

# Flintshire Community Safety Partnership- Domestic Homicide Review

## **Executive Summary of the Overview Report**

### **Into the homicide of Marie on 14<sup>th</sup> September 2014**

2017

**Panel Chair: Jenny Williams: Strategic Director of Social Care and Education Services,  
Conwy.**

**Independent Author: Sue Maskell. MA AASW CQSW**

## Acknowledgement

It is very important for us to acknowledge that in producing such a report as this we are looking at the circumstances of the life and death of someone who was valued and dear to her family members and that the family are left to deal with their shock and sorrow. We can only hope that our efforts to learn lessons from the tragic loss of their family member Marie (pseudonym), has not added to their distress. So, in the production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality; balancing the need to maintain the privacy of the family and the need for agencies to learn those lessons related to practice, which have been identified during the review of this case and also of course, acknowledging that this report will become public as is required by the Home Office.

Additionally, and perhaps unusually we have contacted and/or interviewed past partners of the offender, who came forward to the police after the murder of Marie. We are grateful for their willingness to be engaged in this process, knowing the distress that they experienced in doing so. It is important to acknowledge that it is their expressed and firm wish that lessons might be learned from their experiences and that these lessons might prevent harm occurring to others.

## **1. INTRODUCTION**

**1.1. This Domestic Homicide Review examined the circumstances surrounding the death of Marie (pseudonym). Marie was a 45 year old woman who lived in a small rural village in Flintshire. Marie was murdered on the 14th September 2014. Marie was divorced and she had never lived and with the offender (P1).**

**1.2. Marie was a much loved family member she had two children and she also had a mother, siblings, nieces and nephews, who all live in the local area. So Marie was a mother, a sister, a daughter and an aunt, she is sorely missed by her children and her family. Marie had a stable home life and worked for a company in a nearby town.**

**1.3. During the course of the police investigation it was established that Marie had only recently met P1, the man who murdered her. They met through an internet dating site, which is not unusual these days. They had been seeing each other for only a few weeks prior to Marie's death, the exact time being unclear, but estimated to be between four and six weeks. The relationship was therefore in its earliest stages and P1 and Marie did not live together.**

**1.4. On the 13th September 2014 Marie had been out with her nephew to a public house in a nearby town and P1 joined them there. It was stated to the report author, by a family member, that Marie had mentioned that P1 was a jealous man and possessive, and so it is thought by her family that Marie had intended to end her relationship with P1. Given that is the view of the family; it is interesting that although P1 had joined Marie at the public house. Marie then returned without him to her home, being taken there by her nephew in the early evening as Marie was due into work the next day. It appears though, that shortly afterwards P1 arrived at Marie's home.**

**1.5. A 999 call was made from the mobile phone of Marie after her return home from the public house. The telecommunications operator said they could not hear anything and so the call was not forwarded to any emergency service. During the course of the DHR the police were asked again to check the circumstances of this call.**

**1.6. The police told the report author that after Marie's death, a transcript of the 999 call was made by North Wales Police. This transcript could only be made from a significantly enhanced audio and even after that significant enhancement, the call was still not clear. Unfortunately, the evidence is that the operator would not have been able to hear what was being said by Marie or P1 at the time. The call was made at 19.07 hours on 13th September and lasted only 12 seconds. There is nothing to be heard in the transcript to indicate whether Marie was asking for help during the call.**

**1.7. P1 attacked Marie on the evening of 13<sup>th</sup> September 2014. During the course of the attack he assaulted and strangled her. P1 admitted that he had waited to call an ambulance and this was indeed mentioned in the Judge's summing up at the sentencing**

hearing. P1, when he was interviewed for the purpose of this DHR, confirmed unsolicited, that he waited a long time to call the ambulance.

- At 02:35 hours on 14th September 2014 the Welsh Ambulance Service received an emergency call from a man, now known to be P1, who stated that he had found his girlfriend (Marie) unconscious on the floor after she had been drinking, the caller was given advice regarding resuscitation.
- A Community First Responder (CFR) was dispatched to attend and was the first person to arrive at the home at 02.50hrs
- At 02.57hrs the CFR confirmed that Marie was in cardiac arrest. After the ambulance arrived advanced life support resuscitation was initiated, however, tragically at 03.09hrs Marie was confirmed to be dead.
- At 03.11hrs the police were informed of the incident and arrived at the address at 03.35hrs.
- At 03.44hrs, following initial enquiries; P1 was arrested on suspicion of the murder of Marie.
- At 18.31hrs on 16th September 2014, P1 was formally charged with the murder of Marie and was remanded in custody, pending a Crown Court appearance.

1.8. Subsequently, on 19th December 2014, P1 appeared before Crown Court where he pleaded guilty to the murder of Marie and he was sentenced to life imprisonment with a recommendation that he must serve at least 17 and half years before he is considered for release. In his sentencing address the Judge said that Marie had died as a result of asphyxiation and strangulation and she had been severely beaten in a ferocious attack.

## **2. The Review Process**

**2.1. This summary outlines the process undertaken by the Flintshire Domestic Homicide Review Panel in reviewing the death of Marie.**

**2.2. On the 26th September 2014 Flintshire Community Safety Partnership convened an extraordinary meeting at which it was agreed that the circumstances of the death of Marie met the criteria for a Domestic Homicide Review and that a review should be conducted in accordance with Home Office Guidance and the guidance developed by Flintshire Community Safety Partnership.**

**2.3. On the 29th September 2014, the Chair of the Flintshire Community Safety Partnership, the CEO of Flintshire County Council, formally notified the Home Office of the intention to carry out a Domestic Homicide Review.**

**2.4. At the first panel meeting it was reported by North Wales Police that proceedings had been initiated in relation to offences committed against five further women who had come forward following the reporting of the murder of Marie and who reported being the victim of domestic violence related offences committed against them by P1.**

**2.5. As a result of the investigations that were conducted into their accounts, P1 was additionally charged with seven charges of Actual Bodily Harm in respect of 4 of the Victims. At his court appearance P1 pleaded 'not guilty' to these additional charges. As a result of his guilty plea to the offence of murder, a decision was made that the seven additional charges would not be proceeded with and were ordered to 'lie on file'.**

**2.6. It was agreed in a panel meeting in January 2015, to communicate with the Chief Crown Prosecutor in Wales, outlining the panel's wish to extend the parameters of the DHR to encompass the period of the relationships that P1 had with the additional alleged victims. In order for the Panel to do this, authority was sought from the Chief Crown Prosecutor to include in the DHR those 7 prosecution cases that had been ordered to 'lie on file'. The Chief Crown Prosecutor provided his authority for the cases to form part of the review.**

**2.7. During the subsequent initial review of these cases it was identified by the panel that some of the relationships dated back to 1991. So, the panel agreed that the review would remain focused on the period from 1st May 2005 to 14th September 2014. The reason for this decision was that the panel had concluded that processes and procedures had changed significantly since 2005 and so the context of the reported earlier assaults would be measured against processes that had by now been significantly changed and therefore any lessons likely to be learned would in fact already have resulted in changed law, policy and practice.**

**2.8. However, this notwithstanding, there was an exception and this was because after the DHR report author accessed the statements, made by 5 of the women who came forward, it was found that, allegedly, P1 continued to make serious threats to the woman known hereafter as V2. So, although V 2's relationship with P1 took place before the 2005 timescale of the review (V2 was P1's first wife), panel agreed that V2 should be offered an interview as part of this process; an offer which V2 accepted.**

**2.9. The panel were eventually informed that a total of eight women approached North Wales Police after the death of Marie was reported in the press. Whilst seven of these women had provided formal written statements to the police; one woman was spoken to by police but declined the opportunity to provide a formal written statement.**

