn lessons that relate to their practice.

1.4 The sharing of that information was essential if the objectives of the review were to be met and, importantly, if lessons for the future were to be identified and acted upon.

## 2. Introduction

2.1 For the purposes of this review document, the victim will be known as Julie and the offender as P.

2.2 Julie was not a native of North Wales, having been born and raised in the Midlands of England, before moving with her parents to Cheshire. It was whilst there that she entered into a relationship with a man and, as their relationship developed, they moved away from Cheshire and settled in Flint, North Wales.

2.3 After moving to Flint Julie gave birth to a child that was the result of a relationship with a local man, however, this did not cause the break up her relationship with her partner. It was whilst she was pregnant with that child that she and her partner moved into the home where she was to remain settled for the next 16 years, prior to her death.

2.4 Unfortunately, Julie's partner, who was significantly older than she was, passed away from a serious illness not long after they had moved into their new home together, when Julie's child was about two years old.

2.5 Sometime later, Julie began another relationship with a man that lived in the local community, and she went on to have two further children with him. That man is the offender, P. Julie had lived in Flint for over 20 years at the time of her murder, she was 46 years of age.

2.6 At 10.01am one morning in October 2018, North Wales Police (NWP) received a telephone call from Julie's landline. The call was made by a man, who has since been identified as P, the long-term partner of Julie.

2.7 Within that call he made a statement that suggested that he was responsible for causing his partner mortal harm. He went on to indicate that she was in the bathroom.

2.8 It was twelve minutes later, at 10.13am, that the first officers from North Wales Police arrived at the scene and, having received no response to their knocks at the locked front door and being unable to see any obvious signs of a disturbance, they started to make their way to the rear of the property.

2.9 As the first officer approached the gate that led into the rear garden, she was approached by P, who was heavily bloodstained to his face, clothing and, in particular, his hands. It was also apparent to the officer that P was under the influence of alcohol.

2.10 Taking into account the content of the phone call and the clearly apparent physical evidence, the officer immediately cautioned and arrested P. She then asked him where his partner was, to which he responded, 'in the bathroom." As the officer took P into custody two of her colleagues entered the house via the rear door.

2.11 Upon entering the property, the officers immediately noticed numerous footprints in blood on the laminate flooring. They searched the other parts of the downstairs area of the property, finding nothing more of note, before then proceeding up the stairs.

2.12 As they ascended the staircase it was apparent, from the further physical evidence before them, that a serious altercation had taken place on the landing, at the top of the stairs and in the bathroom, the door of which was half open.

2.13 The officers checked the bathroom, and the body of the victim was found on the floor. She had sustained grave physical injuries and was clearly dead.

2.14 Life extinct was formally pronounced at 10.25am, by a paramedic who had subsequently attended the scene and viewed the body. The scene of the attack, and its surroundings, were the subject of a thorough forensic examination and search.

2.15 During this search a heavily bloodstained claw hammer was recovered from the back garden of the neighbouring property. P would later acknowledge ownership of that hammer

2.16 Whilst being booked into police detention, at the custody suite at St Asaph, P acknowledged to one of the officers that he realised what he had done, a fact that he reasserted to one of the custody nurses a couple of hours later.

2.17 P went on to tell the nurse that his consumption of alcohol had increased in recent days, owing to the fact that his stepchild's natural father had re-entered their lives. During his subsequent interviews, P acknowledged the fact that he was a heavy drinker, but he showed no remorse for his actions whatsoever.

2.18 Indeed, he took no ownership for his actions at all, claiming not to even recall any argument or altercation with Julie He claimed only to remember waking up in the lounge and then going outside, to the shed, where he consumed some strong cider that he had hidden there.

2.19 P sustained his claim of only partial recall when he referred to returning to the house, claiming only to remember going upstairs, suggesting that he had decided to do some work on the landing floorboards.

2.20 He recalled washing his hands in the bathroom, when the bathroom door was allegedly slammed on his toe. He could not provide any detail at all as to how this event had supposedly occurred.

2.21 P made a further claim that Julie had grabbed his face but was unsure as to whether that alleged incident had happened on that day or the day before. Thereafter, he said that he had no further memory of events.

2.22 P claimed not to know how the victim sustained the injuries that killed her although, when shown the hammer recovered from the garden next door, he did recognise it as his own. He claimed not to recall taking it upstairs or throwing it into the garden.

2.23 He acknowledged that he was annoyed about his stepchild's father reappearing in her life, after they had recently bumped into each other at the local car auctions.

2.24 He denied that the subsequent renewal of communication between that man and Julie had made him feel jealous. He also denied that alcohol made him argumentative or aggressive, claiming that it actually made him 'mellow'.

2.25 Finally, P claimed not to recall the significant statements that he made at the property that he shared with Julie and in the custody suite. When the interviewing officers played the 999 call, he acknowledged that it was his voice on the recording but claimed not to be able to remember making the call.

2.26 A subsequent post-mortem examination recorded the cause of death as, 'severe blunt force head injury due to multiple hammer blows.'

## 3. <u>The Review Process</u>

3.1 Following a meeting of the Flintshire Community Safety Partnership, it was agreed that the murder of Julie met the criteria for a Domestic Homicide Review (DHR) and that a review should be conducted in accordance with Home Office guidance.

3.2 An independent Chair was identified, and a panel convened.

3.3 On 7th March 2019 the first panel meeting was held, at North Wales Police Divisional Headquarters, at St Asaph, at which the panel were briefed by the Senior Investigating Officer (SIO).

3.4 The suspect, P, had been charged, in October 2018, with the murder of his partner, Julie, and he had been remanded in custody, awaiting trial, following his initial appearance at Mold Magistrates Court.

3.5 A plea of Not Guilty had been entered, with a defence of 'Loss of Control' being pursued by the defendant.

3.6 The SIO outlined the ongoing lines of enquiry for the panel, including the fact that enquiries were being made with a number of previous partners of P, as it was known that he had a significant and lengthy history of domestic violence, some of which had not been reported at the time at which it had occurred.

3.7 Included in that history of violence was an assault on the victim, as a result of which she incurred a broken nose and attended hospital, in 2018.

3.8 The SIO also outlined a key line of enquiry that related to a previous partner of the victim, who was also the father of the victim's eldest child, who had recently been in close contact with his child and, subsequently, the victim also.

3.9 Having had nothing to do with his child since their birth, some 16 years previously, he had recently bumped into her at a local car auction. This had led to him visiting and communicating with her and, in turn, it had also led to him communicating and meeting with Julie.

3.10 It was believed that this had been the source of some tension with P, although he denied that assertion.

3.11 Following representations to the panel by the SIO, and due to the fact that criminal proceedings were ongoing, in accordance with Home Office Guidance, it was decided by the Flintshire Community Safety Partnership that the DHR should not be formally commenced until the outcome of the criminal proceedings was known.

3.12 It was also agreed that an independent chair and an independent author be identified.

## 4. Scope of the Review

4.1 It was agreed by the Panel that the scope of the DHR should extend back to 2003, to ensure that all relevant relationships were identified and embraced.

4.2 The author was given the discretion to include any relevant information that extended beyond the stated time parameters, should that information be considered to be relevant and proportionate to the objectives of the review.

4.3 This was due to the fact that the police investigation had identified that the perpetrator had a long history of abusive relationships with women that involved behaviour that may be relevant to this review.

4.4 It was agreed that, to ensure that the clarity of the review was not lost by becoming consumed with other, historic, relationships that only the aspects of those relationships that were considered to be relevant would be embraced.

4.5 That relevance would primarily depend on the involvement of the various public and third sector agencies, which was thought to be limited as much of the perpetrator's previous abuse is believed to have gone unreported.

4.6 Indeed, it was established during a review of the original statement provided by the first partner with whom the perpetrator was known to be violent, an attack for which he was imprisoned, that he had previously assaulted her in 2002.

4.7 It was further established that the North Wales Police attended that incident. Therefore, that incident became the point of commencement for this review.

## 5. Purpose of the Review

5.1 The review is conducted in a way that ensures that it is seen as a learning exercise and not as a means of apportioning blame.

5.2 The purpose of a Domestic Homicide Review is to:

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

5.3 The review will also seek to understand the following, in terms of whether improvement could have led to a different outcome for Julie

- Communication and information sharing between services with regard to the safeguarding of adults and children.
- Communication and information sharing within services.
- Standards of professional and organisational practice.
- Domestic abuse policies, procedures and protocols.
- Whether the service provided in this case, by the respective agencies, represents effective and efficient multi-agency working

## 6. Involvement of Family

6.1 The support of Julie's children, who all agreed to meet with the Author as part of the review is very much appreciated. No specialist advocacy was put in place as both of the younger children, who were not adults unlike their elder sibling, had been offered the opportunity by the local Social Services department to be supported by an independent person and they had chosen not to embrace that offer.

6.2 In any event specialist advocacy was not deemed to be necessary as an existing and positive relationship was already in place with the NWP Family Liaison Officer and the meetings did not involve an interview or significant quest for specific information.

6.3 The children of Julie were not interviewed by the Author but, during his meetings with them, they provided a limited insight into their lives, and that of their parents. Their declared support for the review is very much valued.

6.4 The eldest child of Julie, who will be known as A, is now living with their biological father, whilst Julie's two other children are currently in foster care. The eldest child did not wish to discuss the review in any detail or their experience of living with their mother and step father, choosing only to indicate their support for the review.

6.5 The two younger children will be referred to as B and C respectively. They were not interviewed as witnesses as part of the police investigation and the DHR Author chose to embrace that policy to prevent further potential trauma from being created for the children.

6.6 They are all still in contact with the Family Liaison Officer from North Wales Police, who arranged and attended the meetings between the Author and the children, one of whom is now an adult and was accompanied by their biological father.

## 7. Confidentiality

7.1 It is a Home Office requirement of the report that it is anonymised.

7.2 As explained in the introduction, where it is appropriate within the narrative for a name to be used, the victim will be referred to by the pseudonym, Julie. This use of this name has been agreed by her children.

7.3 The offender will be referred to by the use of the letter P.

7.4 Other members of the victim's family will be referred to by the use of a letter.

7.5 Julie's eldest child will be referred to by the use of the letter A and her two other children by the use of the letters B and C respectively.

7.6 Other victims of the offender will also be referred to by the use of a letter. A key to the assignment of the letters can be found at Appendix 3 to this review document.

## 8. Contributors to the Review

8.1 The perpetrator was also afforded the opportunity to contribute to the Review, which he accepted. He was interviewed in prison by the Author on 15th October 2019.

8.2 Despite fully engaging with his interview the perpetrator offered no information that was of positive value to the objectives of this review, primarily seeking during his interview to rationalise his actions with regard to his attack on the victim.

8.3 There is no evidence that Julie had any involvement with any organisation that supports victims of Domestic Violence or Abuse.

8.4 Evidence from friends and neighbours, who had a personal knowledge of Julie and her relationship with P, was also used to provide historical context and better inform the understanding of the relationship that existed between Julie and P.

8.5 The evidence of some of P's former partners, whom he also abused and three of whom gave evidence at his trial, was also used, again as a means of securing an informed and accurate understanding of his history of abuse and how he treated women.

## 9. Methodology

9.1 All of the agencies that had contact with the victim and the perpetrator were identified and asked to provide a chronology of that contact within the time parameters identified for the review.

9.2 If that contact was considered by the panel to be significant and relevant, then an appropriate manager within that agency was asked to provide an Individual Management Review (IMR).

9.3 The primary objective of the IMR's is to fully detail, objectively review and critically analyse the actions and involvement of the agency in question.

9.4 In addition to detailing and analysing their involvement, a key objective of each IMR was to identify both Effective Practice and Lessons to be Learned. The identification of Effective Practice is to ensure that that practice is disseminated and built upon by relevant managers and staff currently delivering the services in question

9.5 The identification of the Lessons to be Learned was a means of highlighting areas for improvement and ensuring mistakes were not repeated and to enable both individual and partner agency operational practice and strategic policies to be improved, where appropriate. All IMR's were the subject of objective scrutiny, review and assessment by the independent Author, Chair and fellow Panel members.

9.6 The benchmark for that review process was a standard of service from the respective agencies that was professional, reasonable and proportionate within the context of their dealings with the victim and/or the perpetrator.

9.7 However, it is important to point out that that benchmark is that which applied at the relevant time, in the form of the relevant policies and practices that were in place at the time of the respective incidents that, collectively, represent the practical focus of this review.

9.8 Whilst ensuring that judgements were not made with the benefit of retrospective hindsight the review process, undertaken by the various panel members, identified any omissions, oversights or lack of relevant and necessary detail within the IMR's.

9.9 It was then the responsibility of the respective authors to put that right and, where appropriate, to propose any recommendations that dovetailed with their report findings and which they considered necessary to ensure that service improvement was achieved.

