Executive Summary

Domestic Homicide Review
Under Section 9 of the Domestic Violence Crime and Victims Act 2004 (as amended)

SAFER PEMBROKESHIRE - Pembrokeshire Community Safety Partnership

In respect of the death of a woman Pembrokeshire/DHR/2016-17/1

Professors John Williams and Kate Williams of Aberystwyth University (Independent Chairs and Authors)

Report presented to CSP 20th October 2017

Contents

1. The Review process

This summary outlines the process undertaken by Safer Pembrokeshire domestic homicide review panel in reviewing the homicide of a woman who was a resident in their area.

On 13th April 2016 the Chair of the Pembrokeshire Community Safety Partnership (CSP) was notified of the death of the victim and the case was referred to a multi-agency meeting of the Review Panel (comprising members of the CSP). The group met on 22nd April 2016 to consider the circumstances of the incident resulting in the death against the criteria set out in the Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews 2013 and 2016. The meeting decided that it would initiate a Domestic Homicide Review (DHR), but its commencement would be delayed until a week after the end of the perpetrator's trial.

A report confirming this decision was sent to the Home Office on the 11th May 2016. On the 22nd July, the full CSP approved the draft terms of reference as drafted by the Review Panel. Following this meeting the Community Safety, Poverty and Regeneration Manager for Pembrokeshire County Council contacted the joint DHR chairs to inform them of the case and the decisions that had been taken and to invite them to undertake the review.

In the preparation of this report, agencies have collated sensitive and personal information under conditions of confidentiality. The relationship between the perpetrator and victim and their family, medical and other relevant histories were reviewed going back twelve years. Throughout the discussions the Panel and all agencies involved balanced the need to respect the privacy and dignity of the family and respect for the criminal justice process with the need for all agencies to learn lessons and so improve safety for the future.

The Panel decided it would be appropriate to go back as far as necessary in reviewing the victim and the perpetrators contact with the statutory and voluntary sectors. The Panel felt that an arbitrary cut off point could lead to important information being missed. The DHR covered the period from 2005, the date of the victim leaving school, to the time of her death in 2016.

A total of 18 organisations were contacted in relation to contact with either the victim, perpetrator or both. Of these 16 confirmed contact with either the victim, perpetrator or both, secured their files and completed Individual Management Reviews.

2. Contributors to the review

Individual Management Reviews / reports were received from the following agencies involved with the victim and/or the perpetrator.

- Hywel Dda University Health Board
- Pembrokeshire County Council, Childrens Services
- Pembrokeshire County Council, Adult Services
- Pembrokeshire County Council, Youth Services
- Pembrokeshire County Council, Education

- Pembrokeshire County Council, Housing
- Dyfed Powys Police
- Mid and West Wales Fire and Rescue Service
- Milford Youth Matters
- National Probation Service
- Gwalia
- Gwalia IDVA Service
- The Community Rehabilitation Company
- Welsh Ambulance Services NHS Trust
- Drug Aid Cymru
- Citizens Advice Bureau
- Hafan Cymru
- Advocacy West Wales

Each IMR report noted the contact they had with either the victim or the perpetrator and reviews the nature of their contact, or as in the case of Hafan Cymru and Advocacy West Wales confirmation that there had been no contract with either party.

The Panel scrutinised and quality assured each IMR. Specific issues were raised and discussed at Panel meetings. Requests for further information were made which required the IMRs and chronology to be updated. There was a timely response to all the queries raised.

3. Review Panel Membership

The members of the Panel were senior managers from the key statutory agencies. Some of the members were the authors of the IMRs. IMR authors had no direct contact or management involvement with the case.

- Chairs
- Dyfed Powys Police
- Hywel Dda University Health Board
- Pembrokeshire County Council (PCC)
- Drug Aid Cymru
- National Probation Service (NPS)
- Safer Pembrokeshire CSP
- General Practitioner consultant

4. Author of the overview report

The Review Chairs and authors of this overview reports are Professors John Williams and Kate Williams. Both Chairs are members of the Department of Law and Criminology at Aberystwyth University and have legal training. John Williams is a barrister and has experience of Serious Case Reviews. Kate Williams has legal training, has lectured in law and in criminology and has practical (as a trustee for VSO working with victims of domestic abuse) and research experience of domestic abuse.