**2.10. Again with the agreement of the Chief Crown Prosecutor the independent author was given access to all of the statements, and to the written record of the conversation with the woman who did not wish to make a formal statement. Two of the statements and the written record were read by the author later than the first 5 and were considered by the panel to be in the category of additional information, largely because they did not result in any charges being brought as part of the proceedings following the death of Marie.**

**2.11. It was agreed by panel, following review of all the statements by the report author, that three of the original 5 women who had made statements should be approached and asked if they would be willing to be interviewed as part of the DHR. Of these 5 women, four had made statements resulting in 7 charges. In addition all five women would be asked for their consent to use the information they had given to the police as part of this review. Each gave their written consent.**

**2.12. Three women were interviewed directly by the independent author, two in the company of another panel member. We offered to see one woman, V3 with the DHR report later but she declined that opportunity. A further woman, V1, was spoken to by telephone. No charge was filed in respect of an alleged assault on V1 who first knew P1 in childhood; she met him again within the timeframe of the DHR, via the internet.**

**2.13. A further issue arose when the panel were informed, as a result of reading statements, together with the information contained in a timeline prepared by the police, that there had been a child protection case conference in respect of the children of another former wife of P1. (Hereafter, the former wife of his second marriage will be called V3) Although, this conference took place outside of the time period that was subject of the review, the fact that that there had been a child involved by P1 in an incident of Domestic Abuse, led the panel to request the case conference report so that it could be considered as part of the DHR. It was January 2016 before the minutes of the conference were obtained due to issues around gaining consent and also being certain in which authority the case conference occurred.**

**2.14. The result of having access to the above information can be summarised like this:**

**A. Had other witnesses not come forward, the homicide of Marie would have resulted in a brief DHR due to the fact that the relationship of P1 and Marie lasted only about 4 to 6 weeks. The fact that the statements made by other witnesses resulted in seven charges which were left on file, indicated that there may be lessons to be learned about the response to and management of cases of Domestic Abuse across the agencies prior to the homicide of Marie, the link in all these cases being P1.**

**B. Panel recognised that the potential lessons to be learned arise during a period where law, processes and procedures concerning Domestic Abuse have been modernised and where attitudes have changed, both in the professions and amongst the general public.**

**C. Given there was a Child Protection Case Conference, the Panel believed that there may also be lessons to be learned in the child protection field, even though this conference fell outside the original timescale of the review. Nevertheless, it fell within a period when the impact of Domestic Abuse and its connection to child abuse was already recognised.**

**D. It was the murder of Marie that led to this DHR and so in exploring the other information given by the women it was agreed that a full review of their cases would not result, but even so, if necessary, other agencies involved with the witnesses would be asked to contribute and supply information for panel to review.**

**2.15. The process of the DHR began in January 2015 but due to the above circumstances it was delayed and at that time a report author had not yet been appointed. The review was underway by June 2015 when the report author attended her first meeting with the panel.**

**2.16. This is an unusual DHR report because the scope of the Domestic Homicide Review widened due to the number of witnesses that came forward after the tragic death of Marie in September 2014, at the hands of P1. The report also took longer than expected to complete due to the information that came to light during the review and which panel decided should be considered as part of the review. The full detail of the various reasons for delay is laid out in the main report in the appendix which contains the terms of reference.**

### **2.17. The Family**

**As part of this DHR the family of Marie were offered the opportunity to participate in the review. The offer was initially made by officers from North Wales Police who had supported the family during the investigation. Then through letters from the Chair of the DHR Panel with the Home Office leaflet attached. The communication led to the author of the report meeting with Marie's sister. It was agreed with the sister of Marie that if other**

family members wanted to participate directly then that would be arranged and she agreed to tell them about this and she was given further leaflets to enable the family to understand the process and purpose of participation in the review. The author met with Marie's sister again to go through the report and recommendations with her in July 2016. Since then the family have been kept up to date by letter.

2.18. Although a meeting had initially been arranged with the ex-husband of Marie who is the father of her children, he did not attend as arranged. However, he and his children were offered a further opportunity to do so. He asked to meet with the author when the report was completed and this meeting did take place, he told us that he had made the children aware of this process and talked to them about it. The report author showed him the report content, which applied to Marie and the recommendations of the review.

2.19. At the first meeting with Marie's sister, who said she was representing Marie's family, the main issue raised was about the silent 999 call that we believe Marie made on the night of her murder. The fact a call was made is very distressing for the family, who think that Marie would have been hoping that help would come and yet that hope was in vain. The panel debated this issue at some length and have made a recommendation in regard to the use of mobile phones to call for help, which follows at the end of this summary. After the Quality Assurance process by the Home Office, it was suggested that we should consider referencing the Silent Solutions Scheme and we have done this. Though we should be clear that the call Marie made was of only 12 seconds duration and the operator could not hear and request. This system seems little known about by the general public and many professionals. Clearly that situation needs resolution as recommended by the IPCC in late 2016, after completion of this report.

#### Other participants and offers of participation

2.20. The adult children of P1 were also offered an opportunity to participate. This approach was facilitated through their mother. The offer was declined.

2.21. The offender, P1 was also interviewed as part of this review. He made two main points. To summarise; one point was that he thought that internet dating was fraught with issues and that people rarely told the truth about themselves and he thought therefore that there should be more protection on these sites and more information about the risk. The second had to do with mental health. P1 felt that he should have been more persistent in seeking help for his own mental distress and that he should not have said he was doing fine when in fact he was not. P1 also thought mental health services were not given sufficient priority.

2.22. The agencies participating in the review are:-



- Aneurin Bevan University Health Board (ABUHB)
- Betsi Cadwalader University Health Board (BCUHB)
- Employer of Marie
- Employer of P1
- Flintshire County Council Social Services
- Flintshire County Council Education Service
- National Probation Service
- North Wales Police
- North Wales Fire and Rescue Service
- Sandbach Health
- The Royal British Legion
- Welsh Ambulance Service
- Wrexham Local Authority Children's Services
- CPS who gave consent to use the statements relating to offences which remain on file

**2.23. Agencies were asked to give chronological accounts of their contacts with the victim and/or perpetrator prior to the homicide. Where agencies had no involvement or no significant involvement, they informed the review accordingly. In line with the terms of reference, the DHR covered a ten year period prior to the death of Marie. Additionally, the review explored the case conference, which took place in 2001, which was outside of the original timeline set but which the panel felt was relevant to the history of the offender.**

**2.24. Only one of the above listed North Wales agencies had no contact with the victim or perpetrator and that agency was the North Wales Fire and Rescue Service. Of those contacted none had any kind of contact with Marie during the time that she knew P1, outside of that which is normal, i.e. school or GP contact, until they were called to her home on the night of her murder. Eight agencies had contact with P1. Again none of these contacts occurred during his relationship with Marie until the night of her murder. So with the exception of the normal contact a person would have with their employer, there was no agency involvement with either the victim Marie, or the perpetrator P1 during the short duration of their relationship.**

### **3 Terms of Reference**

#### **3.1. The Purpose of the Domestic Homicide Review is to:**

- Establish what lessons can be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply those lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and interagency working.

(The full Terms of Reference are appended to the DHR report)

#### **4. Key Issues**

**4.1. The DHR provided an opportunity to analyse information obtained from the agencies, the family of Marie, the perpetrator, and the previous partners of the perpetrator whose statements to the police after Marie's death resulted in the 7 charges which remain on file.**

**4.2. In particular Marie's Family asked the review to consider the issues which arise from the use of silent 999 calls to call for help. The panel did debate this at some length and have made a recommendation regarding silent 999 calls. We also after the Home Office letter, considered the Silent Solutions Scheme as referred to in the conclusion of this summary report.**

**4.3. The review also considered whether any of the nine protected characteristics of the Equality Act influenced decisions made by organisations in their contacts with Marie, The Perpetrator and the other victims we interviewed during the review. The panel is satisfied that there were no equality issues.**

**4.4. In regard to the first three purposes of Domestic Homicide Reviews stated above, we found:**

- There were no reports of Domestic Abuse to any agency during Marie's brief relationship with P1. There was no indication through the normal involvement that people have with their place of work or their GP, or in relation to the child still at school (in any of his contact with the school), that anything was amiss. Therefore, there was no mechanism for agencies to communicate with either Marie or each other during Marie's relationship with P1.
- We did not identify any trigger that would have caused Marie to communicate with agencies or to ask for help, before the night of her death, when it is believed she made a brief and silent 999 call.
- There is no evidence, that we know of, that any agency had any cause to act, or that any agency missed any opportunity to identify that there was anything amiss in Marie's life. This was such a brief relationship that, as stated above, agencies

had not received any reports of any incidents or concerns, which would have prompted any intervention.