## 10. The DHR Panel Members

10.1 The panel membership reflected the agencies that had had relevant involvement with the victim and/or the perpetrator and also embraced other individuals or agencies that were able to positively contribute to the objectives of the review.

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|---|---|
| Iwan DAVIES | Chief Executive, Conwy County Borough Council – Independent Chair. |
| Sian JONES | Community and Business Protection Manager, Flintshire County Council |
| Chris WEAVER | Head of Safeguarding Children, Betsi Cadwaladr University Health Board |
| Delyth TAYLOR | Senior Education Social Worker, Flintshire County Council |
| Peter ROBSON | Resources Service Manager, Flintshire County Council, Social Services for Children |
| Marina OWEN | Flintshire Team Manager, National Probation Service |
| Dean JONES | Detective Sergeant, North Wales Police |
| Richard POWELL | Team Leader, Community Safety, Flintshire County Council |
| Abigail RAWLINSON | Flintshire County Council, Secretary to the DHR Panel |
| Victoria ROBERTS | Independent Domestic Violence Advisor |
| Liz HUGHES | Operations Manager, Welsh Ambulance Services NHS Trust |
| Jami JENNINGS | Wrexham and Flintshire Community Safety Manager, North Wales Fire and Ambulance Service |
| Vanessa KYTE | Solicitor, Flintshire County Council |
| Ray GALLOWAY | Independent Report Author |

10.2 The panel was chaired by an independent person.

## 11. Independent Chair

11.1 The Review Panel was chaired by Mr Iwan Davies, Chief Executive of Conwy Borough Council. Mr Davies was a solicitor (for the most part in local government) from 1989 until he took his current post as Chief Executive of Conwy County Borough Council in 2011.

11.2 Mr Davies has had no contact with the family of the victim and is independent of all of the agencies involved.

## 12. Report Author

12.1 Ray Galloway is a former Detective Superintendent and accredited Senior Investigating Officer with extensive experience of investigating homicides and other serious crimes, including serious abuse in a domestic setting.

12.2 He was a member of the Association of Chief Police Officers Homicide Working Group which was responsible for identifying and disseminating best practice in relation to the investigation of homicide offences. He did not serve in North Wales Police.

12.3 Now working independently, Ray was the Director of the NHS related investigations into the activities of Jimmy Savile. He has participated in several Mental Health Homicide Reviews, and he has chaired and authored Domestic Homicide Reviews around the UK, for which he has been trained.

12.4 He has also undertaken independent reviews for the Church of England as well as a number of charities and commercial organisations. He has no association with any of the agencies involved and has acted as the primary link between the family members and the review panel.

## 13. Dissemination

13.1 A list of recipients, who will receive copies of the report, is set out in Appendix 2. The list is in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. An online copy of the report will also be available via the Flintshire County Council website.

## 14. Parallel Reviews

14.1 An inquest was opened and adjourned at Ruthin on 5th November 2018 by John Gittins, Coroner for North Wales East and Central. The adjournment at that time was due to the fact that criminal proceedings were ongoing.

14.2 Following the trial, the Coroner determined that there was no reason, judicially, for him to reconvene the inquest as the statutory determinations, as to where, when and how the murder of Julie occurred, had been fully detailed and explored during the investigation and trial.

14.3 The Coroner has confirmed his considerations and determination, directly, to the author.

## 15. Terms of Reference

15.1 The full terms of reference for the DHR are included as an appendix to the report.

15.2 For ease of understanding all terms that are considered suitable for acronym will also be detailed, in full, when first used within the report.

## 16. Equality and Diversity

16.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

Age
Disability
Gender Reassignment
Marriage and Civil Partnership
Pregnancy and Maternity
Race
Religion or Belief
Sex
Sexual Orientation

The characteristic of Sex was relevant to the abuse perpetrated by P against Julie as he had a long history of abusing her and several of his previous female partners, whereas there was no known history of violence towards men.

Domestic Abuse is a gender based crime which disproportionately affects women. For example, for the year ending March 2022 74.1% of domestic abuse related crimes that were reported to the police related to victims that were female. (Crime Survey for England and Wales, 2022)

Further evidence can also be found in the fact that, in the two year period between the end of March 2019 and the end of March 2021, 72.1% of domestic homicide victims were female compared with 12.3% of victims of non-domestic homicide. (Crime Survey for England and Wales, 2022)

The abusive behaviour of Julie's partner very much reflected that gender based theme of domestic abuse victims. He had a conviction for assaulting a previous partner, for which he had received a custodial sentence, but the true gravity of the risk that he represented to women was never effectively identified, nor managed, by the police or any other agency. The details of his abuse and the fact that his abusive behaviour was often directed at women are presented throughout the review.

Neither Julie nor P had any known disabilities. The misuse of alcohol, which was a regular feature of P's behaviour, is statutorily excluded from the definition of disability under the Act, notwithstanding the fact that they are taken into consideration by the Care Act of 2014.

Both Julie and P were White British and they had been in a relationship together for 15 years. Neither of them is known to have had a strong religious belief. Julie was not pregnant at the time of her murder.

In this case, neither Julie nor P had care and support needs as defined by the Care Act 2014. It was evident to the DHR panel that both Julie and P were able to access local services and did not face any barriers that prevented them from doing so.

There is no suggestion that either of them lacked capacity and the first principle of the Mental Capacity Act 2005 was applied, that being that, 'A person must be assumed to have capacity unless it is established that he lacks capacity.'

The review found ample evidence that both Julie and P had accessed local services and did not experience any barriers in doing so. There was no evidence identified that Julie or P were the subject of any form of discrimination regarding the service that they received from the respective public agencies involved.

Additionally, there was no evidence found during the review that the decisions taken by the respective agencies were influenced inappropriately, or to their detriment, by their gender, religion, personal circumstances or any other factor or characteristic.

## 17. Background Information & Chronology

17.1 Julie was 46 years old at the time of her murder in October 2018. The man responsible for her murder was her long-term partner, P. They had been together since 2003 when she moved into a house in the same road as P. At the time of Julie's murder, P was 51 years of age and unemployed. He lived with her at the same address, along with their two children, aged 11 and 10, and Julie's child from a previous relationship, who was 16 years of age.

17.2 P was a violent and belligerent man with a significant drinking habit. He did not have a job and he did not contribute, financially, to the running of the household, although neighbours talked of how he did, in their experience, contribute to the domestic upkeep of the home by undertaking some housework. About five years prior to her murder Julie had inherited some money following the death of a relative and, whilst P was known to regularly ask her to help him out financially, there was no specific evidence found within the review that this issue caused tension between them.

17.3 The father of Julie's eldest child had played no part in their upbringing, having ended his relationship with Julie shortly after the birth of the child in 2001. However, he had recently come back into their life, having bumped into his teenage child at a local car auction. That meeting had prompted them to start communicating with each other.

17.4 That communication between father and child also led to a renewal of his communication with Julie. This usually took the form of text messages, but it also included visits to their home where they would meet and talk, either in the house or, more usually, in the motor home that Julie owned that was situated at the front of the property.

17.5 Although he was often at home when Julie was meeting with her former partner, P did not participate in their discussions or join them at any stage. It is known that he saw at least one of the texts that Julie exchanged with the father of her child, and it is believed likely that he was jealous of their friendship, although he denied that suggestion in his interviews. Despite that denial, it is believed that his jealousy regarding this renewed friendship was the primary motivation for P's subsequent fatal attack on Julie.

17.6 Whilst recognising that the attack represented a hugely disproportionate response to any jealousy or anger that he may have felt towards the renewed friendship, the primary basis for this hypothesis is P's long history of violent attacks on his female partners.

17.7 Whilst that history of violence commences, according to formal police records, in December 2003, there is a clear body of evidence that it extends back considerably further than that. Indeed, three former partners gave evidence at his trial of his violence towards them.

17.8 One described how he dragged her downstairs by her hair, when she was eight months pregnant, and another described how he had put a cigarette out on her face and beat her badly when she had wanted to go to her work's Christmas Party and, on another occasion, he had threatened her with an air rifle.

17.9 It is clear that his violence towards women was severe, and that abusive behaviour was repeated over a period of more than twenty years.

17.10 One of P's previous partners, who will be referred to as D, had been the subject of an attack for which he was sent to prison. She was interviewed by the review author due to her direct experience of P's violence over a protracted period. It was abuse which had prompted her to report his behaviour to the police.

17.11 Her report, which was made in December 2003 when she was attacked in her home sustaining a broken nose and serious head injuries after being struck with a brass candlestick, was the first officially recorded incident in a lengthy timeline of violence against women perpetrated by P.

17.12 That timeline was to end with the tragic murder of Julie in 2018, but the reality was that, very much in common with many perpetrators of domestic abuse, P's timeline of violence preceded her murder by many years. It had just not come to the notice of the various public and voluntary services.

17.13 This fact is evidenced by the testimony of P's former partners and further detail was provided by D when she was interviewed for the review and described her experience of his abuse, explaining that she had been in fear of, and intimidated by, P since she first witnessed his violent temper a few months after their relationship started, in 1996.

17.14 Asked why she had remained within such an abusive relationship, she explained that she felt unable to extract herself from their relationship due to his persistent threats, which is a situation common to many victims of domestic abuse who often feel physically inhibited and at risk of harm.

17.15 She explained that he had threatened to 'torch my house down at night' which, due to his habit of kicking her front door in and the relative isolation of the location of her house, she took as a credible, and hugely intimidatory, threat.

17.16 When explaining the fear that she had at this time, D went on to explain that, "I always knew that he was capable of what he did to Julie, I always knew he'd go too far." Asked why she felt that way, she explained, "Because of his temper, because he was so violent. His viciousness."

17.17 That viciousness included him kicking D and cracking her ribs after she had fallen to the floor and, also, burning her with a cigarette. All of these attacks happened in her home and were not reported to the police until August 2003. It was then that D decided that she could take the abuse no more. So, she made a formal report to the police after P had come into the house, angry about something, and punched her to the face, causing a cut to the bridge of her nose. As the attack continued, she fled from the house, calling the police on her phone, and ran down the isolated lane where she lived.

17.18 She was met at the bottom of the lane by the responding police patrol, to whom she explained what had happened. The two officers escorted her home but by this time P had fled the scene. D was advised to lock her windows and doors and told that they would find him and address his behaviour. She heard nothing more from the officers that night, or since. She feels that the matter of her abuse was not taken seriously. She is not aware of whether P was ever spoken to. There is no evidence that he was.

17.19 When the police attended her home, some four months later, to deal with the incident in December 2003 for which P was imprisoned, D told them of a further, third attack in her home which had occurred some 12 months earlier, in December 2002. It is evident that D was clearly the victim of repeated, violent attacks in her own home and, by December 2003, she had brought the latter three occasions, all of which had resulted in significant injury, to the notice of North Wales Police. P was prosecuted for the latter attack and given a four-month custodial sentence. D described the support that she received from North Wales Police during that prosecution as, "fabulous."

17.20 From a broader perspective, that knowledge of P's violence and belligerence towards women was also widely known within the local community and there is clear evidence that his abusive behaviour was known to the police, with his abusive behaviour towards Julie specifically being evidenced by the number of times that North Wales Police were called, usually by neighbours, to Julie's home to intervene in domestic disputes.

17.21 One friend spoke of her own mother taking Julie to hospital, after P had assaulted her and broken her nose, although she did not disclose the origin of her injury to the hospital staff. The friend knew both P and Julie to often consume alcohol with P being an abuser of alcohol and often being drunk.

17.22 A long-term friend of the offender described him as domineering and explained that he never liked Julie to have friends, whether they be male or female. The friend also described how P was frequently drunk and that Julie would often tell him to sleep in the camper van on their driveway when he had been drinking.

17.23 Julie's friend referred to another example of how P would seek to apply coercive control over Julie, such as insisting that they leave house parties when he wanted to go home, even if she wanted to stay, but the friend also referred to occasions when Julie had physically assaulted P, during an argument. The theme of the evidence was not one in which P consistently sought to control Julie with violence or other forms of abuse although the occasions where he did seek to apply coercive control were not uncommon.

17.24 The relationship described by the friend included occasions when Julie sought to manage her own safety and that of her children such as her regular removal of him from the family home when he was drunk, either to the camper van at the front of the property or to a neighbour's house. It is evident that his drunkenness could be accompanied by belligerence and violence so she clearly sought to minimise his opportunities to abuse her.

17.25 There were occasions when, despite Julie's efforts to manage his aggression and abusive behaviour, his violence did become a control mechanism. It is within this context that the friend also spoke of multiple occasions when Julie had called at her house, seeking sanctuary in the wake of an argument and, on one occasion about four or five years ago, Julie disclosed to her that, "he's threatened to kill me."

17.26 Another neighbour, who was a close friend, spoke of how Julie and P used to regularly argue and that it would sometimes result in them coming to blows. She also described how P would often drink alcohol to the point where he would become incapable.