5. Terms of reverence for the review

In reviewing the information provided in the Individual Management Review (IMR) and other reports, the Panel agreed the following terms of reference:

- The methods and effectiveness of communication between the agencies and the victim.
- The extent to which information was shared appropriately:
    - Within individual agencies.
    - Between agencies.
- The effectiveness of risk assessment and risk management within the agencies involved.
- The effectiveness of communication between statutory bodies and third sector bodies.
- Were any signs or indications of domestic abuse missed by those agencies having contact with the victim?
- Other matters as considered appropriate by the Panel.

6. Summary chronology

On 1st April 2014 the National Probation Service and the Community Rehabilitation Company were established; prior to that all cases were managed by the Wales Probation Trust. In addition, all cases of those aged under 18's at this time were managed by Youth Offending Services.

Date(s)	Event Comment
09/1982	Perpetrator born
01/1989	Victim born
2005	Victim identified as having emotional behavioural difficulties and moderate learning difficulties. Special Educational Needs status at time of leaving school identified moderate learning and emotional difficulties
06/2005	Victim first known offending. Case dismissed
07/2007	Victim gave birth to a baby boy.
05/2008	20.05.08 victim advised Health Visitor of an incident that had occurred on the 15.05.08 during a home visit the perpetrator reported to be male ex-partner. This shows a willingness to report domestic abuse and a knowledge of who such information should be shared with.
05/2008	Victim's son Assessed by social services. Son staying with maternal with grandparents. Assessment closed by Child Care Assessment Team
06/2008	Health Visitor receives 'high risk' domestic incident notification report from Police, perpetrator was male ex-partner Shows willingness to report domestic abuse and a knowledge of who such information should be shared with
07/2008	Victim's son assessed by social services. Assessment closed by Child Care Assessment Team
01/2009	Perpetrator arrested for possession of controlled substances, charged and bailed
09/2009	Health Visitor receives high risk' domestic incident from Dyfed-Powys Police victim is the perpetrator against ex-partner.
01/2010	Health Visitor receives 'high risk' domestic incident report, perpetrator was male ex-partner, not current perpetrator Shows willingness to report domestic abuse and a knowledge of who such information should be shared with.

07/2010	Victim referred to Mental Health team. She was assessed and found to be feeling very low but not to be suffering from a mental health problem. A decision was taken to monitor her mental health over the short term and refer her to other agencies by signposting. She did not follow up the signposting.
07/2010	Victim's son assessed by social services. Victim's son residing with maternal grandparents as per private arrangement. Referred to Team Around the Family Crisis team and General Practitioner involved with victim.
09/2010	Victim's son living permanently with maternal grandparents as per private arrangement.
09/2010	Perpetrator attacked at a party. He suffered a collapsed lung and possible skull fracture. He was reluctant to make a statement because he feared reprisals.
11/2010	Perpetrator arrested for assault (believed to be connected to his having been assaulted in 09/2010)
02/2011	Perpetrator arrested on suspicion of having kicked in the glass in his then girlfriend's front door. He claimed the door broke when he closed it too hard. No further action was taken due to absence of witnesses. A child, possibly his, present during this event.
06/2011	Perpetrator reported as having kicked his dog.
07/2011	Health Visitor receives 'high risk' domestic incident report from Police, incident occurred 20.06.11 perpetrator was male ex-partner, not current perpetrator Shows willingness to report domestic abuse and a knowledge of who such information should be shared with.
09/2011	Victim referred to Mental Health Team. The assessment found that she was not suffering from a mental illness. Decided to signpost to appropriate services with some short-term monitoring of her mental health. Again, the victim did not follow up on the signposting.
10/2011	Perpetrator charged with shoplifting.
12/2011	Medium domestic incident notification. Shows willingness to report domestic abuse and a knowledge of who such information should be shared with.
12/2011	Perpetrator arrested for drunk and disorderly behaviour – he was verbally abusive and aggressive towards officers. Pelargonic acid vanillylamide (PAVA) spray used.
03/2012	Perpetrator in RTC in London where he suffers factures of both clavicles and the right lamina. Was bailed.
05/2013	Victim arrested for assault on male; not the perpetrator.
05/2013	After arrest victim had a mental health assessment. No serious mental health problems, but needed a change in medication and agreed to contact Prism and make an appointment for herself – this after admitting that she was unable to remember appointments. She refused more support from outpatient mental health. Victim did not follow up the self-referral to Prism
07/2013	Victim convicted of assaults and sentenced to an eighteen-month Criminal Justice Act Community Order with requirements. Worked National Probation Service, The Community Rehabilitation Company and Gwalia (ex-offender floating support programme).Worked with Wales Probation Trust, National Probation Service, The Community Rehabilitation Company and Gwalia over the 18-month period.