- Given the length of the relationship and the lack of any evidence that there was cause either for Marie to contact an agency or for an agency to contact her, we did not find that any action on the part of any agency could have prevented the death of Marie. We have taken account of hindsight bias and we have concluded that in the case of the death of Marie, there was nothing that the agencies could have done to prevent her murder.
- Even if P1's past had been thoroughly collated in records the serious nature of P1's behaviour would not be apparent to anyone, unless Marie, or a third party who was concerned for her, or her children's safety had cause to use the DVDS or CSODS schemes. We have not found any evidence that Marie had cause to make any checks on P1 in the few weeks she knew him. Neither have we found any evidence to suggest that any agency came into contact with Marie during that period of time and had cause themselves to make any background checks on P1 or to advise Marie of any risk that she may be subject to.
- Even if Marie had cause to make any check on P1, with the police for instance, there would have been no record available of his activities pre 2005 on the Police National Computer if the incident had not resulted in a charge. However, details of these incidents would be available on local police systems and dependent on their nature i.e. if they involved child protection / domestic abuse issues may also have been recorded on the Police National Database (PND), if the force where the incident occurred had an electronic record of the incident on their systems .

4.5. If there is one thing we have learned from this review it is that recording offending behaviour really matters, as does the ability of statutory agencies to access that information. Had today's system been in place in 2001 it would have captured the offences for which P1 was charged, but not convicted, in Wrexham and improved information sharing between agencies, when he committed an offence of Common Assault in Flintshire in 2006.

## **5. Lessons to be learned/Prevention of Further Domestic Homicides**

In regard to the fourth purpose of the DHR, the prevention of further domestic homicides and domestic abuse, we made three main findings in relation to the murder of Marie.

### **5.1. Silent 999 calls**

5.1.1: Marie, we believe, must have been concerned for her own safety that night the 13th September 2014, as it is believed that she was the person who telephoned 999 to get help at 19.07 hours. We do not know if she attempted to speak and was prevented from doing so by P1, or whether she made a silent call believing that someone would understand from the call that she needed help and would be able to trace the call and come to her

aid. The enhancement of the recorded call does not assist us further in reaching a conclusion.

5.1.2: It is an urban myth, probably supported by TV programmes, that silent 999 calls always produce an emergency response. It has become customary for parents for instance, to give children mobile phones so that they know where their children are and most of us believe that if the child phoned 999 they would somehow be traced if in need of rescue. This is clearly not the case because, as we have discovered, there are many 'silent calls' in a day and these are not all passed to the police. (We note that there are numerous commercially available 'location sharing applications' for smartphones, which when installed to on to the mobile phone, enable users to identify the locations of others and share their own location via the App and some people install this on their children's phones).

5.1.3: The volume of silent calls (up to 30 million emergency calls per annum, thousands of these are not emergencies but are made by children or accidental calls), means that any plan to trace them is not sustainable within the resources likely to be needed. The other point to make is that whereas a landline can be traced to an address, a mobile would only be traceable to an area covered by a mobile phone. Some mobiles, 'Pay as You Go', are not registered in the same way as contracted phones. Therefore, the protection for potential victims and their families can only lie in debunking the myth that help will always come if any of us make a silent 999 call. We acknowledge, following the Home Office's comments that a system called Silent Solutions is in place. However, this system seems little known about by the general public and many professionals. Clearly that situation needs resolution as recommended by the IPCC in late 2016, after completion of this report.

5.1.4: The DHR Panel have discussed this matter at some length and are of the opinion that if Marie made the silent 999 call herself, then it was with the expectation that she would be helped. This view is probably held by a large number of people and so for safety's sake it is important that the message is given nationally that silent 999 calls, especially from mobiles, are not guaranteed to bring help. In extreme need and lacking the ability to speak, which would apply to Marie, the Silent Solutions system may help, but as stated above that system needs much more publicity for both the public and professionals. Furthermore, in this case the silent call was extremely brief lasting 12 seconds.

## **5.2. Internet Dating**

The panel recognised that there are risks associated with meeting any new partner but these risks may be to some extent increased by the use of social media, which facilitates offenders in finding new victims over wide geographical areas. We concluded that more

public information about keeping safe on line and about taking precautions when meeting new people is needed, given the proliferation of this method of dating.

### **5.3. Offender contact with General Practice**

**5.3.1.** The last two recommendations in regard to the section of the review, which applies solely to the murder of Marie, arose from the chronological history of the offender's consultation with his GPs. As stated above, P1 was interviewed as part of this review and gave consent to access his health records. P1 said that he should have been more persistent in seeking help for his problems, which he defined as mental health issues. The review found that there was some evidence that P1 had indeed from time to time sought help. Firstly he sought help of his own volition, from a substance misuse service in 2001 when he was offered an appointment, which he did not attend. He then sought help from time to time through his GP for what might be termed mental distress; often this appears from the information we had, to coincide with the time that relationships ended. We found that he did not follow through in terms of his engagement with services when referred by his GP, which led to case closure by a mental health access team, when he told staff that he was managing. He has stated that he now regrets that he was not more insistent with staff that he needed help. He is also adamant that he suffered from PTSD but we found no evidence of formal diagnosis of PTSD we found only self-report by P1 to his GP and to the women he met. It is important to note that when P1 last saw a GP it was regarding a physical problem in July 2013 not a mental health issue.

**5.3.2.** So, in the light of the above information the panel concluded that there is potential to consider the role of GPs and other Health Workers when patients report to their GP that they experience angry outbursts and mention that allegations of violence have previously been made against them. Panel noted that this issue arose in a previous DHR presented to the Home Office and that there is guidance for GPs when a person reports they are being abused but guidance is less clear when a person reports characteristics and events, which indicate they may be a risk to others. So we recommend that nationally the role of GPs and Health Workers in reporting potential Domestic Abuse is considered in terms of both developing guidelines for GPs and Health workers and also GP training in this regard. Locally plans are now in place for training (see BCUHB recommendations). We also recognised that the legal and ethical limits on patient confidentiality may be an issue for staff and so we recommend these are re-considered in terms of Health Professionals being given clear guidance about how to manage when Domestic Abuse issues arise in discussion with their patients or are indicated by their patient's presentation.

**5.3.3.** As stated above it is important to be clear that a DHR is not an enquiry into how a victim dies or into who is culpable, as those matters are for Coroners and criminal courts to determine. In this case however, P1 admitted he murdered Marie and he was sentenced to serve a minimum term of 17 and half years in prison.