17.27 The neighbour recalled several incidents in which Julie had suffered injuries as a result of assaults by P, including a serious injury to her cheekbone following a punch from him, which occurred about two years ago and was still causing her pain. She spoke of it being known locally, including by Julie, about P's reputation for having physically beaten his former partners but that Julie chose to continue in her relationship with him.

17.28 The neighbour also spoke about there being blood on the wall in Julie's home and she remembered another incident, from about two years prior to her murder, when she found Julie in her back garden hysterical after being punched in the face by P which caused her to attend hospital. P would clearly act as a bully who sought to intimidate his partner.

17.29 Several other neighbours also confirmed the volatility of the relationship, the catalyst for which was often P's abuse of alcohol, and the fact that Julie would often tell him to leave the house and sleep in the camper van on the drive, or elsewhere. Evidence was also provided that made it clear that P was unhappy with Julie's recently renewed friendship with the father of her eldest child.

17.30 Further evidence of P's abusive behaviour towards Julie can be found in the fact that they both, at different times, presented to A&E or the local Minor Injuries Unit with significant injuries. Some of the injuries were, by any reasonable assessment, highly likely to be the result of a physical attack, such as when Julie presented with a broken nose. The definitive confirmation, as to the true origin of at least some of the injuries, was never effectively explored and confirmed by the respective health professionals with whom Julie and P dealt. Thus, positive intervention opportunities were lost.

17.31 The involvement of North Wales Police, with regard to incidents between P and Julie, started in 2005 with the most recent involvement being in August 2009. Despite his offending history and the gravity of his abusive behaviour, it is somewhat surprising that, whilst he had been sentenced to four months imprisonment for the attack on D in 2003, P had not been the subject of any subsequent prosecution, relating to abuse in a domestic setting, since then.

17.32 The details of the police involvement with the couple and their various presentations at the respective health services are detailed in the next section, the Individual Management Reviews. The fact of the matter is that P's repeated attacks on Julie, and his previous partners, never became the focus of sustained attention by any of the public services. This is primarily due to the fact that they were not reported. Additionally, Julie had no involvement with any of the Third Sector organisations that are dedicated to supporting victims of Domestic Abuse.

## 18. Individual Management Reviews (IMR's)

18.1 Individual Management Reviews are an opportunity for the managers within each of the respective agencies to look openly and critically at each aspect of organisational and individual practice and policy, within the context in which all of the professionals in question were working.

18.2 They must then consider whether such policies and practices need to be amended and improved to ensure that professionals working in similar situations in the future are afforded the best opportunity to prevent further homicides from occurring. Similarly, they are an opportunity to identify examples of Effective Practice which can be embraced and disseminated to other professionals who are working in the same or similar environments to ensure that the same positive outcomes are achieved.

18.3 Following the disclosure and examination of the involvement that each of the respective agencies had had with the victim and/or the perpetrator during the period embraced by the review, Individual Management Reviews were requested from the following agencies:

- *North Wales Police*
- *The Betsi Cadwaladr University Health Board*
- *Flintshire County Council Social Services for Children, and,*
- *Flintshire County Council Education Department.*

18.4 Individual Management Reviews were not required from the following agencies as following a consideration of the event chronologies that they provided, it was apparent that they had had no involvement with either party that was relevant to the objectives of the Domestic Homicide Review:

- *Welsh Ambulance Services NHS Trust,*
- *North Wales Fire and Ambulance Service, and*
- *the, National Probation Service*

18.5 Similarly, there was no involvement of any Third Sector organisation, such as Women's Aid or the Flintshire Domestic Abuse and Sexual Violence Advisor.

18.6 There was also no involvement with any of the other services that are dedicated to supporting victims of Domestic Abuse, such the North Wales Rape and Sexual Assault Service (RASA) which is supported by Flintshire County Council.

18.7 **North Wales Police IMR**

18.8 North Wales Police (NWP) have, during the agreed time parameters, come into contact with the offender in this case on seven separate occasions, in incidents involving three different women. With one exception the seven occasions involved incidents of abuse in a domestic environment. Four of the incidents involved Julie.

18.9 To ensure that all relevant incidents were captured the time parameters for the review were extended back to 2003, which allowed the review to embrace an incident that occurred on 14th December 2003 which was relevant as it involved significant violent abuse by P in a domestic setting.

18.10 For his actions during this incident P was prosecuted and convicted of causing Actual Bodily Harm and Criminal Damage. He was subsequently sentenced to a period of three months in custody.

18.11 The incident itself related to an occasion when P had repeatedly punched a long-term female partner in the face and stomach in her home, including striking her across the head with a brass candlestick, causing a significant gash that required medical treatment.

18.12 In her original statement to the police the victim, who will be referred to as D, detailed a previous occasion, in December 2002, in which P had forcibly entered her home and assaulted her causing bruising to her body. That incident had not been reported to the police at the time and did not form part of the subsequent investigation or prosecution with regard to the 2003 offence.

18.13 It appears that no reference was made as part of the 2003 prosecution to the incident that had occurred twelve months earlier, despite it being retrospectively disclosed to the police by the victim. It was only on the occasion of the 2003 incident that the 2002 incident came to light as it had not been reported at the time.

18.14 However, the fact that P was given a custodial sentence for the 2003 attack reflects how the court viewed the gravity and seriousness of the offence. There is no indication that a referral was made to any partner agency with regard to the incident.

18.15 On 14th January 2004, a date which preceded his conviction for the incident which had occurred exactly a month earlier, in December 2003, P was the subject of further police attention. On this occasion a different woman, who will be referred to as E, and at the time described herself as a friend of P, reported the fact that he had entered her home, apparently angry and upset about a separation from another partner.

18.16 She further explained that he became so threatening and abusive that she fled from her home, with the fact that she left her young children inside the property being a reflection of the extent of his aggression and the fear for her own safety that she was experiencing at the time.

18.17 The officers attending this incident appear not to have been aware of P's very recent arrest and charge, for the December 2003 assault, and no arrest was made. The decision not to arrest appears, primarily, to be due to the fact that no complaint of assault was made by E when she had fled from her home, and no resumption of the breach of the peace was foreseen by the officers.

18.18 At the time, largely as a result of the information provided to them by E, who told them that she and P were friends, the attending officers did not know P to actually be a partner of the victim. It is likely that E was in fear of P at the time. The result was that the officers escorted E back to her address and took no further action in terms of the offender. It appears that she was not supportive of further police action and there is no evidence that a statement was taken from her.

18.19 Due to the presence of children in the home a child protection referral was made by the officers. However, no mention was made in that referral of the very recent arrest and charge, and the relevant context in terms of the fact that that arrest and charge had been the result of a domestic abuse incident that had occurred just four weeks earlier, in December 2003. No detail is available as to which partner agencies, if any, the referral was shared with as the current NWP crime system does not contain that information.

18.20 The following year, on 30th May 2005, North Wales Police received a call from the woman, Julie, whom P would eventually go on to murder, some 13 years later. This is the first recorded instance of her reporting an assault, or abuse of any kind, by him.

18.21 Julie reported, in the early hours of the morning, that P had attended at her home address and assaulted her by slapping her twice to the face, throwing her to the floor and kicking her to the groin. When police officers attended she had a clear lump on her head, her face was flushed, and she was complaining of pain in her groin. She also had spots of blood on her clothing which she claimed was blood from the offender after she had punched him during their altercation.

18.22 P was subsequently traced by the officers to a local address and found to have injuries to both of his eyes. He was arrested and taken into custody. However, as the victim did not wish, or was not confident, to pursue a formal complaint of assault he was later released without charge and, also, without interview. In accordance with the Home Office recording guidelines of the time, a crime of assault was still recorded by North Wales Police and, due to the fact that P was recorded as the offender, the crime was recorded as 'detected'. He was notified by post of that fact.

18.23 An integral part of the process that relates to a circumstance in which a victim of crime does not support a prosecution is the endorsement of the 'unwilling victim' form. This form was appropriately completed by the officers dealing with the offence and signed by the victim. There is no record of any referral being submitted regarding this incident.

18.24 It was some three years later, on 19th February 2008, that a neighbour reported hearing another disturbance between Julie and P. Upon police attendance P had left the scene and Julie reported that no violence had been involved. It became apparent from enquiries made at the scene that the tension between the couple had been simmering for days and had, at its heart, his apparent heavy drinking and unwillingness to assist with their now two young children. Julie described what had occurred as a petty argument. She endorsed the officer's notebooks to that effect. P was subsequently traced by the officers to his own property, nearby. They removed keys to Julie's address from his possession. They also warned him not to return there, under sanction of arrest should he do so.

18.25 A referral, which was considered by the Public Protection Unit and shared with Social Services, was submitted, classified as a standard risk. The referral document mentioned the presence of children but, once again, it did not contain any reference at all to P's history of domestic violence offending and his significant conviction for assaulting a previous female partner, in December 2003. This omission of relevant detail is believed, by the IMR author, to be the potential result of the fact that such information may not have been available to the officers as there had been a change in the crime recording software used by NWP.

18.26 Notwithstanding that change in computer software, the relevant conviction would have been evident if a basic PNC check had been conducted, but there is no record of such a check being undertaken by the officers who attended the incident at the time. However, as the initial report was that of assault it would be reasonable to expect that a PNC check would be undertaken in such circumstances.

18.27 It was some 18 months later, on 12th August 2009 that another domestic disturbance was once again, reported by a neighbour and resulted in police attendance at Julie's home address. When the officers attended the scene it was apparent that both Julie and P were under the influence of alcohol and no reports of violence were made.

18.28 Due to the potential for the reported disturbance to reoccur P was the subject of positive action by the officers as he was removed to a friend's house in another town. A referral was made to the Public Protection Unit and, due to the mention of children, it was shared with Social Services. On this occasion it was classified as a medium risk. Once again, the referral made no mention of the previous conviction or previous incidents of domestic abuse and there is no record of whether the neighbour, who was the original informant, was spoken to by the police patrol, nor a reason why.

18.29 A prolonged period, of more than 8 years, then ensued before P came to the attention of the police again in relation to abuse in the domestic setting. This followed a referral that had come to NWP via the Social Services department of Flintshire County Council. The referral originated from the fact that, on 27th January 2018, North Wales Police were notified that P had presented at Holywell Hospital complaining of soft swelling to his right wrist. He was in the company of Julie and one of their children, C, who was 10 years of age at the time. During the examination of his injured wrist P had become agitated and he had left the consultation room. He was followed outside by the examining nurse who witnessed him having an anxiety attack.

18.30 As the nurse sought to attend to him he disclosed to her that, the previous evening, he had lost his temper with his child, C, and slapped the child across the face. The nurse described him as being remorseful as he made this disclosure.

18.31 The child in question was observed to be content in the company of both parents and no injuries from the slap were visible on their face. Both parents gave their consent for the incident to be reported by the hospital to Social Services. P confirmed that support was needed by his family. Following the referral, a strategy meeting was held, on 29th January 2018, between North Wales Police and Social Services. Once again the referral did not contain P's offending history, including his propensity for violence. No specific action was decided upon by the two agencies, other than the fact the family would be signposted for support by Social Services.

18.32 The above incidents represent the full involvement of NWP with P in circumstances that relate to abuse in a domestic setting. The only other occasion when the family came to the attention of NWP during the relevant period came in July 2017, six months before the previously mentioned referral from the hospital, but it did not relate to domestic abuse.

18.33 This involved Julie reporting her, then 15-year-old eldest child, A, as missing from home having not returned home from school at the normal time. The child still did not return home during the evening, despite being in telephone contact with their mother. Enquiries with the school revealed that A had left the school premises at about 11.30am, without formal consent, and not returned during the school day.

18.34 Following the report to the police A was eventually located in a supermarket in Holywell, safe and well and in the company of a boy of a similar age. They were returned home after stating that they had merely left school and not returned home, as per their normal routine, as they had wanted to stay out with friends.

18.35 Following research being undertaken on the family a referral was made to Social Services, although no consideration appears to have been made as to whether A's behaviour was potentially linked to any issues at home. There is nothing further of note with regard to this incident that is relevant to this DHR.

18.36 **Betsi Cadwaladr University Health Board (BCUHB) IMR**

18.37 Whilst Julie, P and their three children resided in the Flintshire area, they actually accessed their health care from the Denbighshire area of North Wales. This is not unique to this family as most families who live in border counties find it more accessible to go to their nearest acute hospital, register with a local GP and access minor injury units within that area.

18.38 BCUHB provided care to the family when they accessed the Emergency Department (ED) in Ysbyty Glan Clwyd and the Minor Injury Unit (MIU) situated in Holywell Community Hospital, predominantly for the treatment of injuries. The General Practitioner (GP) also provided primary care services to the family and provided support in relation to mental health and alcohol issues in relation to both Julie and P.

