FLINTSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW
RELATING TO THE HOMICIDE OF 'JULIE'
IN OCTOBER 2018

EXECUTIVE SUMMARY

CONTENTS

Introduction

1. This is an executive summary of the Domestic Homicide Review (DHR) commissioned by the Flintshire Community Safety Partnership in relation to the murder of 'Julie' by her partner at their home address, in Penyffordd, North Wales in October 2018.

2. Comment: *Julie is a pseudonym chosen, in consultation with Julie's children, all of whom were minors at the time of her murder. Julie had no other family. Due to their respective ages, and the trauma of having lost their mother in such violent and tragic circumstances, the children understandably chose to make only a limited contribution to the DHR process. The DHR panel fully understood this position and extended their sincere condolences to the children for their sad loss.*

3. On the morning of a date in October 2018 North Wales Police attended at the home address of Julie, having received a phone call from the landline there. The call was made by a man who identified himself as Julie's partner. He indicated in the call that he had caused her mortal harm.

4. When officers from North Wales Police attended the property and conducted a room search it was quickly established that Julie, who was found upstairs in the bathroom, had been the subject of a brutal attack that had resulted in her death. Her partner, who had waited at the property, was immediately arrested and taken into police custody. Following several interviews he went on to be charged with Julie's murder.

5. Having subsequently been notified of the death, and the related circumstances, by the Senior Investigating Officer (SIO) the Flintshire Community Safety Partnership met and agreed that a DHR should be conducted in accordance with Home Office guidance.

6. A panel was convened and held their first meeting on 7th March 2019. An independent Chair and Author were, respectively, identified and agreed. However, following representations to the panel from the SIO, with regard to ongoing lines of enquiry, it was agreed that the DHR should not formally commence until the ongoing criminal justice proceedings had been concluded.

7. In May 2019 Julie's partner was convicted of her murder and sentenced to life imprisonment with a minimum tariff of 22 years.

Contributors To The Review

8. It became evident during the course of the DHR that Julie, her partner, and her children had interacted with a range of public agencies during the period that they had lived in Flintshire, which dated back in excess of 20 years.

9. The agencies in question, and which contributed to the DHR, were as follows:

- North Wales Police
- Betsi Cadwaladr University Health Board
- Flintshire County Council Social Services for Children
- Flintshire County Council Education Department

10. As primary contributors the above agencies were represented on the DHR Panel. The following agencies were also represented on the panel to ensure that all relevant knowledge and expertise was available both to the Independent Chair and Author during the course of the DHR:

- National Probation Service
- Welsh Ambulance Services NHS Trust
- North Wales Fire and Ambulance Service
- Independent Domestic Violence Advisor.
- Flintshire County Council Community Safety

The Purpose of The Review

11. A Domestic Homicide Review is a learning exercise and not a means of apportioning blame.

12. The purpose of a DHR 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.

- Prevent domestic homicide and improve service response for all domestic violence victims and their children through improved intra and inter agency working.

- Contribute to a better understanding of the nature of domestic violence and abuse.

- Highlight good practice.

13. The review also sought to understand the following, in terms of whether improvement could have led to a different outcome for Julie:

- Communication and information sharing between agencies with regard to the safeguarding of adults and children.

- Communication and information sharing within agencies.

- Standards of professional and organisational practice.

- Domestic Abuse policies and protocols.

- Whether the service provided in this case, by the respective agencies, represents effective and efficient multi - agency working.

Terms of Reference

14. The following Terms of Reference were provided to the Independent Author by the commissioning body;

- Whether family, friends or colleagues were aware of any abusive behaviour that was 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.

- 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, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Scope of The Review

15. As the police homicide investigation had identified that the perpetrator had a long history of abusive relationships with women it was agreed by the DHR Panel that the scope of the DHR should extend back to 2002 to ensure that all relevant relationships were identified and embraced.

16. This year was chosen as the early stages of the police investigation had established that a previous partner had been violently attacked by the perpetrator in 2002, and that North Wales Police had attended the incident. As a result the incident in question became the commencement point for the DHR.

The Brief Circumstances

17. Julie was aged 46 when she was murdered, in October 2018, by her 51 year old partner, with whom she had been in a relationship since 2003. Julie had a sixteen year old child from a previous relationship whilst she and her partner had two further children, aged 11 and 10 years, respectively, at the time of her murder.

18. Her partner was a violent and belligerent man with a significant drinking habit. He also had a long history of abusing previous female partners, several of whom gave evidence against him at his trial.

19. The father of Julie's eldest child had recently bumped into his teenage child at a local car action and that meeting had prompted renewed communication, such as text messages, between him and his child, as well as with Julie, also. He then started to visit them both at their home or, more usually, in a motor home that was parked outside the front of the property.

20. It is believed that this renewed communication, and the jealousy that it prompted, was the primary motivator for the subsequent fatal attack on Julie by her partner.

21. That attack came one morning in October 2018 and came to the attention of North Wales Police as a result of a phone call from Julie's partner who indicated during the call that he was responsible for her death.

22. Upon the arrival of the first police officers they found Julie's partner in the garden of the property under the influence of alcohol and in clothing that was heavily bloodstained. As he was taken into police custody he told the arresting officer that Julie could be found upstairs, in the bathroom.