## **Lessons Learned for the remainder of the Domestic Homicide Review**

**6.1. The remainder of the DHR explored the previous relationships of P1, which provided an extensive insight into his history; it also provided a background context for his behaviour towards Marie, which tragically led to her death.**

**6.2. During the timescale set by the panel in the terms of reference for the DHR, (which was the ten years before Marie's death in September 2014); the panel became aware of 8 women, in addition to Marie, who had some involvement with P1. Some relationships are reported to be very brief, lasting for only a month or few weeks. Others lasted 6 months or a year most were not 'live in' relationships. P1 was twice married prior to the timeframe of the review, though one divorce coincided with the start year of the 10 year timeframe.**

**6.3. Five women report having met P1 on line, adding to the importance of the recommendation made by panel about the use of internet dating sites. One of these women was in contact with P1 having not seen him since her youth. This woman, V1, said she ended the relationship swiftly, after being assaulted by P1 in front of another person. All the women mention in their statements to the police that they, not P1, ended their relationships.**

**6.4. When P1 was interviewed by the report author he mentioned that he had suffered from PTSD (see above). Some of the statements made by the women, who contacted the police after the death of Marie, also mention that P1 told them he suffered PTSD. He also spoke to us of being emotionally abused by his father when a child. We were told that he gave the women he met various reasons for the alleged PTSD; according to the women, these reasons ranged from childhood abuse, to losing his first wife and children through divorce, trauma in service with the RAF and suffering Domestic Abuse himself. PTSD was, according to the medical records we have seen, never formally diagnosed, so it appears that PTSD was a self-reported condition.**

**6.5. This report illustrates that P1 was skilled at the grooming and control of both individuals and environments. P1 would hide his behaviour in the plain sight; not only of his victims but of his work colleagues too, this was part of P1's grooming process. We found evidence that P1's offending behaviour stretches over 23 years and in that time we were told that he had assaulted and controlled his victims and caused fear and alarm to children and in the case of one child, physical injury. The evidence we have seen indicates that P1 had a modus operandi, which was about seduction and possession and control, which eventually led to alleged serious assault of at least 4 women, an actual conviction for assault in 2007 and eventually to Marie's tragic death.**

**6.6. It is important to restate here that the DHR does not have the purpose of enquiring into how a victim died, or into who is culpable, as those matters are for Coroners and**

criminal courts to determine. So therefore, similarly, in terms of the Panel looking at the past relationships of P1, it is with the intention of exploring whether lessons could be learned by agencies, which may help future victims of Domestic Abuse and prevent homicides and not to allocate culpability. The DHR focused upon the five women from whom the police took statements of complaint that led to the 7 charges in respect of four of them, these charges still remain on file. These women were called by Panel, V1 to V5. Consent was gained from these women to use the information they gave within the DHR.

6.7. P1 entered a plea of not guilty to the additional 7 assault charges made against him. Following his guilty plea to the murder of Marie these charges remain 'on file'. This review explored the information given to it and could not comment on the veracity, or otherwise of the information given, since the cases remain on file. So this information is used acknowledging that whatever the outcome of any potential future hearing, the women who participated told of their own experience and their own reality, for which the panel is very grateful.

6.8. From the evidence gathered during the DHR there were four major areas that the panel and therefore the report focused upon:

#### **7. The first additional area covered by the review: A Child Protection Case Conference 2001.**

7.1. The First area explored by the DHR Panel was a Child Protection Case Conference in Wrexham in 2001. The Child Protection Case Conference took place due to a violent incident attended by the police. The conference occurred much earlier than the review timeline but panel felt this event was relevant to the DHR, as evidence of the length of time over which the behaviour of P1 (which finally led to the homicide of Marie) persisted and in particular because a child was recorded as being injured on the occasion that the Child Protection Case Conference covered. P1 was charged in relation to these injuries but the case did not proceed.

7.2. We acknowledge in the DHR that since 2001 there have been many changes to practice, policy and procedure. Indeed there has also been new legislation in relation to Domestic Abuse and also a new Children Act in 2004 and more recently the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act, 2015. From the panel's point of view, and as far as the DHR is concerned, the most important conclusion from this section of the DHR was that all workers, from every discipline, should be certain to exercise 'professional curiosity' and carefully risk assess the ability of a victim of Domestic Abuse to protect children, especially when the abuse is severe and there is no clear evidence that a relationship is ended.

7.3. The panel concluded that the timescale of involvement of SSD with the family in Wrexham was very short given the situation and the seriousness of the assaults reported.

It could be argued there was insufficient time to test out the plan, which was put in place with the family. The Social Worker was optimistic about the parents' cooperation, however the grooming and control of the offender was seminal to any full assessment of risk, and this element of the assessment of risk is not fully apparent. With the value of hindsight we found that P1 was still very much part of the life of V3 at the time the case was active in Wrexham. We now know that the children, both the subject child and her siblings and P1's children stayed at the family home when P1 was present against the terms of the protection plan, though we have no evidence that this occurred before Social Services closed the case, or whilst the couple lived in Wrexham. We do know that the children had staying access and were left in the care of P1 whilst the mother worked and after the couple had moved to Flintshire and P1 and V3 had married.

7.4. So, the Panel wish to emphasise that practitioners should be careful to consider all children who may be in regular contact with a violent person and not only those who are permanently resident in a household, where there is domestic abuse, as there may be children who have regular 'staying contact'. The Panel is in agreement with Wrexham Social Services Department's conclusion that practice has changed since 2001 and we agree about the importance of the use of genograms and thorough information sharing between agencies; but in child protection cases this information should also be shared between counties when families move. We know that not all the children in this matter resided in Wrexham or Flintshire. Domestic Abusers may well have children from previous relationships and they too should be considered when assessments are made and their parent/carer should be informed of any risk to them as a result of any new investigations.

7.5. The Panel also made the observation that risk assessment tools are now used in Domestic Abuse cases and these are of course very useful but they are no substitute for 'Confident Competent Practitioners' who take into account all the information available and are also alert to an offenders' attempts to groom and control environments and workers, as well as their victims.

## **8. The second additional area explored by the DHR Panel**

### **Verbal Threats against V2**

8.1. The second period the panel considered, involved V2 who was P1's first wife. V2's relationship with P1 also preceded the timescale of the review. However, when V2 was interviewed by North Wales Police following Marie's death, she stated that very serious verbal threats continued to be made towards her, many years after her divorce from P1, and some of these threats fell within the DHR timescale.

8.2. V2 married P1 and lived in RAF accommodation with him at the start of the 1990s. The author interviewed V2 for the purpose of this review and she explained how she had suffered a severe level of violence, which began straight after her marriage to P1 and



whilst he was serving in the RAF as an RAF police dog handler. Having heard V2's story one of our aims was to ensure that the level of violence that V2 reported and which is alleged to have taken place on RAF premises, would result in more proactive action and protection for victims than it had in the past.

8.3. We found that there is no national protocol/arrangement for how the Armed Services and Civilian Police respond to and manage Domestic Abuse incidents relating to service personnel or their families; or to Domestic Abuse incidents which take place on Ministry of Defence property. Therefore, the panel thought it appropriate that a recommendation is made that a protocol is developed for North Wales between any Military Forces based here, currently this would be the RAF, and the North Wales Police. Panel also recommend to the Home Office that such protocols should be a national requirement as this would provide consistency of response.

8.4. Moving evidence was given to the DHR by V2 about how she suffered and yet was not listened to by agencies in the past, especially when she lived abroad on an RAF base. There was also evidence from her that that practice issues about attitudes and approaches to victims need to be followed up in training. These practice issues are about the need to be sensitive to victims when they contact services at any level, from the receptionist or call handler, to the police officer or court official. To do this, all staff should keep at the forefront of their own minds the courage victims need to find, in order to make contact with services and the fear they have of doing so. Not forgetting that violence and control may well increase if the perpetrator becomes aware of the contact.

8.5. V2 told us about a call she made when she became aware, through her own children, of the fact that the children of V3 were not allowed to stay with V3 if P1 was present. V2 said being concerned about the safety of her children she contacted the police and social services. The panel are of the opinion that when V2 did this she was not given sufficient information with which to protect her children. So the panel concluded that parents and carers should always be given enough information to assist them in protecting their children when they make enquiries due to concern about the risk an abusive person may present. So, panel have recommended that workers are given sufficient training support and guidance to enable them to be confident about what information they can give. The guidance and training should also direct workers to the statutory avenues now available regarding information sharing such as the CSODS and DVDS

8.6. We wish to note that we learned a great deal from speaking to victims about the lasting impact of trauma on families who suffer domestic abuse and the difficulties still inherent in seeking help.