18.39 Health Visitors and School Nurses, who are employed by BCUHB, delivered Child Health Services to the children. Even though the mental health case notes of Julie, were unavailable to the IMR Author, it is known that primary care mental health services were provided to her, for a 2-month period, in 2009. BCUHB also provided maternity services to Julie in 2007 and 2008.

18.40 For the purposes of this review, the interaction of the various health services with Julie and her family and, in particular, her presentation with her own injuries are worthy of closer scrutiny. That scrutiny is undertaken in the 'Analysis' section of this document.

18.41 Julie presented six times with injuries between 2005 and 2017. She presented once to her GP, on four occasions to A&E and, on one further occasion, to the MIU at Holywell. She presented with a range of facial and hand injuries. Julie also presented to her GP with a history of depression and low mood, prior to her second and third children. Following the birth of her children she suffered another episode of depression and was referred to the Community Mental Health Team. In August 2009 the GP has noted that Julie was not coping and was using alcohol.

18.42 On four separate occasions P also presented with injuries, twice to his GP, once to Holywell MIU and once to ED. The injuries related variously to his finger, chest, wrist and, most seriously, a hip fracture, which he attributed to a fall whilst intoxicated. There is clear evidence that he spoke to his GP about the extent of his alcohol use. He also suffered from panic attacks and stress due to difficulties coping with his children.

18.43 **Flintshire County Council Social Services for Children IMR**

18.44 There were five referrals made to Flintshire Children's Services during the period from 2009 to 2018. However, despite the five referrals, it is clear from the chronology that there was no direct contact made with either the children or the parents during this time period.

18.45 Despite that lack of direct contact, there were sufficient concerns in two of the referrals to have undertaken an investigation under Section 47 of the Children's Act 1989, in accordance with the All Wales Child Protection Procedures (AWCPP) 2008. During this process it would have been obligatory to have seen and spoken to the children and to gain their personal accounts.

18.46 The first referral, on 17th August 2009, came from North Wales Police who had attended a report of a domestic disturbance at the home address. Upon attending the officers had found both Julie and P to be under the influence of alcohol. Julie was found in the front seat of the family car, on the drive. No specific concerns were raised but, due to the circumstances and the fact that both parents were intoxicated, it appears that the police officers considered it prudent to make a referral regarding the children.

18.47 The second referral came on 16th May 2011, from an ED doctor at Glan Clwyd Hospital. This came after Julie had brought one of her children, B, in with a laceration to their forehead, three days earlier, on 13th May 2011.

18.48 She had explained to the staff that B had sustained the injury following a fall and hitting their head on a metal bar. The wound was serious enough to require suturing under a general anesthetic. The following day, Julie had returned to ED with B, reporting that the child had fallen again, and the middle sutures had been disrupted.

18.49 There had been no apparent delay in returning B to hospital. There was no sign of fresh injuries and the relationship with their mother appeared to be appropriate. Bite marks were noted on B's arm, which their mother explained as coming from B's younger sibling, C. Concerns were expressed by the doctor, after consultation with the Pediatric Registrar, hence the referral.

18.50 The third referral, which occurred on 19th July 2017, followed a report that the eldest child, A, was missing from home. A was found by the police, safe and well, but the circumstances of them going missing prompted a referral. As stated in the North Wales Police IMR, A had left school during the day and, when they didn't return home as per their normal routine, they were reported as missing by their mother. A was later found with a boy of a similar age in Holywell. Following the referral contact was made with the family and enquiries were made but no formal action was considered necessary.

18.51 The fourth referral came on 27th January 2018 and followed a disclosure that P had slapped his child, C, a different child to the one that had been brought in with the head injury. Following further investigation of the circumstances of the slap the matter was downgraded from a Child Protection referral to a Care and Support intervention. The case was closed on the 8th February 2018, when the parents did not take up the offer of active support.

18.52 The most recent referral during the relevant period came less than two weeks later, via the school, after A had made a disclosure with regard to the behaviour of a male lodger at their home address who appeared to be making inappropriate advances to them via phone messages. Following consultation with the school and Julie, regarding her eldest child, no further Social Services action was undertaken. The matter was closed on 19th February 2018.

18.53 **<u>Flintshire County Council – Education Services IMR</u>**

18.54 The involvement of the Education Department in terms of matters that are relevant to the objectives of the review are limited as, during the various involvements of the respective children with Education professionals, the threshold where safeguarding concerns became evident was never reached. The issues that were addressed in the Education environment will be detailed, in turn.

18.55 In terms of C, the main concern of the primary school that they attended was their poor attendance record which, as the result of a register check on 16th January 2018, was recorded as 75.48%. The absences, all of which had been authorised by the school, were all recorded and categorised as 'medical reasons'. Nevertheless, this level of absence prompted a letter to C's parents from the Education Welfare Officer (EWO).

18.56 The EWO explained in the letter that his role was to provide advice and support to the school and parents. It also made reference to the fact that he was aware that C's parents were seeking a medical diagnosis for the child, seeking to explain the child's behaviour. The EWO asked the parents to advise him of any future outcome for the medical assessment that was being sought. There is no record of that outcome being provided.

18.57 In terms of B, information was provided by the Additional Learning Needs Coordinator at the High School that they attended, relating to teacher concerns about their use of their mobile phone in school. It is recorded in school records that staff at the school had reported seeing B on their mobile phone to their mother during every lunchbreak. It is further recorded that this caused the staff some concern but there is no detail as to whether those concerns were ever addressed with B, personally. The only detail provided by the Pastoral Lead at the high school is that teachers had observed B on their phone to their mother.

18.58 It is not documented, nor has information subsequently been provided by the school, as to whether it was ever established why B was contacting their mother every day. For example, did B do so as the result of concerns that they had for their mother's welfare or was it due to a more straightforward reason, such as the fact that they enjoyed a close personal relationship.

18.59 In terms of A, it is apparent from the Education records that they were a frequent truant and was repeatedly poorly behaved at the High School that they attended. There is also specific reference to a Child Protection referral that related to concerns about a 28-year-old lodger that was staying at their home address.

18.60 The referral states that the man in question was a friend of the eldest child's siblings, although this would appear to be unlikely as the siblings will have been aged 11 and 10 years old respectively at that time. The supposed friendship between the man and the children is not explained in the referral. The concern which prompted the referral appears to have been inappropriate attempts by the man in question, via a text message, to develop his relationship with A.

18.61 Other than that specific issue it does not appear that the details of their home environment were ever personally explored with A when their truancy and behaviour were addressed with them. Indeed, the issue of a potential link to the home environment does not appear to have been explored with any of the children at their respective schools when the issue of their absences, truancy or other behaviours have been addressed with them.

## 19. Analysis

19.1 This section of the review details the critical analysis of the actions undertaken by the respective agencies. The analysis is undertaken, in the first instance, by the IMR authors. However, to ensure completeness, objectivity and candour, that analysis is the subject of review by the Independent Chair, the Author and all other members of the DHR Panel.

19.2 **North Wales Police**

19.3 When analysing the actions of NWP, it is important to recognise the fact that the issue of Domestic Violence, and other forms of abuse in the domestic environment, has, over the period that this review embraces, evolved and developed significantly in terms of its profile and prioritisation in policing and society in general. Correspondingly police officer attitudes and support mechanisms have, over that time, become more professional and appropriate, as have the relevant operational policies.

19.4 It is within that context that we must, objectively, view the actions of the officers, and other staff that either attended the respective incidents or had some part to play in the actioning, or otherwise, of the subsequent referrals. Notwithstanding that fact, the gradual progression in the professionalisation of police response during the relevant period does not explain or mitigate the consistent theme of omission in terms of the failure to include P's relevant offending history when NWP have made referrals to partner agencies.

19.5 Such omissions must, by any objective evaluation, be considered to be significant and cannot reasonably be explained away by the introduction of new crime and/or incident recording software by the force. Any inter agency referral must, if it is to be effective and afford partner agencies the opportunity to make informed decisions as to their own course(s) of action, include all relevant information. It is apparent that the police referrals consistently did not do so.

19.6 The first incident that is formally recorded, in December 2003, involves the most serious physical attack of all of the incidents that were dealt with by NWP during the period under review. Whilst the attack did not involve Julie, the eventual murder victim, it remains relevant as it was the start of the recorded offending of P with regard to violent abuse in a domestic setting. Unfortunately, there is a paucity of documentary material available in NWP records relating to the incident. This is thought to be primarily due to the passage of time and a change in the police software used for the management of investigations.

19.7 Despite that fact it can still be established that positive police action was taken, which resulted in P being prosecuted and given a custodial sentence for the assault. What is not clear is why the conviction related to the relatively minor offence of 'Actual Bodily Harm' whilst the injuries sustained by the victim, the circumstances of the assault, and the original charge all appeared to support the more serious offence of 'Wounding'.

19.8 Such a criminal justice outcome may have been the result of a number of factors, such as a plea bargain, CPS policy or the evidence available to the prosecuting authorities. Not least, in evidential terms, will have been the medical evidence relating to the injuries sustained by the victim, which included a significant head injury. Such evidence will have been pivotal in terms of the charge that was originally laid. However, whilst the detail of that evidence is not available to the DHR author, the police report does indicate that the victim received a wound to the head that subsequently bled heavily, which would explain the charge of wounding that was originally pursued.

19.9 Whilst it is not clear whether the eventual conviction for the lesser offence was primarily the result of a guilty plea, the decision to accept that outcome will have been one for the prosecutor and not the police, even taking into account the likelihood that the police will have been consulted. The outcome of the prosecution process does not represent a shortcoming on behalf of North Wales Police. They took positive action against the identified offender; he was charged, he was convicted, and he was given a custodial sentence.

19.10 The most significant question relates to the risk presented by P, particularly to women, and how that risk was identified and acted upon. In terms of that risk, and its effective identification and assessment, the statement made to the police by the victim of the assault in December 2003 makes the sustaining risk very clear.

19.11 In her statement, D details an occasion when she had previously been assaulted in her home, by P, and held there against her will. This incident had occurred 12 months earlier and included the victim being punched to the head and kicked. D also included in her statement the fact that P had attended at her home in August 2003, assaulted her and gone on to damage doors and her television. She had run from her home and found protection via a police patrol that was responding to her call for help. However, despite witnessing her distress and the fact that D had run from her home it appears that no positive police action was taken against P, who had left the house by the time that the police officers arrived. It has not been established why this was the case but the actions of the officers appears to be insufficiently positive.

19.12 The previous violent incident, of December 2002, had not been reported to the police at the time and, given that D's injuries were, she claims, nothing more severe than bruises, the opportunity to pursue a charge for the assault may have been lost due to prosecution time restraints, as she reported the matter some 12 months later.

19.13 In relation to that incident, a charge of 'false imprisonment' could also have been considered, following D's assertion that she had been held against her will, but there is no evidence that that option was ever considered. What is of more relevance to this review is the fact that such evidence does not seem to have formed part of any assessment of P's risk to women.

19.14 From the three incidents detailed by D, two of which had been attended by NWP officers and all of which had resulted in her sustaining significant injuries, it is clear that P represented a sustaining and overt risk to women. In December 2003 he seriously wounded a woman in her own home and she provided evidence that he had previously assaulted her, and held her against her will, 12 months earlier. He was charged with wounding her, yet he was still given bail.

19.15 Whilst on bail for that offence he went on to terrify another woman, once again in her own home, even before he was convicted for his attack the month before. However, the relevance of the link between those multiple incidents was not recognised which does not constitute an effective identification, or management, of the risk to women that P represented.

19.16 In relation to P's offending whilst on bail, in January 2004 he was in a relationship with the victim, E whilst on bail for assaulting D. It appears that the fact of his relationship with E was not established at the time by the officers but it is understandable why E did not share that information with the police.

19.17 She had seen for herself P's aggression and abusive behaviour when she witnessed his attack on D, the previous month. This is known as D referred in her statement to the fact that E had turned up at D's home during the attack on her. Therefore, having seen the extent of the violence that P was capable of, it is understandable why E fled her own home when he, some weeks later, became threatening and abusive to her, also.

19.18 What is clear is that P was engaged in multiple relationships within a small locality as it appears that he was involved with D, E and Julie herself at the time of these incidents. The evidence indicates that he was terrorising at least two of the women. Indeed, had he not been granted bail, for the wounding offence against D, the subsequent incident involving E could not have occurred.

19.19 The fact that the three matters were not linked, and considered collectively, when assessing the risk that P continued to represent must be considered to be a significant oversight. This is particularly so as the latter two incidents were only a month apart and the first two involved the same woman, D, at the same venue, her home, where she should have been safe.

19.20 A child protection referral was submitted after the incident with E, but the most crucial information of all, that being the link between the two incidents of December 2003 and January 2004, was not included. A simple PNC check would have revealed the fact that P was on bail, with a court case pending but that crucial information was omitted. It is not known how the referral was managed or dealt with.