23. A search of the property revealed that a violent altercation had taken place and Julie was subsequently found, as indicated, in the bathroom. Such was the gravity of her injuries, it was immediately clear to the police officers that Julie was dead.

24. A heavily bloodstained claw hammer was later found in the rear garden of the property next door. It was later identified as the weapon used by Julie's partner to inflict her fatal injuries. A subsequent forensic post mortem examination recorded the cause of death as 'severe blunt force head injury due to multiple hammer blows.'

Engagement With Family Members

25. Julie's two youngest children were met by the DHR Author, in the company of the Police Family Liaison Officer (FLO). However, they did not provide any information that was of significant value to the DHR.

26. Similarly, Julie's eldest child was also met, in the company of the FLO and her biological father, but no information of any value to the review was imparted during the meeting.

Key Issues Arising From The Review

27. Both Julie and her partner were well known to a number of public agencies, particularly Police, Health, Education and Social Services.

28. There was a theme, throughout the DHR, of agencies often fulfilling nothing more than their own, limited, professional function when dealing with Julie, her children or her partner. This resulted in the broader perspective, in terms of their abusive relationship, not being recognised and, in turn, addressed.

29. The referrals made by North Wales Police to their partner agencies, usually following allegations of domestic abuse, consistently lacked the relevant offending history of the perpetrator. Relevant context was not provided and, thus, fully informed decisions and assessments were not able to be made.

30. The risk that the perpetrator represented to women was never fully identified and acted upon by North Wales Police. This is despite their knowledge of his abuse and violence towards women extending back to 2002.

31. The need for effective, improved record keeping by Social Services professionals, supported by the need to apply appropriate professional curiosity, was highlighted as essential.

32. Julie presented six times to the NHS, in the form of her GP, a Minor Injuries Unit and the Emergency Department of her local hospital, between 2005-17. On each occasion she had injuries that were significant in terms of her being the victim of domestic abuse.

33. There is no evidence that specific consideration was given to the issue of domestic abuse by the health professionals that treated her. It appears that no enquiry was made with her as to the true cause of her injuries.

34. A more proactive exploration of the reasons for absences, truancy or specific behaviours at school, by the various Education professionals involved, may have achieved a better understanding of their home environment and how it may be contributing to their behaviour.

35. An understanding and awareness of domestic abuse and of the potential opportunities for its identification needs to be improved across the public agencies that came into contact with Julie and her family.

Conclusions

36. The relationship between Julie and her partner was an abusive one, in terms of his abuse of her. He often sought to assert physical control over her, usually following his abuse of alcohol.

37. Whilst no evidence was identified within the review that her partner sought to assert control over Julie with specific regard to the renewal of her friendship with the father of her eldest child, it is clear that her partner's jealousy was a significant motivating factor in terms of his fatal attack upon her.

38. The sustaining threat that Julie's partner 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, was undertaken in a small geographical area, and sometimes in the same street.

39. 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.

40. 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, both within the community and the officers and staff of North Wales Police, would be of significant benefit in the future.

41. The poor standard of the information sharing by the public agencies involved prevented them from working together effectively to identify and address any safeguarding concerns.

42. The 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.

43. There was a lack of professional curiosity demonstrated by the health professionals that dealt with Julie with regard to the potential link of her various injuries to domestic abuse that she was suffering.

44. Insufficient steps were taken by Social Services 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 with regard to any risks that sustained.

45. Opportunities were not taken by Education professionals to obtain a more informed understanding of the children's domestic environment when dealing with them and/or their mother.

Recommendations

1. The Chief Constable of North Wales Police should be satisfied 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 officers and staff.

2. A staff training programme and awareness raising campaign, within the organisation and externally, should be undertaken by North Wales Police with regard to Clare's Law. The primary aim would be to ensure that the details of the legislation is understood by NWP staff and within the community.

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

4. To provide bespoke training to the three Emergency Departments and Minor Injury Units across the Betsi Cadwaladr University Health Board (BCUHB), focussing on 'Routine Enquiry' Domestic Abuse, SafeLives RIC and referral to MARAC and other support services.

5. To fully implement the Violence Against Women, Domestic Abuse, Sexual Violence Service User procedure across BCUHB.

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

7. The Chief Officer for 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 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.

8. The Chief Officer for 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.

9. The Chief Officer for 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, including the context, considerations and rationale.

10. The Chief Officer for 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, Wellbeing of Future Generations (Wales) Act 2015 and the Data Protection Act 2018. Also, within the context of Domestic Abuse, the National Strategy on Violence Against Women, Domestic Abuse and Sexual Violence, 2016-2021.

11. The Chief Officer, Education and Youth, should ensure;

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

    The implementation of Group 2 (Ask and Act) of the National training Framework for relevant Education professionals.

    The implementation of Group 3 (Enhanced Understanding of VAWDASV for Organisational Champions) of the National Training Framework for those relevant professionals deemed to be appropriate.

12. Head Teachers in Flintshire and Denbighshire to satisfy themselves that such training as detailed in Recommendation 11 is taking place and that its provision is being recorded.

13. The Chief Officer (Education and Youth) to cause a review to be undertaken of the information sharing processes and processes that are currently in place in Flintshire and Denbighshire to ensure that 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.

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