**9. The third area of the second part of the DHR concerned the only criminal conviction of P1.**

**9.1. The review found that there was an incident, which took place at the end of 2006 and for which P1 was convicted and sentenced in 2007.**

**9.2. P1 met V4 after his relationship with his second wife, V3, ended. P1 was working locally in Flintshire and he moved in with V4. They were introduced by mutual friends. V4 told us that she was not only assaulted at home but also, like some other women P1 met, at a scooter rally. V4 said that the children were in the house when the assaults at home took place. They would be upstairs and were told not to come down if anything happened. However, sometimes assaults would spill into the children's rooms. In fact it was one of the children who called the police after the assault, which took place in the early hours of the 19th December 2006; the police had already been called by V4 late on the evening of the 18th December 2006 and had already visited the house.**

**9.3. We found that there were failings in 2006/7 and these are summarised below:**

- Whilst we acknowledge the independence of courts, we hope that courts can also benefit from the learning in DHRs. We found that the court did not, it appears, follow Probation's recommendation in 2006, which means an opportunity to address the offender's behaviour through mandating that he attend the IDAP course was missed.**
- Poor recording practice was evident in Social Services records.**
- A lack of support to and communication with the victim by agencies, particularly face to face, led to a missed opportunity to discover that the order made by the court, which prohibited P1's contact with V3, had been breached.**
- A failure by the social worker to carry out the home visit recommended by the Domestic Abuse panel and her supervisor to assess the risk to the children.**
- Lack of any follow up support to the children or face to face assessment of the risk to them and to P1's birth children, who were sometimes present at V3's home.**
- It appears that in 2006 there was some knowledge of the assaults which took place previously in Wrexham. However, it is not clear whether this was passed on in any way which would have assisted the assessment of risk by Social Services and the Domestic Abuse Panel.**

**9.4. Panel noted that there is, from December 2015, a remedy in law which did not exist throughout the period when P1 was apparently abusive and controlling of a number of women. The panel also notes that a national advertising campaign is, at the time of writing the report, raising awareness about 'Coercive Control', which should be a core**

element of all training across the multi-disciplinary network in North Wales and elsewhere.

9.5. The new 'Violence against Women, Domestic Abuse & Sexual Violence (Wales) Act' 2015, requires that the Welsh Government National Training Framework be embedded across Wales. This multi-level training framework will ensure availability of quality and consistent training across all public services, which is aimed at raising awareness of Gender Based Violence, Domestic Abuse and Sexual Violence, changing attitudes and improving the nature and quality of support provided to victims. The police though are not included in this requirement for training, so we have recommended that local police forces will need to ensure their PVPU officers access it, as is commensurate with their duties.

9.6. The panel notes that the assault carried out in 2006 and described by V3, illustrates the importance of the role of the IDVA. It also illustrates the importance of face to face assessment of risk to children and of communication with victims; including the nature of that communication, which needs to be sensitive to the level of fear and trauma suffered.

9.7. Lastly it was clear from our interview with V4 that P1 was known to be violent by a number of people and that neither neighbours nor friends reported their concerns to any agency. At the time of writing this review it seems the reluctance to report concerns about domestic abuse is as strong as ever, despite national awareness of Domestic Abuse and the continuing development of responses to it and despite the level of public access that now exists to reporting helplines.

9.8. Given the length of time since P1's conviction in 2007 the Panel notes there are a series of improvements that have already been made by the agencies but there are also additional recommendations from the National Probation Service and Flintshire County Council Social Services as a result of the findings of the DHR and these recommendations and action plans are attached to the DHR. In addition to the recommendations made by the agencies, the panel also made recommendations and these follow this summary.

#### **9.9. National Probation Service**

9.9. 1. The NPS recommended that offender managers should ensure they undertake multi-agency checks at key stages of supervision and review. So, Probation Offender Managers have been reminded of the importance of making checks with relevant agency colleagues at key stages of review; the outcome being improved risk assessment and management of cases informed by multi-agency information

9.9.2. NPS also recommended that Offender managers should ensure regular contact with cases with non-supervisory requirements. So, Offender Managers have been reminded of the importance of ensuring that interviews are arranged with cases at key stages of

sentence plan review, to ensure assessments are current and reflect the circumstances of the case.

#### **9.10. Flintshire Social Services Department**

**9.10.1. Flintshire Social Services recommended that it was important to incorporate the impact of domestic violence on children and young people into the Social Services' single assessment document and assessment process, so that children and young people's needs are identified and appropriate support provided.**

**9.10.2. Flintshire also recommended that their procedures for domestic violence are reviewed and updated to cover:**

- **Standard referral processes to MARAC where there are 14 or more risks identified in the 'Safer Lives Tool' or there are significant professional concerns**
- **The requirements for PNC checks for DV cases**
- **Active consideration of the network of contact that perpetrators of domestic violence have with children and young people and the need to notify/share information for their safety**

**9.10.3. The third recommendation that Flintshire made was about case recording guidance which needed review and updating to ensure that there are clearly articulated standards for appropriate case recording.**

**9.10.4. Work has already begun on Flintshire's recommendations as can be seen in the action plan.**

#### **10. The fourth area explored by the DHR Panel**

**10.1. There was an incident, which occurred at a Royal British Legion Bikers Rally in Wales, in July 2013, which resulted in the need for the victim's hospital attendance.**

**10.2. The assault on V5 took place in July 2013, and as described by her, is consistent with the other reports about the behaviour of P1. These reports were made to the police after Marie's death by women who do not know each other and are not in contact with each other. V5 described the assault as a very forceful open handed slap to the head, that she said "was maximum impact, least visible damage," a description that fits entirely with the statement made to the report author by V4. At the time of the assault P1 had again been drinking and indeed alcohol is said to be a frequent factor when P1 attacked his partners, though the report author has been told that this was not always the case. When he was interviewed for the purpose of this DHR by a panel member and the report author; P1 denied the level of this assault, and his responsibility for it.**

**10.3.** This assault was very upsetting, frightening and indeed traumatising for the victim and her daughter. Those who were in contact with her at the time of the assault failed to assess the level of impact and seriousness of the abuse. The trauma has had a long lasting impact on V5 and her daughter.

#### **10.4. Aneurin Bevan University Health Board**

The Health Board responsible for the hospital that V5 visited are ABUHB and they acknowledged that processes which were in place in the hospital at the time of V5's attendance were not followed. In the intervening time, Domestic Abuse Training has been provided to staff and a dedicated Domestic Abuse ABUHB web based site has been established for staff as a resource and as part of an awareness raising campaign. Going forward recommendations, which were made by ABUHB, will focus upon the 'Ask and Act' guidance across the organisation. Outcomes will be monitored through the Health Board procedures and the Regional statutory Violence against Women, Domestic Abuse and Sexual Violence Board, on which ABUHB has senior representation.

#### **10.5. These recommendations were;**

**10.5.1. Recommendation 1:** To increase the identification of those experiencing violence against women, domestic abuse and sexual violence and to offer timely referrals and interventions for those identified as at risk. [This guidance also addresses the direct link between domestic abuse and child maltreatment]

Aneurin Bevan University Health Board must ensure that the targeted enquiry under the statutory guidance 'Act and Act'; is implemented across the organisation.

**10.5.2. Recommendation 2:** Aneurin Bevan University Health Board works to the All Wales Child Protection Procedures [2008]. To remind frontline staff to consider the risk to children and the need to make a child protection referral, when a parent or close relative is identified as experiencing violence against women, domestic abuse and sexual violence.