19.21 Notwithstanding the apparent shortcomings of the referral and the risk assessment process, the relative historical context of the police action that is under scrutiny must be considered. The incidents concerned occured more than 14 years before the fatal attack on Julie and, as such, whilst they, and their outcomes, remain relevant, they cannot reasonably be considered as contemporary causal factors in terms of the fatal attack that is the focus of this review. Yet, having acknowledged that caveat, the relevance of the incidents in 2002/3 emanate from the fact that, whilst the incidents in question relate to women other than Julie, they all involve significant domestic abuse. Despite that fact, the clear risk that P represented was never recognised by North Wales Police.

19.22 The incident of May 2005 is notable due to the fact that it is the first time that Julie and the offender have come to the attention of NWP as part of the same incident. Whilst the police action must be considered within the context of policing priorities and policies that prevailed at the time, it is relevant that this incident occurred in the year following the passing into law of the Domestic Violence Crime and Victims Act 2004, which was a watershed piece of legislation.

19.23 This new legislation made Common Assault an arrestable offence and introduced the option to courts of restraining orders, even without a conviction. The new Act was a clear and tangible demonstration that Domestic Violence, and any related crimes, were a governmental priority and it provided police forces with the authority upon which they could prosecute offenders and protect victims. Most UK police forces, by this time, had dedicated Domestic Violence Units and had trained their officers to take positive action when dealing with incidents of domestic abuse.

19.24 The police file relating to the May 2005 incident is classified as an 'unwilling victim crime record'. This relates to instances where victims of crime do not wish to support a prosecution against an offender and, so, no further police action is taken in terms of pursuing a prosecution.

19.25 It is also important to recognise the fact that the Home Office Counting Rules (HOCR), which guided police forces as to the recording and classification of crimes, and what outcomes would constitute the detection of a crime, were very influential at that time in terms of operational policing practices. According to the HOCR of the time, when a complaint of assault was recorded and the offender had been identified, that crime could be recorded as 'detected', even if the victim had been unwilling to support a prosecution, as in this case. Therefore, despite the seriousness of the injuries sustained by Julie and the extent of P's violence towards her, the recording of a detection is likely to have been considered to be a positive outcome for the police, within the context of the closely scrutinised, performance indicator culture that prevailed at the time. Such Home Office policies allowed a crime to be detected without an arrest having to be made and a charge brought, provided that the offender was actually identified.

19.26 Notwithstanding that culture, it is the statutory legislation, and not the Home Office guidance, that should always take primacy in terms of influencing police action. This is particularly so when that legislation is victim focused and intended to protect. Indeed, in terms of the incident in May 2005, positive policing action was taken by the officers who attended, in that P was arrested and taken into custody. But, despite that initial positive intervention, the positive theme is not sustained as P is subsequently released from custody, without being interviewed or his offending otherwise explored. Additionally, no referral, of any kind, was made with regard to the incident. This fact is especially significant when the gravity of the assault is taken into account. Julie had a clear lump on her head, she had been thrown to the floor, kicked to the groin and the presence of blood from P was on her clothing. This was in addition to the fact that the couple had a four-year-old child.

19.27 The apparent oversight of no referral being made is compounded by the fact that the officers seem to have been unaware of P's previous convictions and offending history. It is proposed within the IMR that this may well be due to a change in the crime recording software being used by the force during the relevant period. That proposal does not withstand scrutiny. A fundamental, and routine, check of the Police National Computer (PNC) by the officers dealing with the incident would have revealed P's relevant conviction, thus making the fact of the new crime recording software irrelevant. Furthermore, it is not credible to suggest that the introduction of new software by the force would completely erase relevant offending histories and incident records.

19.28 A somewhat ironic fact with regard to this incident, is that the person whom P asks to be informed of his arrest is the woman, D, who he was convicted of assaulting at the end of 2003, just over two years previously. It would appear that that connection was not known, or recognised, by the officers who dealt with P on the night. P was released from custody the next morning without any apparent attempt to advise Julie as to the measures that could be taken to support her, should she wish to pursue a prosecution. Also, P was not required to complete the 'non-compliant victim' form, prior to his release that would have been necessary to complete the case file.

19.29 The investigation into the incident appears to have been finalised with a letter to P, advising him that the crime of assault will be recorded as 'detected', with him as the offender. Whilst this would have been in accordance with the aforementioned Home Office Counting Rules, it does not reflect a desire and commitment to practically support the victim, Julie, or proactively manage the risk presented by a repeat offender.

19.30 Somewhat surprisingly, when one considers the gravity of the incident in May 2005, it is not until three years later, in February 2008, that P comes to the attention of North Wales Police again. Once more, the incident was reported by a concerned neighbour and involved suspected Domestic Abuse. Despite claims by the informant that Julie had been the subject of an assault, this was not confirmed when she was spoken to, although Julie did advise the officers that the dispute had been ongoing for some four days and related to P's drinking.

19.31 Julie, who, by that time had a young child, fathered by P, in addition to a child to a previous partner, left her home to stay with a neighbour. P was warned to stay away from her address. It does not appear that the neighbour, who suggested when they called that Julie had been assaulted, was spoken to by the attending patrol.

19.32 It is not known why the neighbour was not spoken to. It may well be that they asked not to be approached by the officers or asked to remain anonymous. There are no police records available that would allow an informed judgement to be made on that issue. What is clear is that the officers did take steps to protect Julie and her children. Positive action was taken to ensure their safety and she was found a safe haven with a neighbour as she shared with the officers that tensions had been raised and had sustained for a period of several days.

19.33 A referral was made and shared with Social Services although, once again, it does not appear that, initially, any background checks were made that would have informed the partner agencies to whom the referral was made. It would appear that relevant checks were subsequently undertaken when the case was later reviewed. However, a decision was made by the reviewing officer that the information gleaned from those checks did not justify any further action other than the original referral.

19.34 It was some 18 months later, in August 2009, following another call from a neighbour that the police were next called upon to address a further domestic dispute between P and Julie. On this occasion, despite there being no reports or evidence of violence, the officers took positive action by removing P to Prestatyn and, thus, negated the chance of a recurrence of the dispute.

19.35 Due to the presence of children a child protection referral was made. It was discussed during the morning Public Protection briefing and shared with Social Services as a medium risk. No further enquiries appear to have been made by Social Services.

19.36 Following that incident, it was more than 8 years before the family came to the notice of North Wales Police again.

19.37 A referral in January 2018 had its origin in a disclosure by P, at Holywell Hospital, that he had slapped one of his children in the face the day before. It appears that a decision was taken that no police action was necessary. A strategy meeting was held between the Police and Social Services where it was decided that the Social Services Department should 'signpost' the family for support. This would appear to be a reasonable decision, when considering the incident in isolation, but the inefficiency of the police checks is, once again, evident with the fact that no previous conviction check was undertaken which resulted in the omission of vital information and an inaccurate endorsement on the file that the father had, 'no history'.

19.38 A routine check would have revealed his conviction for domestic assault and his propensity for violence. The belief that P had no relevant offending history will have formed part of the considerations at the strategy meeting. Of course, even had the strategy meeting been aware of the father's offending history, it could still be rationalised that, with there being no injury to the child, who was found to be at ease with their father, no prosecution would have been pursued. However, this is far from certain and it does not excuse the poor standards displayed by those managing a child protection issue. Had P's history been known, as it definitively should have been, then that may have led to the decision to obtain an account from the child, probably with the assistance of Social Services.

19.39 Of relevant context, also, is the fact that P had attended hospital with a wrist injury. Given his violent history it may have been prudent for that fact to have been considered when deciding whether he should be the subject of a formal interview. But, the relevance of that injury, or otherwise, is now impossible to establish.

19.40 The police action with regard to the report of A as a missing person, in July 2017, is of limited relevance to this review as the teenager was found within an hour of being reported missing and in circumstances that did not suggest a risk of harm was evident. However, the inefficiency of the record checks is again evident as P is not recorded as their father, stepfather or guardian and no mention of the domestic incidents involving their parents is recorded on the referral.

19.41 Overall, the themes that emerge from the police involvement with P is one of positive action being taken to deal with the respective incidents, in isolation, but a chronic lack of efficiency in terms of their background checks, risk assessments and support to partner agencies.

19.42 It is of little use for referrals to be made, almost as a matter of routine, if the information contained in those referrals is either inaccurate or omits vital information, as was the case so often with the referrals that were submitted relating to the offender in this case. In this specific regard North Wales Police consistently, over a period of several years, fell short of the professional standard that they must, by any objective and reasonable assessment, be expected to attain.

19.43 **Betsi Cadwaladr University Health Board (BCUHB)**

19.44 Between 2005-2017, Julie presented six times with injuries, once to her GP, on four occasions to the Emergency Department (ED) and, on one occasion, to Holywell Minor Injuries Unit (MIU). The actual volume of presentations, over a period of 12 years, is not in itself hugely significant. However, the nature of the injuries sustained, which included both facial and hand injuries, is absolutely significant. This is particularly so with regard to the occasion when Julie presented at hospital with an injury which involved a deviated nasal septum, a broken nose.

19.45 On all occasions on which either Julie or P presented at the GP, the hospital or MIU, appropriate medical treatment was given by the BCUHB staff. However, there is no evidence to suggest that specific consideration was ever given to domestic abuse in terms of exploring the true cause of the various injuries. For example, on 30th May 2005, Julie presented to her GP with a facial injury but it appears, from the GP's notes, that no consideration was given to domestic abuse and, thus, no relevant enquiry was made with her that may have revealed more.

19.46 On 28th July 2006, Julie visited ED with a finger injury that was significant enough to require an x-ray and a splint to be applied. Whilst her GP was advised of this fact, via a report from the hospital, there does not seem to have been any consideration at all of domestic abuse by either the hospital staff or her GP practice.

19.47 On 9th September 2009, Julie had a face to face consultation with her GP, with regard to the results of an x-ray of her eye after she had presented with a bruise to her face, and, whilst some enquiry appears to have been made as to the origin of the eye injury, as it is recorded as being the result of 'just messing around', there is no evidence that the enquiry was focused on domestic abuse or, in light of her previous history, her use of alcohol.

19.48 Most significantly of all, in terms of the injuries sustained by Julie, is the occasion when she was seen in the Emergency Department, on 8th December 2016, with a deviated nasal septum. Following the assessment of her injury, she was referred to the Ear, Nose and Throat Clinic but, whilst a report was sent to her GP, there is no ED record available for assessment.

19.49 There is no evidence that the issue of domestic abuse was ever addressed with Julie when she has presented with this injury. This would appear to be a significant oversight on behalf of the health professionals who treated her as this injury, which involves damage to the bone and cartilage that divide the nasal cavity, is often the result of some form of physical trauma, such as a punch.

19.50 Whilst all of the injuries with which Julie presented, to whichever element of the NHS, could have been sustained in a non-abusive context, the latter two examples, a bruise to her eye and a broken nose, should, by any reasonable and objective assessment, have been the subject of further enquiry by the health professionals involved.

19.51 Notwithstanding the fact that the respective injuries occurred seven years apart, the very nature of the injuries should have been the trigger for specific enquiries to be made with regard to domestic abuse. The fact that they were not constitutes opportunities missed, although, whilst recognising this oversight, it must be placed within the broader context of the attitude of the BCUHB and its relevant training provision to its staff.

19.52 In particular, it is appropriate to acknowledge the fact that Domestic Abuse Awareness Training has been embedded within mandatory training across BCUHB for more than ten years. The 'All Wales Pathway, Antenatal Routine Enquiry into Domestic Abuse Minimum Standards' were developed and implemented in 2009.

19.53 The two primary aims of the Pathway were as follows:

a. To ensure that Health Professionals in Wales carry out routine enquiry for domestic abuse within the antenatal period; and
b. To ensure that disclosures are appropriately recorded, and support systems implemented.

19.54 The fundamental objective of the Pathway, and the supporting assessment tools, was to embed the culture within the Health Service whereby women, during the antenatal period, were afforded safe opportunities to disclose the fact that they were the subject of domestic abuse. A complementary objective was for such disclosures to be appropriately recorded and acted upon which, too often, has previously not been the case, which mitigates against the full understanding of individual cases by those who are not familiar with the individuals concerned. Subsequently, all midwives and health visitors were trained in what was known as 'routine enquiry', using the Hurt, Insult, Threat, Shout (HITS) screening tool.

19.55 This training was further supported by the use of the Co-ordinated Action Against Domestic Abuse (CAADA) and the Domestic Abuse, Stalking and Honour-Based Violence (DASH) risk assessment checklist, together with relevant referrals to Multi Agency Risk Assessment Conferences (MARAC).

19.56 As the Pathway was introduced in 2009, and Julie delivered B and C in 2007 and 2008 respectively, the midwives and other health professionals involved with her care are likely to have had only a basic awareness of potential domestic abuse issues and how they may be explored when a patient presents at hospital or a clinic. However, that awareness is unlikely to have met the standard expected following the introduction of the dedicated training and awareness raising programme that were delivered as a result of the introduction of the minimum standards referred to above.