11/2013	Victim suffers slashed wrists. Admitted to being self-inflicted, though she did not remember doing it. Mental Health assessed again and referred to General Practitioner for alteration of medication. This was done in 12/2013 Scored 0 on Women Abuse Screening Tool (Domestic Abuse)
07/2014	Perpetrator claimed to have been assaulted in the face at a nightclub by a named male. Welsh Ambulance Service and Dyfed Powys Police attended and he was taken to hospital Crown Prosecution Service pre-charge advice was submitted. Outcome was no further action due to evidential difficulties.
07/2014	Perpetrator visits General Practitioner due to depression.
08/2014	Perpetrator assessed by mental health team. Recommended low level intervention and medication
01/2015	Police received report of people arguing at victim's address. They then received another report about a fire. They arrested both victim and perpetrator. Victim set fire to her home. Charged with arson. Perpetrator charged with possession of cocaine.
02/2015	Victim convicted of arson and imprisoned for 24 months (to be served at Eastwood Park) and four licence conditions attached.
02/2015	Child Care Assessment Team contacted by National Probation Service to undertake assessments for the victim and her child. Checks completed and forwarded to National Probation Service.
10/2015	Victim released from custody. Working primarily with National Probation Service, Mid Wales Fire and Rescue Service, and Gwalia. At this point the victim was clean of all substances and had enjoyed training as a nail technician. She was positive and had ambitions. Whilst support started positively, a lot of the third sector support was provided via electronic means rather than face to face, which may have had negative impacts.
02/2016	Perpetrator called 999 and asked for an ambulance. Paramedics find victim unconscious at home, she is later pronounced dead. Paramedics were suspicious of the circumstances and called the police.
02/2016	Perpetrator arrested on suspicion of murder of victim.
02/2016	Perpetrator charged with victim's murderDetained at Swansea Prison until the trial on 09/2016.
09/2016	Perpetrator convicted of murder and sentence to life in prison.

7. Key issues

The Panel identified a number of key issues arising out of the IMRs and its deliberations.

I. The need to raise awareness of the DHR role and process amongst agencies and practitioners, in particular the importance of professional bodies advising on the sharing of information.
II. The need to ensure agencies proactively engage with clients (particularly those who have complex needs) and monitor levels of engagement.
III. The risks of over-reliance on the client self-referring, particularly where they are likely to disengage with services.
IV. The importance of face to face contact with clients and the risks involved in over-reliance on electronic communications.
V. Whilst recognising that key practitioners will be unavailable as a result of illness or annual leave long breaks in face-to-face engagement should be avoided.

VI. The need for commissioners to ensure that successful bidders have protocols in place to address disengagement by clients and/or failures to engage.

8. Conclusions

The outcome of this case was not predictable and the IMRs and deliberations of the Panel do not identify any contributory failings in the way in which different agencies responded to the needs of the victim and perpetrator that might have avoided her death.

The recommendations of the Panel focus on ways in which support for people might be improved for them to achieve greater well-being. It is significant that upon leaving prison, the victim had addressed her drugs issue and had received training as a nail beautician. This was not enough to alter the outcome.

9. Recommendations from the review

The Panel believes the death of the victim was not predictable and that there is nothing any of the agencies involved with the victim or the perpetrator could have done to prevent it from happening. The recommendations below must be read within that context. They are intended to identify issues that agencies may consider in the hope that in other cases they could provide support for people to reduce the risk of a homicide or serious injury.

The Panel recommends that steps should be taken to ensure that all agencies and practitioners processes are fully aware of the role and purpose of a DHR. This relates to the expectation that information must be shared and that this does not, subject to data protection principles, compromise the duty of confidentiality. It is also important that agencies and practitioners are aware that the DHR process is not about apportioning blame or responsibility, but rather about identifying lessons that can be learnt.

Agencies working with people considered vulnerable, particularly because of mental health issues, should proactively engage with clients and monitor their level of engagement. Self-referrals should be used carefully and only when assessed as being appropriate.

Agency communications with disengaged and chaotic clients should predominately be face to face. Electronic communication should be kept to a minimum, used only when considered appropriate

Agencies should ensure contingency plans are in place to cover key workers' periods of sickness and/or holiday. Long breaks in face-to-face engagements with clients, particularly when there is ongoing intensive work, should be avoided.

When entering contracts for the provision of support services commissioners should ensure that successful bidders are fit for purpose. This includes having protocols describing how the provider will establish and maintain contact with clients, particularly those where there is unwillingness to engage, a risk of disengagement or a lack of engagement.