#### **10.6. The Royal British Legion**

**10.6.1.** The rally organisers, who are volunteers, did to some extent deal with the situation following the assault; they took V5 to the hospital and the next day to the train station and they separated P1 from her. However, panel concluded that there was a failure to appreciate the seriousness of such violence and from what we have been told during this DHR, P1s behaviour was known to members of the TRBL Bikers Group prior to July 2013.

**10.6.2.** TRBL is a much respected, indeed revered organisation in British Life, the DHR Panel concluded that as such, TRBL need to ensure that their organisation, at every level, has a zero tolerance of Domestic Abuse and follows procedures laid down by the organisation.

**10.6.3. Panel have recommended that TRBL develop a specific policy and procedure in order to manage such incidents and that their mission statement in TRBL Safeguarding policies contains a statement of zero tolerance of Domestic Abuse.**

**10.6.4. TRBL also need to ensure that the organisation does not appear to condone such abusive behaviour by allowing anyone to remain in any kind of role, which appears to give them authority, once a member has offended in this way.**

**10.6.5. The Royal British Legion has written to panel stating that they accept these recommendations.**

**10.6.6. The CSP Board recommended that WCVA and NCVO provide guidance for all Voluntary Organisations, which ensures a robust standard for Child and Adult Protection Procedures within Voluntary Organisations and provides procedures for reporting Domestic Abuse. The guidance should make a statement about nil tolerance of Domestic Abuse. Guidance should also be provided for voluntary organisations about participation in DHRs and other serious case reviews.**

## **11. Learning about the behaviour of the offender from Victims**

**11.1. Given the commitment of members of the public to the production of this Domestic Homicide Review we felt that the Executive Summary should contain a summary of learning from the interviews with women and the statements made available to the DHR.**

### **11.2. Hiding Offences in plain sight**

**As a panel we were told how P1 habitually told the women he met and also at times workers he met, about his past offending behaviour, which he minimised. This meant that people felt he was being open and honest with them. This tendency of P1 to self-revelation led to the people around him thinking that his behaviour was explicable and that he was changing, or would change. We found during this DHR that there is still a tendency for people to “Take people as they find them”. In the case of those who commit serious abuse of their partners, this is a dangerous stance for potential partners to take. The panel concludes that there should be more emphasis in Domestic Abuse literature and advertising on how victims are groomed and controlled, because P1’s tendency to hide his violent behaviour in plain sight; was a common theme evidenced throughout this review and no doubt part of his grooming technique.**

### **11.3. Alcohol Use, Abuse and Violent Behaviour**

**Unsurprisingly, we found that P1 had often been drinking before he was physically abusive. P1 recognised, during the interview with him, the risk of his behaviour re-occurring if he was in a ‘drinking’ situation. However, it should be noted that he was described as possessive and controlling to an extent which amounts to coercive control, even when he had not been drinking. Several of the women used the expression of**

walking on eggshells, because it was not possible to know what would trigger P1 to lose his temper.

#### **11.4. Minimising Offences**

As stated above P1 did not hide his past, he talked openly about it. This had the effect of women knowing about his past before anyone else told them; therefore they thought he was being honest, open and reformed. P1 made well controlled and almost disguised, disparaging remarks about victims when interviewed for this DHR. Whilst he did not go as far as to say assaults were their fault, he nevertheless made sufficient mention of their characteristics so as to hint that they were not all innocent victims. In this he totally minimised his own responsibility for his behaviour. He was able though to admit he was a big man and that a victim would be very afraid of him. He made no attempt to diminish his responsibility for the murder of Marie.

#### **11.5. Assaults on parts of body where injury is less evident**

The pattern of assault described to us was fairly consistent, with the head being usually the target. This would often mean that injuries were hidden by hair. Several women commented to us that they were hit “like *he’d done it before*”. Other injuries were in areas more likely to be clothed and so we conclude that practitioners should be extremely wary of making assumptions when they do not immediately observe physical injury, when they are attending Domestic Abuse situations, or dealing with victims of abuse.

#### **11.6. Calls late at night**

Whether or not P1 consciously knew that late at night the resistance of people is lower or that they are more fearful, we don’t know. We do know that the women were often contacted late at night and that they were less able to either cope with his threats or resist his demands. This is part of the grooming and control process. It is now recognised that people are checking their phones at all hours and take tablet devices and phones to bed. One way of reducing the threat from abusive and controlling behaviour is simply to reduce the possibility of late night contact by having a social media and phone curfew and so only answering devices when rested and when other people and agencies are more easily contactable.

#### **11.7. Access to help lines**

Whilst on the subject of phones, we perceive there to be increased reliance on support being offered via phone helplines. It is therefore important to note that some victims feel that using such support may not be possible due to coercive control being exercised over their lives and also a preference for face to face contact for instance from a drop in centre. So there is certainly a need for other forms of support.

## **11.8. Seeking help**

**11.8.1.** Much of what we have heard from victims is about how hard it still is to seek and use help, (including medical help for injuries), to report offending behaviour and to recover from being groomed, controlled and assaulted. We heard how hard it is to realise what is actually happening to you as a victim, especially if you are normally a strong competent woman running a family and with a working life. The women we spoke to said they had the feeling that ‘this simply does not happen to people like me’.

**11.8.2.** We heard from their mothers how children are traumatised by Domestic Abuse and how they so often suffer from hearing or seeing abuse and in one case being directly physically assaulted. We heard how children try to move on by not talking about what happened.

## **11.9. Reporting by neighbours, friends, family and the General Public**

Of significant importance is encouraging reporting by victims, friends, neighbours and relatives, when they know abuse is occurring. People need supporting and protecting when they come forward. It was clear to us that in spite of all the progress made in managing cases of Domestic Abuse we still have a long way to go, in order that victims feel safe enough not only to report abuse but also to go through with a prosecution. The same applies to the ‘post reporting stage’, in terms of victims feeling able to access suitable help for their physical and emotional injuries.

## **11.10. Quality of Practice**

In many ways our findings on balance are much more about quality of practice than about procedure. We heard from the Victims we spoke to how important every step of dealing with them is and how that is about empathy and receptiveness, from the very first stage. This applies from the point at which victims contact reception staff, to contact with professionals who see people in A and E or a GP surgery and extends to contact with volunteers. Personal engagement and a listening approach, without doubt makes a difference as to how able victims are to proceed to disclosure. Post disclosure support also matters because of the evidence that trauma is very hard to recover from. Therefore, the DHR Panel have made a series of recommendations about training of staff, with an emphasis on a listening empathic approach to dealing with Victims.

## **13. Recommendations and assigned responsibility**

### **RECOMMENDATIONS**



**Recommendation 1: Mobile Phones and Calls for Help: Recommendation for Regional Domestic Abuse Advisor and National Recommendation for Welsh Assembly and Home Office, to be monitored and progressed locally by the Safer Communities Board**

11.23: Where a person had dialled 999 from their mobile phone then unless they provide details of the nature of the emergency situation and give details of their location information to the BT Emergency Call Handler help is not guaranteed to come. This is especially true for those persons who use unregistered 'Pay as You Go' mobile phones. Users of mobile devices are less likely at any rate to be located than those who use landlines.

So:

- a) All spoken advice and leaflets nationally and locally should reflect the above.
- b) The advice and guidance given on how to seek help in an emergency situation and the pitfalls of relying on silent calls needs to form part of any training or publicity.
- c) The Silent Solutions method needs wide ranging and frequent publicity and needs to feature in advice leaflets, procedures and training for all agencies who give advice, or assist victims of Domestic Abuse both locally and nationally.

**Recommendation 2: The Risks Inherent in Internet Dating: National Recommendation**

We recommend that there is a national information advert about the risks inherent in using internet dating sites and personal disclosure on line. This should include information on how to meet safely, and on recognising the first signs of coercive control and abuse and what to do about that.