19.57 Therefore, as that specific training programme had not yet been completed at that time it would not have been an organisational expectation for the 'routine enquiry' into domestic abuse to have been carried out. That expectation would have, definitively, been in place if Julie had delivered her children after 2009.

19.58 From a broader perspective, during the earlier period, which was prior to the introduction of the minimum standards, there is no evidence to suggest Julie suffered any domestic abuse injuries during her pregnancy. This is based on the fact that Julie did not present with any injuries or make any reports to her midwife.

19.59 Since the introduction of the Pathway, in 2009, monthly audits have been carried out to monitor compliance with regard to staff making the routine domestic abuse enquiries of antenatal mothers. Action plans are developed and monitored if compliance is lower than expected. Since 2012, the making of a routine enquiry regarding domestic abuse has been embedded within high-risk areas within BCUHB, such as the Emergency Department and the Mental Health Division.

19.60 In addition to presenting with their various respective injuries, both P and Julie also disclosed alcohol use to their GP including, on one occasion, after he had fractured his hip whilst intoxicated. Despite this, there is no evidence to suggest that screening tools were used, and subsequent referrals made to specialist alcohol services for assessment and treatment. This is despite P's drinking clearly having an impact on family life and the dynamics within the domestic environment. The links to alcohol use, and the fact that such risks are often associated with domestic abuse, were clearly missed. The lack of such a referral is surprising as P had been previously known to the Substance Misuse Service in 2003. That referral had been due to his frequent intoxication, his inability to control his temper, his violence towards his partner, incidents of self-harm and hitting doors with fists. That abuse of alcohol has continued, with the review finding significant evidence that he would regularly drink to the point of rendering himself incapable.

19.61 It is recorded that P explained his behaviour at that time as being the result of relationship issues. In light of this disclosure there is more than a reasonable potential that the injury to his hand may have been the result of his violent temper. But, this potential link was not explored by the health staff. This is despite the fact that the link between his alcohol use and the domestic abuse of his partner had been identified in 2003, as referred to above, and admitted by P himself during his involvement with the Substance Misuse Service.

19.62 In addition to the alcohol abuse which resulted in P's involvement with that support service, both P and Julie also disclosed depression and low mood. He, additionally, disclosed anxiety and panic attacks. Julie was treated by her GP with anti-depressants and, additionally, she was referred to the First Access Team, whom she saw on four occasions, between May and June 2009. Unfortunately, access to these records has not been possible, other than a letter that was sent to the GP from the First Access Team which stated that stress management strategies had been used.

19.63 The stresses addressed related to Julie having three young children, her feeling of being overwhelmed by the pressure associated with managing a young family, and her feeling of being socially isolated with an associated loss of self-confidence. It is not possible, from the contents of the letter, to clarify whether domestic abuse, specifically, was considered or explored by this team. The fact that it was not referred to in the letter would suggest that it was not. What is evident is that practical support was offered, with a referral to Homestart, a voluntary organisation which seeks to help families with young children to deal with the stresses of life. It is unclear whether the Homestart volunteers actually gained access to the house, as that further information is not available. What is reasonable to conclude is the fact that as P and Julie had their two children, B and C, within 11 months of each other, it will have been a very challenging time for the family.

19.64 As Julie already had a child from a previous relationship, they then had three young children to raise. This challenge will have been made more difficult by the fact that there was only a limited income available and, as P was a regular and heavy drinker, this will have further impacted detrimentally upon the family budget.

19.65 During this period only universal services appear to have been provided. Overall, what a review of the health records reveals is the fact that proactive enquiries relating to domestic abuse were not undertaken when Julie presented with her various injuries, including the injuries with the greatest potential link to domestic abuse. There is no documented explanation as to why such enquiries were not made despite the fact that if staff are unable to carry out such enquiries it is good professional practice to record the reasons why this was the case. For example, when the patient is accompanied by his/her partner and the opportunity to speak to them alone was not afforded. No such reasons were recorded on the occasions that Julie presented.

19.66 However, it is reasonable to conclude that such records, such as to why domestic abuse was not addressed, will only have been made if the thought to address the matter in the first place had occurred to the staff in question. What this repeated oversight has highlighted is the need for bespoke training in the relevant service areas, concentrating on embedding that routine enquiry into domestic abuse, which may lead on to a referral to MARAC and other relevant support services. Such a training programme would require both funding and senior management support if it is to be effective.

19.67 From a strategic perspective it would appear that the necessary organisational focus on matters of domestic abuse could have been improved during the period in which Julie and P came into direct contact with the various health services. It is within this context that the absence, for part of this period, of a dedicated strategic post with responsibility for domestic abuse may be considered to be relevant.

19.68 Between 2016 and 2018, the BCUHB Corporate Safeguarding Team underwent a strategic review of roles and responsibilities. A key outcome of that review has been the incorporation of safeguarding responsibilities into the roles of the Head of Safeguarding Children and Safeguarding Specialist Midwife.

19.69 In 2018, an internal audit concluded that during the period when there was no dedicated strategic responsibility for domestic abuse there was a reduction in the routine enquiry performance. Additionally, BCUHB's training compliance considerably reduced during this period. This led to the Safeguarding Practice Development Lead reviewing the Group 2 Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) training package. As a result, this training package has since been adopted nationally, across the whole of Wales, for all Health Boards to use. The Service User procedure has also been reviewed and recently ratified. One of the tangible and positive outcomes of this renewed focus has been the fact that the compliance data for this training within BCUHB, and the Health Board as a whole, has since seen a significant improvement.

19.70 The recent training compliance data demonstrates a significant upward trajectory, with a compliance position of 74.3%, across the Health Board in December 2019. This compares very favourably to a compliance figure of just 39.4% when the internal audit was originally undertaken, in January 2018. A performance target of 85% compliance has been put in place by the Health Board management, who are working to achieve and sustain that target as a means of ensuring that the Pathway objectives are fully embraced and implemented by those staff that are best placed to identify and support victims of Domestic Abuse.

19.71 **Flintshire County Council - Social Services for Children**

19.72 The first referral to Social Services for Children came on 17th August 2009 and followed police attendance at a domestic dispute which had, apparently carried over from the previous night, when Julie is believed to have also smashed a glass at the house. All three children had been checked safe and well in their beds and P removed from the premises. The focus of the police report appears to have been the behaviour of the parents and no concerns were raised by the officers with regard to the children's welfare.

19.73 The All Wales Child Protection Procedures (AWCPP) were adhered to as a result of the referral but, despite the fact that both parents were found to be drunk, no further enquiries were made into this matter. The basis and rationale for this decision was the judgement that the relevant AWCPP (2008) threshold was not considered to have been met. Had the judgement been that that threshold had been met, then further action would have been required by the department.

19.74 In relation to the next referral, of 16th May 2011 from Glan Clwyd Hospital, it is the judgement of the IMR author that it would have been appropriate to undertake a formal strategy discussion with North Wales Police, to determine whether a single, or joint service, home visit should be made.

19.75 Such a home visit would have provided an insight into the domestic environment and family dynamics. A home visit would also have afforded the opportunity to determine whether an investigation, in accordance with Section 47 of the Children's Act 1989, and the All Wales Child Protection Procedures (AWCPP), needed to be undertaken.

19.76 The forehead wound sustained by the child that prompted the referral was apparently a significant one as they required a general anaesthetic to have it sutured. A second attendance at hospital by the child and their mother the very next day, would, on the face of it, appear to be a further basis for concern. However, the records reveal that the second attendance was due to the suturing of the original wound being disrupted following another fall, and not the result of a fresh injury. A day was taken up by the Social Services staff unsuccessfully seeking to make contact with the ED Doctor who had made the referral. Contact was eventually made with the Safeguarding Nurse at the hospital on 19th May 2011. She undertook to make further enquiries and feed it back.

19.77 On 23rd May 2011, the Safeguarding Nurse reported back to Social Services on her findings. They were consistent with the initial referral, with no concerns being raised about the welfare of the child. She also provided the further clarity that the bite mark on B was believed to have been inflicted by a two-year-old sibling. Contact was also finally made, that same day, with the ED Doctor who explained that the primary rationale for their referral was the fact that, whilst not being an expert, they felt that the mother's explanation of the mechanism of the head injury was unlikely. However, the relationship between mother and child was considered to be sound and appropriate.

19.78 Later that day a strategy meeting was held with North Wales Police with the outcome being that the local Health Visitor should be notified, and that Julie should be invited into the Social Services office to discuss the head injury and her supervision of the children. The rationale for that decision, which constitutes a downgrading of the referral and the proposed action, is not recorded. It was not until 21st June 2011 that a letter was sent to Julie inviting her to a meeting at the office, one week later, which would have been over six weeks since the initial referral, which represents an inappropriate delay.

19.79 Two days later, a telephone interview was undertaken with Julie, who had stated that she would be unable to make the proposed meeting on 28th May 2011. During the interview Julie refuted any suggestion that the injuries sustained by B were attributable to her lack of supervision of her children. She confirmed that she had taken advice from her health visitor and claimed that her youngest child was going through a 'biting phase'. She proposed that she would wrap her children up in cotton wool.

19.80 The decision by the Social Services staff to agree to a telephone interview in these circumstances is most certainly open to challenge. This is especially so when the nature of the injury, and the doctor's concerns about the credibility of the mother's explanation, are considered. The alternative option, to have visited the home environment and to have seen the child, in person, would have been a more thorough policy to have adopted.

19.81 The third involvement of Children's Social Services occurred on 19th July 2017, when Julie's eldest child had not returned home from school. Child A had left school early and was eventually located by the police in a supermarket in Holywell, safe and well. The child advised the officers that they had wanted to spend time with friends as it was their last day at high school. The child's mother had no concerns and no further action was taken. This would appear to be appropriate in the circumstances.

19.82 The fourth involvement of Children's Social Services came on 27th January 2018, following P presenting at the Minor Injuries Unit at Holywell. He had presented with an injury he claimed to have sustained two weeks previously after hitting his arm with a hammer. The involvement of Social Services came as a result of P becoming agitated and having a panic attack which led to them disclosing that he felt stressed and that he had slapped his child, C, across the face the previous evening. He further explained that he had lost his temper as a result of C defecating in their trousers.

19.83 No injuries were noted on C and the child appeared happy in their father's company, however, the Social Worker in the Emergency Duty Team noted that a referral would still be made to NWP. Following subsequent consultation with NWP, later that same day, it was agreed to undertake a home visit, on 29th January 2018, as no injuries were evident on the child. On that date the nurse who made the original referral subsequently clarified that her motivation for the referral was not just the slap of the child, it was the fact of the stress being exhibited by P and the potential for that to increase tension within the household. She also reported that the family was in need of support. Later that day a strategy review has been undertaken and a decision was made not to undertake a Section 47 investigation but to downgrade the response to Care and Support, to be delivered by the Targeted Support Team.

19.84 In the professional opinion of the IMR Author this was not a sound decision and, thus, the response should not have been downgraded, as described. A more appropriate response would have been to undertake a joint, or single, agency Section 47 investigation.

19.85 Correspondence was sent to the family, asking for them to make contact with Social Services. However, on 8th February 2018, the case was closed without the letter having been responded to. No further update is recorded. The lack of response from the family to that correspondence should have alerted the Service to there being potential issues within that family unit that needed to be the subject of further, more proactive, investigation. It was apparent from the fact that the father had struck his child, and the fact that the child had soiled their clothing, that tensions existed within that domestic environment.

19.86 It is also likely that a more proactive and positive policy, such as that facilitated by a Section 47 investigation, would have led to a more informed understanding of the family unit and its workings. Whilst it is considered unlikely that NWP would have contributed to a joint investigation, due to the timeframe and lack of evidence to suggest a criminal assault, it would have been prudent to visit the child and to speak to them in person. Additionally, there was an unreasonable delay in securing contact with the key health professionals that had made the referral, which inhibited both the expediency and effectiveness of the decision-making process. Overall, the management of the referral was neither expeditious nor effective. The fifth, and most recent, involvement of Social Services came as the result of a referral from the Safeguarding Officer at A's High School, on 19th February 2018, just over a week after the previous case had been closed.

19.87 The referral was prompted by a disclosure from A that a male family member, aged 28 years, was staying in the family home. Child A further disclosed that the lodger had messaged them and 'tried it on' a few times and Child A also shared a message from the lodger with the school Safeguarding Officer, which read, 'if you want a kiss, you know where I am. I want to but I don't know if you do.' Child A had confided in their mother but she had, allegedly, responded by saying that the message was cute, and that A should not worry about it.

19.88 The following day, following contact between Social Services and the Safeguarding Officer, it transpires that Julie became aware of the Safeguarding Officer's contact with A and that she was not happy about it happening without her consent. Child A was reported as not being very forthcoming and that Julie had stated that she would never allow her child to be put at risk. The Social Services team manager took the decision that there was no further role for Children Services at that time. The case was closed on 20th February 2018 as the team were satisfied with the outcome recorded by the school staff in relation to the referral.

19.89 Whilst policy appears to have been followed with regard to that specific referral, the question as to whether the broader consideration of what might be occurring within that family unit should have been undertaken still remains, particularly when the context of the recent referral of less than a month earlier is considered.

19.90 **Flintshire County Council – Education Services**

19.91 The primary theme of the occasions when interactions with the respective children may have been relevant to the review is one of when opportunities to more proactively explore the reasons for absences, truancy or specific behaviours at school may not have been taken. A lack of professional curiosity was demonstrated by the Education professionals dealing with the children and their parents or, more precisely, their mother as she is the parent who attended the meetings called with regard to her children. The following represent potential opportunities missed;

19.92 There is a significant body of evidence that Child A was regularly poorly behaved and disruptive at school, with this behaviour sustaining over a significant period of time. On at least one of the occasions when their behaviour has been the subject of discussion, A has apparently disclosed that there was something concerning them at home, but the detail of that concern was not further explored or identified.

19.93 The regularity of A's truancy and the extent of their disruptive behaviour at school should, by any reasonable assessment, have prompted further exploration as to whether the home environment was contributing to this behaviour. Meetings were held, including with A's mother, that were opportunities, such as via a 'what matters' conversation, to explore their potential vulnerability. Such a discussion could have been used to identify how A's siblings were performing at their respective schools and to explore with A's mother her own views as to what may be contributing to her eldest child's behaviour.

19.94 Additionally, it does not appear that referrals to support services such as the Young People's Counselling Service, 14-19 Pathways Team, Learning Coach or Behaviour Support Service were considered. Such services could have been embraced as alternative means of identifying the causes of and/or improving A's behaviour and whether they were expressing themself through that behaviour. It is reasonable to expect that a more professionally curious attitude would have been adopted to explore and understand what was happening within the family and not to accept things at face value, as seems to have been done.

19.95 Whilst disclosures of disharmony, tension or abuse are often not made proactively by young people or their parents, facilitating an environment in which people feel confident and supported to make such disclosures is very important. It does not appear that such opportunities to disclose were afforded, although, it must be acknowledged that A was not a person that engaged enthusiastically with many people. Whatever the opportunities provided to them, A may not have shared with the teachers the trauma that undoubtedly existed in their home environment in any event. But, not to have sought to explore that potential during the various conversations relating to A's behaviour seems to represent opportunities missed.

19.96 In terms of the Child Protection referral that related to the lodger at home, it appears that no real efforts were made to identify the person in question, with the unlikely explanation of him being the friend of one of A's younger siblings apparently being accepted. This lack of information diluted the impact of the referral.

19.97 In terms of B, the issue relating to the lunchbreak routine of using their mobile phone to contact their mother at home, once again, appears to be something that was only partially understood. Whilst it is acknowledged by the staff at the school that this caused them concern, that concern does not appear to have translated into any positive action. For example, it is not known whether it was ever identified by the staff as to whether this daily routine was prompted by any concern that B harboured for their mother's well-being or whether it just reflected the closeness of their relationship.

19.98 B also had a poor attendance record yet, other than a single letter to the parents, this has not prompted any attendance meetings which would have provided an opportunity to obtain an insight, with at least one of the parents, into the domestic environment and relationships. There is also no documented evidence of a referral to the Education Welfare Service being considered as a means of developing an understanding of the situation.

19.99 A similar theme is evident with regard to C, who was still at primary school at the time of their mother's murder. Again, there is no evidence of the Education Welfare Service being considered nor any Behaviour Support involvement. Such services may have been utilised had an Individual Education Plan been formulated but this was not the case. The focus, following a check on the school attendance records, was C's rate of absence. Yet, whilst all of their absences were recorded as 'medical reasons' this did not prompt a referral to the Community Paediatrician for School Health.

19.100 It was also known by the school about the involvement of CAMHS and that, at the request of C's parents, a referral had been made to the NDT. However, the outcome of that referral was never determined, although this is most likely the result of the outcome not being shared with the school by the parents.

19.101 In summary, the consistent theme, with regard to how all of the children were managed and supported within the Education environment, appears to be one in which their poor attendance records and, in A's case, consistently poor behaviour, were the subject of very limited intervention. Potentially valuable opportunities to gain an insight into their personal well-being and their domestic environment were not created and explored.

19.102 It may well be that the undoubted tensions that existed at home between their parents may not have been disclosed during the discussions that further intervention would have prompted but, the fact is, that will now never be known. The demonstration of further professional curiosity may have led to a more informed understanding of the domestic environment being experienced by the children. However, it must be acknowledged that it is far from certain that any such understanding would have extended to the knowledge that domestic abuse sustained in the home environment.

## 20. <u>Effective Practice and Lessons Learned</u>

20.1 Domestic Homicide Reviews are a key source of information with regard to informing and developing policy and practice at both a national and a local level, with the primary objective being the prevention of further abuse and homicide.

20.2 To that end this section of the report highlights the effective practice and areas for improvement that have been identified by the respective IMR authors, and agreed by the panel, as a means of forming the basis for the improvement of future practice and safeguarding victims.

## 21. <u>Effective Practice</u>

21.1 The professional practice identified in this case which was considered by the panel to be effective, in terms of its usefulness as a basis for improvement in the future was very limited.

### 21.2 <u>North Wales Police</u>

21.3 Positive action, in a variety of forms, was taken by the police officers who attended the various incidents of domestic abuse, or other potentially abusive behaviour, which were reported by third parties, usually in the form of concerned neighbours.

21.4 That positive action sought to remove any perceived risk that existed at the time, usually in the form of actually removing the perpetrator himself, albeit temporarily.

21.5 Referrals were made to partner agencies, as a means of advising them of potential risks that may sustain in the domestic environment, usually with regard to the well-being of Julie and her children. (Some referrals related to previous partners of P).

21.6 **Betsi Cadwaladr University Health Board (BCUHB)**

21.7 The GP referred C to the Family Wellbeing Service (FWS). The FWS is a low-level mental health service, aimed at people under the age of 18 years, in need of support with emotional problems. Referrals into this service are undertaken using a criterion that is applied via the asking of specific questions to determine if the FWS is appropriate.

21.8 Once referred, the patient is seen by a member of the Child and Adolescent Mental Health Services (CAMHS) team. If from that point, there are further issues that are not appropriate, a further referral will be made to the correct tier within CAMHS. This service has been running across North Denbighshire via Cluster Practices and continues to run at present.

21.9 Attendances at Holywell Minor Injuries Unit by the children of Julie were communicated appropriately to the GP and Health Visitor, and safeguarding children's referrals made, when appropriate. Good advice and support were given to P by the Occupational Therapist who was based in the GP practice, in relation to his anxiety.

21.10 **Flintshire County Council Social Services for Children**

21.11 No specific examples were identified as evidence of effective practice.

21.12 **Flintshire County Council – Education Services**

21.13 No specific examples were identified as evidence of effective practice.

## 22. Lessons Learned

22.1 The identification of lessons that can be learned and the associated areas for improvement is a further critical aspect of Domestic Homicide Reviews. They help inform future policy and practice as a means of preventing or minimising harm. The following lessons to be learned have been identified in this review:

**North Wales Police**

22.2 The primary lessons to be learned for from the review relate to inter agency referrals and the identification and management of sustaining risks. In particular it is essential that, if liaison between partner agencies is to be effective, the information that is shared between those agencies must be accurate, relevant and complete.

22.3 It is apparent that the various referrals made by North Wales Police were not reviewed effectively prior to being forwarded to, or shared with, the respective agencies for which the information contained in the referral documents was intended. If those receiving referrals, such as the Social Services for Children team, are not provided with all of the relevant and available information then their subsequent assessments and considerations will, by definition, be incomplete and not fully informed. In turn, the decisions that are then made as a result of those considerations will also be made on the basis of incomplete information.

22.4 When the information that is missing from the referral document relates to a known, and potentially sustaining, risk to the safety of women, as it did in this case, then that is a matter of significant concern. The importance of such key facts being omitted is amplified when that risk is presented by the very person whose abusive actions have prompted the referral itself, as was the situation in this case.

22.5 It was a consistent theme of the referrals made by the various officers that attended the incidents of domestic abuse, over a period of some 16 years, that they lacked absolutely fundamental information that related to P's conviction and offending history and, in particular, his propensity for violence against women. Whilst the officers often addressed the immediate threat that was sustaining at that particular point in time, which was usually the presence of P himself, the fundamental issue of his repeated offending and his enduring threat was not effectively identified and addressed.

22.6 The standard of the referrals made by North Wales Police, with regard to the incidents that have been the focus of this review, repeatedly fell short of that which would have enabled a more effective understanding of the threat posed by P to be achieved by all relevant partner agencies. Whilst the positive police actions demonstrated a fundamental awareness of the immediate needs of Julie and the other victims who preceded her abusive experience, Julie was never signposted, or positively guided, to a relevant domestic abuse support organisation or, even, the specialist units within North Wales Police itself that could have supported her.

22.7 Whilst the referrals do suggest a broader, overarching awareness of how other agencies may be able to contribute positively, usually to ensure the safety of the children, there is no evidence that the police referrals ever had as their objective the specific highlighting of the recurring theme of domestic abuse, often involving serious violence.

22.8 The question that must be posed is whether the consistently poor standard of referrals was due to poor individual practice or organisational weakness in terms of the lack of effective processes in place to quality assure such important documents. As the theme of incomplete referrals extends over a period of 16 years it is likely to be the latter as multiple officers are involved yet the outcome remains largely the same, that being that the full and relevant facts of an abusive relationship are not being conveyed to partner agencies and the risk to women represented by a repeat offender is neither identified nor managed effectively.

22.9 North Wales Police now have an improved working relationship with, and make referrals to, a Domestic Abuse Safety Unit (DASU), who are an organisation that is able to provide access to nine separate Independent Domestic Violence Advisers (IDVA), all of whom are nationally accredited.

22.10 The IDVA's provide specialist support for females and males, aged 16 years and over, who have been assessed as high risk of serious harm or homicide. The primary role of the IDVA is to ensure the safety of the victim and to minimise the risk of any harm. The IDVA's work in partnership with the police, and other agencies, to reduce the risk of harm, enhance the safety of their clients and help them to rebuild positive lives.

22.11 **Betsi Cadwaladr University Health Board (BCUHB)**

22.12 The key lessons to be learned from the review relate primarily to the ineffective application of the 'Routine Enquiry' domestic abuse process. It is apparent that several opportunities were missed by health staff to afford Julie the opportunity to disclose her abuse when she presented with injuries that should have prompted further enquiries from those treating and caring for her.

22.13 Similarly, opportunities were missed to question P with regard to the true origin of the injuries with which he presented. There is no evidence that either the selective or routine enquiry domestic abuse processes were implemented. Indeed, it appears that there was no consideration of domestic abuse at all, across all services within BCUHB, when either Julie or P presented with injuries. Additionally, even though both P and Julie disclosed that they were drinking alcohol heavily, there is no evidence of a referral to a specialist alcohol service.

22.14 The Neuro Development Team (NDT) took the decision not to undertake a neurodevelopment assessment of C, based on the information provided to them by the CAMHS team, as they determined that there was no evidence in the referral letter to suggest that C had a neurodevelopment disorder. Therefore, as C did not meet the criteria for assessment, they were not placed on the neuro development waiting list.

22.15 It would appear, from a review of the communication between the two teams, that the NDT have followed appropriate guidance and process. As the neurodevelopment assessment of C was declined by NDT the case was then closed by CAMHS, without further options being explored. It is important that the CAMHS team fully understand the criterion applied by the NDT.

22.16 **Flintshire County Council Social Services for Children**

22.17 The primary themes of the lessons to be learned from the review by the Social Services for Children Department relate primarily to the principles of effective record keeping and a lack of professional curiosity.

22.18 The decision not to visit the children, with regard to the two referrals, of 16th May 2011 and 27th January 2018, are not explained by any recorded rationale. The full context of the decisions taken, and the considerations applied prior to making those decisions are not recorded. More proactive steps could have been taken that would, in all likelihood, have resulted in a better understanding of the dynamics of the relationship of the parents and the family as a whole.

22.19 What is less certain is that, as a result of visits to the family home, the threat that P represented to Julie would have been identified but at least opportunities could have been created, via personal conversations, for Julie and/or the children to share any concerns that they had relating to P's behaviour.

22.20 There is poor case recording in terms of the casework transcript. It does not explain or contextualise actions or demonstrate clear decision-making outcomes. The process by which decisions were arrived at and what options were considered needs to be clearly evident in case files if they are to be retrospectively understood and act as a reliable record of events.