**Recommendation 3: Advice on Safeguarding whilst using Internet dating sites: Local Recommendation North Wales: Community Safety Partnership.**

We recommend that advice on safeguarding whilst using internet dating sites and other social media should be included in those areas to which we already have ready access and can make changes this includes; council safeguarding web sites, domestic abuse advice web sites and leaflets and police advice pages.

**Recommendation 4: Training for GPs and Health Workers regarding patient's disclosures that may indicate Domestic Abuse: Local BCUHB and National Recommendation.**

We recommend that training is provided to GPs and Health Workers about how to recognise and deal with Domestic Abuse issues that may arise in discussion with their patients, including how to manage disclosures from patients about abuse, which they indicate they may be perpetrating against their partner or family members.

**Recommendation 5: National recommendation regarding 'Threshold Guidance' and training for GPs and Health workers regarding patient's disclosures that may indicate**

## **Domestic Abuse. Home Office with Royal College of Physicians and the Royal College of Nursing**

We recommend to the Home Office that discussion take place with the Royal College of Physicians and the Royal College of Nursing to ensure that the legal and ethical limits on patient confidentiality are re-considered in terms of Health Professionals being given clear guidance about how to recognise and manage when Domestic Abuse issues arise in discussion with their patients or are indicated by their patient's presentation. This should include how to deal with disclosure from patients about significant anger control issues, which may indicate to a GP or other Health Worker that the patient may be a danger to others, including the patient's partner or children.

### **Recommendation 6: Protocol between Military and Civilian Police Services: North Wales Police and RAF Valley.**

We recommend that a protocol for managing incidents of Domestic Abuse is developed between North Wales Police and RAF Valley.

### **Recommendation 7: Protocol between Military and Civilian Police Services: National Recommendation to Home Office.**

We recommend that nationally consideration is given to developing protocols between civilian police forces and military police services across the British Isles where they do not already exist.

### **Recommendation 8: The Importance of a listening and empathic approach in all staff contact with victims: North Wales Regional Safeguarding Board.**

Panel recommends that supervision and training of staff across the multi-agency network, including training of reception and ancillary staff, emphasises the importance of a listening and empathic approach. This training should ensure that staff keeps at the forefront of their minds the courage that it takes to ask for help or to report abuse.

### **Recommendation: 9 Awareness of increased danger when victims report abuse: North Wales Regional Safeguarding Board Adult and Children and Regional Training Consortium VAWDASV Strategic Board.**

We recommend that staff are trained to recognise that when a person is reporting domestic abuse or planning to leave an abuser that the victim of abuse is likely to be at increased danger if the perpetrator becomes aware of their action or intention.

### **Recommendation 10: Procedural Guidance on the Disclosure of adequate information to parents so that they can protect their own children: North Wales Regional Safeguarding Board/Adult and Children.**

We recommend that all agencies concerned with safeguarding check that their procedures give sufficient guidance to staff to ensure that workers disclose adequate information to

parents and caregivers of children and vulnerable adults in order that parents and carers are able to protect those for whom they care. This guidance should include reference to schemes that are already in place such as the Domestic Violence Disclosure Scheme (Claire's Law) and the Child Sex Offender Disclosure Scheme, which was introduced in order to raise public confidence and increase the protection of children. This disclosure scheme includes routes for managed access to information, regarding not only those individuals who are convicted child sex offenders, but who pose a risk of harm to children. Such persons would include those who have been convicted of serious domestic violence.

**Recommendation 11: Training and Supervision relating to disclosure of information to parents: North Wales Regional Safeguarding Board Adults and Children.**

We recommend that training and supervision of staff responsible for safeguarding should always include a reminder of their duty to give sufficient information to parents and carers so that vulnerable children and adults are protected.

**Recommendation 12: Following up on recommended actions from Supervision by Senior Workers: Flintshire County Council.**

Flintshire Social Services should ensure that during the supervision of fieldwork social workers that supervisors carefully record the instructions given to the worker. Supervisors should then check that the instructions have been carried out. Supervisors should note that these tasks have been completed and if not should make sure that they are promptly followed through.

**Recommendation 13: Clear Recording of Decisions, and reasons for decisions, in Decision Making Forums: North Wales Safeguarding Boards for Children and Adults**

We recommend that agencies should review their recording policies to ensure that all decisions and recommendations from panels, case conferences and other decision making forums are clearly recorded and that the reasons for those decisions are clear in the notes of the meeting.

**Recommendation 14: National Recommendations to the Home Office regarding the role of Courts:**

Whilst we recognise the independence of the courts and that sentencing guidelines exist we make a national recommendation that Courts consider carefully the opportunities that may be missed to moderate an offender's behaviour if they do not follow the recommendations of the National Probation Service in those cases where it has been identified that it would be appropriate and beneficial for the offender to attend a treatment programme. If the court decides not to follow such a recommendation the reason should be documented.

**Recommendation 15: Retention of Court Records: Home Office**

We recommend that nationally, court records should be retained for a sufficient period so that any review, such as a serious case review or DHR, can benefit from access to those records. Ten years would be a reasonable timescale.

### **Recommendation 16: Recommendation from DHR Panel to National Training Consortiums Wales**

*(Panel notes that it is already a requirement that all front line staff and managers in Wales will be trained on national minimum standards for implementation of the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. A Regional Training Consortium will be set up in North Wales for the purpose of rolling out the delivery of Welsh Government National Training Framework and will run for 5 years).* **The panel recommends that the findings of the DHR are fed to the organisers and trainers in order to ensure that training emphasises that assessments must be robust and dynamic and not over reliant on single tools.**

### **Recommendation 17: The use of Tools in Domestic Abuse work and The Importance of Assessment: North Wales Regional Training Consortium.**

17. a. We recommend that training and supervision focuses upon quality assessments which emphasise the use of professional curiosity and judgement and avoids over reliance on tools.

17.b. Professionals should be trained to recognise that tools are frameworks for the collection of information and to assist in assessment but they are not the complete assessment of risk; which should be a dynamic process involving the collection and evaluation of all the relevant information available including the voices of victims and families. 'Safe Lives' is part of that assessment and not the whole of it; the outcome of the use of the 'Safe Lives' tool should be measured together with all other information available.

17. c. When making an assessment in cases of domestic abuse the focus on the victim should not detract from also gaining sufficient information about the perpetrator to protect those with whom he has or is likely to come into contact. So agencies need to note that 'Safe Lives', which has replaced the 'CAADA DASH' tool, does not cover this area of an assessment currently. Therefore, assessors must ensure they gain sufficient information about a perpetrators circle of contacts to ensure the safety of all other vulnerable contacts is taken into account.

### **Recommendation 18: Recommendations re: Training to the North Wales Regional Training Consortium**

18. a. The Panel recommend that training programmes ensure that practitioners and their managers are careful to consider all the children and young people who may be in regular contact with a violent person and not only those who are permanently resident.

18. b. The training of frontline staff, that attend multi-agency meetings and make assessments in regard to victim safety across the age ranges, should include a section which

covers the grooming and control of workers and of the multi-agency network. This is in recognition that abusers attempt to control environments, including professionals as well as their victims.

18. c. Training on risk assessment in domestic abuse should include reference to the phenomena of hiding offences in plain sight, as this is similar to 'Disguised Compliance' in child protection work and can mislead and falsely reassure practitioners.

18. d. Training needs to help practitioners explore the complexity of working in the area of personal relationships and to raise awareness of the conflicts of loyalty which exist for the victim when reporting abuse or considering ending relationships.

**Recommendation 19: Involvement of relevant North Wales Police personnel in the regional training in respect of the implementation of the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015: North Wales Police**

Panel notes that the police are not included in the requirement for training regarding the implementation of the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and so we recommend that Domestic Abuse Officers and PVPU officers in Wales undertake training that is commensurate to their role.