22.21 The quality of recording is inconsistent across the different types of referrals and their associated records. The attempts to speak to the parents were impacted by time delays which fall outside good practice expectations. The failure to physically meet the parents and/or children is also inconsistent and not properly explained or accounted for. The engagement with partner agencies is sporadic and the records demonstrate inconsistent attempts at establishing or sustaining effective and focused communication.

22.22 **Flintshire County Council – Education Services**

22.23 It is evident that the level of understanding and awareness of domestic abuse, and the potential opportunities for its identification, is insufficient within the Education Services community. The standard of record keeping has also, at times, been below the standard that should be attained by Education professionals.

22.24 It is apparent that domestic abuse awareness training would develop and enhance the current level of understanding as opportunities were missed to encourage or, at least, provide the appropriate environment for disclosures about their home environment from the three children of the victim, Julie.

22.25 There is no current system within the Education environment that enables a strategic or holistic overview to be applied to any safeguarding issues that relate to siblings, especially if they are at different schools. The fact that, in this case, the schools in question were located in two separate county council areas did not help any cross referencing that may have otherwise occurred, especially with regard to the two youngest children, had they stayed at the same primary school together.

22.26 The new Child Protection Online Monitoring and Safeguarding System (CPOMS) and the ONE system may enable such cross referencing to be achieved as the systems are able to work across Local Authority boundaries.

22.27 These systems, if utilised effectively, will enable an informed, overall understanding of safeguarding issues, as they relate to different members of the same family to be achieved.

22.28 The commencement of Operation ENCOMPASS, which was established in Flintshire in January 2020, should also facilitate better sharing of relevant information between the relevant public and Third Sector agencies, to the benefit of those who are the victims of domestic abuse.

## 23. Conclusions

23.1 It is clear that P was physically abusive to Julie, usually following his abuse of alcohol. Her multiple visits to NHS facilities, such as hospital, a Minor Injuries Unit or her GP, with a range of injuries are likely to have been the result of his physical abuse of her.

23.2 P's notable temper was a factor in much of his physical abuse of Julie and his previous partners, with alcohol often being the catalyst for that behaviour. P would also apply coercive control over Julie, sometimes seeking to control her personal behaviour, but there is insufficient evidence to conclude that such coercive control was a regular and consistent aspect of his abusive behaviour.

23.3 Whilst the review did not find evidence that he sought to assert such control over Julie with specific regard to the renewal of her friendship with the father of her eldest child, it is clear that his jealousy was a significant motivating factor in terms of the fatal attack that he perpetrated.

23.4 The link, between P's abuse of alcohol and his abusive behaviour had been known since 2003 and there was evidence that he used that abuse to control Julie, although it was not a consistent theme of his behaviour.

23.5 There was also evidence that she sought to manage her safety, and that of her children, when he was drunk, insisting that he leave the family home overnight or sleep in the camper van at the front of the house.

23.6 Effective measures were consistently taken by North Wales Police to manage the immediate threat that the perpetrator represented when they attended the respective incidents of domestic abuse embraced by this review.

23.7 However, the sustaining threat that P represented to women in the domestic environment was never effectively recognised or managed. This is despite the fact that his abuse of women and his use of physical violence to control them, often fuelled by alcohol, was undertaken in a small geographical area, sometimes in the same street.

23.8 Despite that threat not being recognised there was no continuing sequence of events, no chain of causation that went unchecked and subsequently led to the murder of Julie. Significant periods of years went by without the involvement of any agency with Julie, her children or the perpetrator.

23.9 The use of Clare's Law in the area would not have contributed to Julie's safety as it is evident that P's reputation for physical violence towards his previous partners was well known within the local community, including his previous imprisonment for violence. However, it is not known whether those members of the community who were aware of P's previous abuse of women knew where to seek advice and address any concerns that they may have harboured.

23.10 Consultation with North Wales Police and the lead Domestic Abuse and Sexual Violence Advisor in North Wales confirmed that a greater awareness and understanding of Clare's Law, and the related legislation, within the community and NWP would be of significant benefit for the future.

23.11 The standard of information sharing by the various public agencies who had significant involvement with Julie, her children and the perpetrator, prevented those agencies from working together effectively to identify and address any safeguarding concerns.

23.12 That information sharing was hindered by the similarly poor standard of information gathering, when key opportunities arose, to secure a better understanding of the domestic environment that endured.

23.13 There was a lack of professional curiosity from the health professionals that dealt with Julie, when she presented with injuries, with regard to the potential link of those injuries to domestic abuse.

23.14 The fact that the link to physical abuse was not determined diluted the true and complete understanding by the police and other agencies of the abuse that P was perpetrating. There was no evidence that he was ever referred to a perpetrator's programme, despite evidence of his repeated abusive behaviour being available to North Wales Police.

23.15 There was a similar lack of professional curiosity from the Social Services for Children staff involved with assessing and managing the referrals that related to Julie and her children.

23.16 Insufficient steps were taken by Social Services for Children staff to achieve personal interaction with Julie and her children that may have afforded an insight into their domestic environment and better informed the professionals involved of any risks that sustained.

23.17 However, it must be recognised that the referrals in question did not contain important aspects of information that would have better informed the assessments, such as P's relevant conviction and offending history.

23.18 Opportunities were not taken by the Education staff to obtain a better understanding of the children's domestic environment when dealing with them, and/or their mother, with regard to their attendance records or specific aspects of their behaviour.

23.19 There is a theme, throughout the review, of agencies fulfilling nothing more than their own, limited, function when dealing with Julie and/or P and not considering the broader picture in terms of what was a relationship in which Julie was being abused.

23.20 Furthermore, with regard to North Wales Police and BCUHB there is clear evidence that those individual functions were not fulfilled effectively as even the most basic standard of investigation and query is likely to have identified that Julie was the subject of abuse.

23.21 It is not unusual for victims of abuse not to volunteer details of their situation but if the Police and Health professionals demonstrated greater professional curiosity, and then shared that information with the other agencies, also, a more effective and informed assessment of the potential options could have been undertaken.

23.22 Any informed assessment of the risk that P posed to women, and Julie in particular, is likely to have concluded that that risk was significant, and sustaining, such was his long and continuing history of abusive behaviour.

## 24. Recommendations

### 24.1 North Wales Police

24.2 It is considered by the IMR author that the current police policies and procedures of North Wales Police address the shortcomings that have been highlighted within this review, so no recommendations have been proposed that relate specifically to new policy or procedure.

24.3 The relevant incidents of abuse that have been the focus of the review extend back to 2003 and, during the intervening period, the policing of domestic abuse has improved significantly.

24.4 The evidence provided to the review by NWP relating to current training and operational practice related to the 'Domestic Abuse Matters – Responding Well' training programme. The programme contained specific reference to multi agency working, including referrals, and had been formulated in response to the recommendations from a previous DHR in North Wales. Evidence was provided that the training programme is supported by specific, domestic abuse related, force policies and operational practices.

24.5 Whilst acknowledging the provision of that evidence, it is the view of the DHR Author, Chair and Panel that, due to the fact that the primary shortcomings in professional practice identified within this review relate to North Wales Police, it was considered by the panel to be appropriate that two recommendations should be made to ensure that existing policy and practice relating to Domestic Abuse is being implemented effectively.

24.6 To that end, the following recommendations were agreed by the panel.

### 24.7 Recommendation 1

The Chief Constable of North Wales Police should satisfy themselves that the current force policies and training relating to Domestic Abuse and Safeguarding, including how they relate to the sharing of relevant information with other agencies, are fully understood and are being implemented effectively by their officers and staff.

24.8 **Recommendation 2**

A staff training programme and an awareness raising campaign, both within the organisation and externally, should be undertaken by North Wales Police with regard to Clare's Law to ensure that the details of the legislation, and how it can be used, are understood by relevant NWP staff and within the community.

24.9 **Betsi Cadwaladr University Health Board (BCUHB)**

24.10 **Recommendation 3**

To ascertain compliance data, on a quarterly basis, in relation to the 'Routine Enquiry' Domestic Abuse process, across the three Emergency Departments in Ysbyty Glan Clwyd, Ysbyty Gwynedd and Ysbyty Maelor.

24.11 **Recommendation 4**

To provide bespoke training to the three Emergency Departments and Minor Injury Units across BCUHB, focussing on 'Routine Enquiry' Domestic Abuse, SafeLives RIC, referral to MARAC and other support services.

24.12 **Recommendation 5**

To fully implement the recently ratified Violence Against Women Domestic Abuse Sexual Violence (VAWDASV) Service User Procedure across BCUHB.

24.13 **Recommendation 6**

The Chief Executive of BCUHB to ensure that operational and strategic accountability for Domestic Abuse is clearly identified within the Corporate Safeguarding Team.

**Flintshire County Council Social Services for Children**

24.14 **Recommendation 7**

The Chief Officer – Social Services should ensure that organisational systems exist to monitor compliance with relevant organisational policies to ensure that when Partner Agencies make a referral to Social Services for Children that a clear, dated and auditable record of the communication between agencies is made. The context and rationale for any decisions, together with the outcome, should be recorded.

24.15 **Recommendation 8**

The Chief Officer (Social Services) should ensure that organisational systems exist to monitor compliance with relevant organisational policies to ensure that when a child is not seen, following a referral, that a clear rationale is recorded with a full account as to why that decision was taken, including context, considerations and rationale.

24.16 **Recommendation 9**

The Chief Officer (Social Services) should ensure that organisational systems exist to monitor compliance with relevant organisational policies to ensure that, when a matter is not constituted as a Section 47 investigation, there is a clear and rigorous record as to why that decision was made, the context of the decision, the rationale and the considerations undertaken.

24.17 **Recommendation 10**

The Chief Officer (Social Services) should convey a clear indication to key staff about the need for effective partnership working, embracing relevant legislation and guidance. That being, the Social Services and Wellbeing Act (2014), the Wellbeing of Future Generations (Wales) Act 2015, the Data Protection Act and, within the context of domestic violence, 'The National Strategy on Violence Against Women, Domestic Abuse and Sexual Violence' (2016-2021).

24.18 **Flintshire County Council – Education Services**

24.19 **Recommendation 11**

The Chief Officer (Education and Youth) should undertake the following: -

To review the compliance amongst staff of Group 1 of the National Training Framework on Violence Against Women, Domestic Abuse and Sexual Violence.

To ensure the implementation of Group 2 (referred to as 'Ask and Act') of the National Training Framework for relevant Education professionals.

To ensure the implementation of Group 3 (referred to as 'Enhanced Understanding of VAWDASV for Organisational Champions) of the National Training Framework for relevant professionals, if deemed appropriate.

24.20 **Recommendation 12**

Head Teachers in Flintshire and Denbighshire to satisfy themselves that such training, as detailed in Recommendation 10, is taking place and that its provision is being recorded.

24.21 **Recommendation 13**

The Chief Officer (Education and Youth), to cause a review to be undertaken of the information sharing processes and protocols that are currently in place in Flintshire and Denbighshire to ensure that the effective sharing of safeguarding related information between schools and colleges, especially in terms of siblings or other members of the same family group, can be achieved effectively.

24.22 **Recommendation 14**

School staff to apply professional curiosity to ensure that matters of concern do not go undetected and recorded with pupils. Education staff need to satisfy themselves that current processes and systems are both rigorous, robust and provide assurance that matters of concern do not go undetected across the school staffing group.

## APPENDIX ONE

## TERMS OF REFERENCE

Whether family, friends or colleagues were aware of any abusive behaviour demonstrated by the perpetrator towards the victim, prior to the homicide.

Whether there were any barriers experienced by the victim, her family, her friends or her colleagues in reporting any abuse in Flintshire or elsewhere, including whether she knew how to report domestic abuse should she have wanted to.

Whether there were opportunities that were missed for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim.

Whether there were opportunities that were missed for agency intervention in relation to domestic abuse regarding the victim of the perpetrator.

To identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

To give appropriate consideration to any equality and diversity issues that appear pertinent to the victim and/or the perpetrator, such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

## APPENDIX TWO

## DISSEMINATION LIST

- The Family of The Victim
- Flintshire County Council
- North Wales Police
- North Wales Fire & Rescue Service
- Welsh Ambulance Service NHS Trust
- Betsi Cadwaladr University Health Board
- Denbighshire County Council
- Office of The Police and Crime Commissioner for North Wales
- North Wales Safeguarding Board

## APPENDIX THREE

## LIST OF THOSE REFERRED TO IN THE REPORT BY THE USE OF A LETTER

**A** The eldest child of Julie, aged 16 years at the time of her murder (not the biological child of P)

**B** The second child of Julie, aged 11 years at the time of her murder (child of P)

**C** The third child of Julie, aged 10 years at the time of her murder (child of P)

**D** A previous partner of P, the first person known to have reported being assaulted by him, in December 2003. (He was given a custodial sentence for the assault.)

**E** A previous partner of P who ran from her home, in January 2004, when P arrived there angry and abusive.