**Recommendation 20: TRBL has a zero tolerance approach towards Domestic Abuse.**

We recommend that The Royal British Legion has a mission statement in its safeguarding policies which makes it clear that TRBL has a zero tolerance approach towards Domestic Abuse.

**Recommendation 21: Managing Partner Based Violence on the premises or at events organised by or on behalf of TRBL**

We recommend that TRBL develops a specific policy on managing incidents of Domestic/Partner based violence that occur either on their premises or at events that are organised by or specifically on behalf of TRBL.

**Recommendation 22: Holding positions in TRBL when it is known a member has carried out an act of Domestic /Partner Abuse: The Royal British Legion**

We recommend that TRBL ensure that all its officials and organisers think very carefully about placing anyone in any position within the organisation, however lowly the role, after they have committed an act of Domestic Abuse at a TRBL event. We say this because doing so not only gives the message that tolerance of such abuse exists within the organisation but it may further assist the ability of the perpetrator to coerce and control others.

**Recommendation 23: Recommendation to Welsh Council for Voluntary Action and National Council for Voluntary Organisations regarding the need for clear guidance that ensures adequate standards for protection procedures in voluntary organisations.**

We recommend that WCVA and NCVO provide guidance for all Voluntary Organisations, which ensures a robust standard for Child and Adult protection procedures within Voluntary Organisations and provides for procedures for dealing with and reporting Domestic Abuse. The guidance should include a nil tolerance stance to Domestic Abuse. Such guidance should also refer to the various serious case reviews which may take place for instance Child Practice Reviews, Adult Protection Reviews and Domestic Homicide Reviews and the importance of full participation in these reviews when requested.

**Recommendation 24: Advice to victims to switch off phones and devices late at night: Community Safety Partnership**

We recommend that advice to victims given directly or via leaflets, on line etc. includes advice to switch off phones and devices to avoid being contacted when made vulnerable by tiredness or being awoken from sleep.

**Recommendation 25: The importance of a listening approach: Community Safety Partnership and NWRSB.**

We recommend that supervision and training across the multi-agency network, including training of ancillary and reception staff, emphasises the importance of a listening approach and aims at ensuring that staff keep in the forefront of their minds the courage it takes to ask for help and to report abuse.

**Recommendation 26: Recognising there is a risk of increased danger to victims when reporting abuse: Community Safety Partnership**

We recommend that staff are trained to recognise that when reporting domestic abuse or planning to leave an abuser, a victim is likely to be in increased danger if the perpetrator becomes aware of this.

**Recommendation 27: Support for Family, Friends, Neighbours and the General Public: Welsh Government Proposed Publicity Campaign:**

The panel will request that the Welsh Government publicity campaign regarding Domestic Abuse includes reference to supporting family, friends, neighbours and the general public to report abuse and how they can report.

**Recommendation 28: Supporting the public to report Domestic Abuse: National Recommendation: Home Office and Welsh Government.**

We recommend that national discussions about further developments aimed at the prevention of Domestic Abuse includes how relatives, neighbours, friends and the general public can be encouraged and supported to report abuse.

## FLINTSHIRE DOMESTIC HOMICIDE REVIEW

### Terms of Reference

#### 1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Flintshire Community Safety Partnership in response to the death of Marie on 14<sup>th</sup> September, 2014.

1.2 The DHR has been commissioned as the death meets the criteria defined in the statutory guidance issued by the Home Office of an incident involving 'a person to whom he was related or whom he was or had been in an intimate personal relationship' (Home Office 2011:5). This is a statutory requirement under the Domestic Violence, Crime and Victims Act 2004.

#### 2. Chair and Membership

2.1 Jenny Williams, Strategic Director of Social Care and Education Services at Conwy County Borough Council has been appointed as Chair of the review panel. Jenny Williams has had no contact with any family member or any of the women who came forward. She is chair of the regional Safeguarding Children's Board and a member of the National Safeguarding Board.

The following organisations are represented on the panel:

Organisation
Betsi Cadwaladr University Health Board
Conwy County Borough Council
Domestic Abuse Safety Unit
Flintshire County Council
National Probation Service
North Wales Police
North Wales Fire and Rescue Service
Welsh Ambulance Service Trust

### **3. Purpose of the Domestic Homicide Review Specialist Panel**

- 3.1 Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- 3.2 Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- 3.3 Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- 3.4 Apply these lessons to service responses including changes to policies and procedures as appropriate and
- 3.5 Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- 3.6 Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

### **4. Scope of the Review**

- 4.1 The Panel will focus on the period between 1<sup>st</sup> May 2005 and 14<sup>th</sup> September 2014.
- 4.2 Within the scope of the review all significant and relevant contacts made with the deceased (during the time of her relationship with the perpetrator); the perpetrator; and any other identified persons.
- 4.3 Organisations who have had significant contact with those persons identified in section 4.2 will be requested to participate in the review process, and may be required to complete an Individual Management Review (IMR), as directed by the Panel.

### **5. Purpose of Individual Management Reviews**

- 5.1 The following areas will be addressed in the Individual Management Reviews and the Overview Report:
- 5.2 Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.



- 5.3 Whether there were any barriers experienced by the victim or her family/ friends/colleagues in reporting any abuse in Flintshire or elsewhere, including whether she knew how to report domestic abuse should she have wanted to.
- 5.4 Whether there were opportunities for professionals to ‘routinely enquire’ as to any domestic abuse experienced by the victim that were missed.
- 5.5 Whether there were opportunities for agency intervention in relation to domestic abuse regarding the victim or alleged perpetrator that was missed.
- 5.6 The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services.
- 5.7 The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, alleged perpetrator e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

## **6. Sharing of Information**

- 6.1 Partners and organisations that have been approached by the Panel to share information should refer to the Home Office’s Statutory Guidance on Domestic Homicide Review, should issues regarding consent arise.
- 6.2 Legal queries regarding information sharing will be addressed by Flintshire County Council’s Legal Department, and should also be considered by the legal department of the respective organisations.

## **7. Publication**

- 7.1 The Panel will follow the guidance set out by the Home Office in respect of publication. It is a requirement that the Overview Report shall belong within the public domain.
- 7.2 The Panel will identify persons who should have sight of the report and overview report, prior to publication.

## **8. Frequency of Meetings**

- 8.1 Meetings will be convened at the direction of Chair. The administration and co-ordination of the Review will be undertaken by Flintshire County

## Appendix 2

Acronym	Meaning
ABUHB	Aneurin Bevan University Health Board
A and E	Accident and Emergency
AWCPP	All Wales Child Protection Procedures
BCUHB	Betsi Cadwalader University Health Board
BT	British Telecom
CAADA DASH	Co-ordinated action against Domestic Abuse Stalking and Harassment
CEO	Chief Executive Officer
CFR	Community First Responder
CID16	Criminal Investigation Department reporting system for sharing information with SSD
CPS	Crown Prosecution Service
CSODS	Child Sex Offender Disclosure Scheme
DA	Domestic Abuse
DA Panel	Domestic Abuse Panel
DAO	Domestic Abuse Officer
DHR	Domestic Homicide Review
DVDS	Domestic Violence Disclosure Scheme
GP	General Practitioner
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advisor
IMR	Internal Management Review
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference

NHS	National Health Service
NPS	National Probation Service
NSPCC	National Society for the Prevention of Cruelty to Children
NWP	North Wales Police
OASYS	
PNC	Police National Computer
PTSD	Post-Traumatic Stress Disorder
PVPU	Protection of Vulnerable People's Unit
P1	ID given to the perpetrator of the victim
RAF	Royal Air Force
RAG	Risk Assessment Grading
Section 47	Shorthand for the requirement to investigate child protection concerns under the Children Act 1989
TRBL	The Royal British Legion
SSD	Social Services Department
WAST	Welsh Ambulance Services NHS Trust
V1, V2, V3, V4, V5	Ex Wives or Ex Partners of P1