Domestic Homicide Review Report: Executive Summary

Sue
Date of Death: February 2021

Independent Report Authors – Mary Ryan and Janice Dent

Review Completion Date: July 2023

Official Sensitive Government Security Classifications 2018

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THE REVIEW PROCESS

This summary outlines the process undertaken by Torfaen Community Safety Board/Public Service Board domestic homicide review panel in reviewing the homicide of Sue who was a resident in their area.

The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members:
Sue, aged 74, White British
Bob, aged 71, White British

Criminal proceedings were completed in March 2022 and the perpetrator was found guilty of murder and sentenced to life with a 20-year minimum tariff.

The process began with an initial meeting of the Community Safety Partnership in October 2021 when the decision to hold a domestic homicide review was agreed.

All agencies that potentially had contact with Sue and/or Bob prior to the point of death were contacted and asked to confirm whether they been involved with them. Five of the eight agencies contacted confirmed contact with the victim and/or perpetrator and were asked to secure their files.

CONTRIBUTORS TO THE REVIEW

Agency information from the following agencies formed part of the review:

- Gwent Police
- Aneurin Bevan University Health Board
- Welsh Ambulance Service Trust
- Cyfannol Women's Aid
- Bron Afon Housing Association

All information and panel members were independent in that they had not been directly involved in the circumstances surrounding the death.

THE REVIEW PANEL MEMBERS

The review panel met 8 times and included representation from the above agencies, and local authority leads, including the Community Safety Partnership. All members were independent and had no previous contact with either party.

Name	Agency	Job Role
Mary Ryan	Independent Author – Newport City Council	Head of Adult and Community Services
Janice Dent	Independent Author – Newport City Council	Partnership and Policy Manager
Ann Hamlet	Independent Chair – Aneurin Bevan University Health Board	Head of Safeguarding (since retired)

Finn Madell	Independent Chair – Newport City Council	Head of Corporate Safeguarding
Kelly Beaumont	Cyfannol Women's Aid	Support Services Manager
Jane Rees	Welsh Ambulance Service Trust	Safeguarding Specialist
Howard Stanley	Aneurin Bevan University Health Trust	Head of Safeguarding
Neil Blyth	Gwent Police	Detective Inspector
Jodi Evans	Bron Afon Housing Association	Support Services Manager
Steve O'Connell	South Wales Fire and Rescue Service	Group manager for Torfaen and Blaenau Gwent
Lesley Groves	Torfaen County Borough Council	Housing Manager
Kate Williams	Torfaen County Borough Council	Group Manager (Community Safety)

AUTHORS OF THE OVERVIEW REPORT

Both Chairs/authors are employed by Newport City Council and had no connection with Torfaen's Public Services Board. They are therefore considered independent in their roles within this review.

Mary Ryan was the Head of Corporate Safeguarding, with an overview of Children, Adult and Education service and managed the regional Violence Against Women, Domestic Abuse and Sexual Violence Team for Gwent. Mary is currently employed by Newport City Council as the Head of adult services.

Mary is qualified Social Work, CQSW, DIPSW, ASW, AMHP, MSc Advanced Social work practice. Mary has also completed the Home Office Domestic Homicide Training and completed Significant Incident Learning Programme (SiLP: University of Portsmouth).

Mary is an experienced reviewer and author of Adult and Child Learning reviews as well as Domestic Homicide Reviews.

Janice Dent was employed as the Regional Lead Advisor for Violence against Women, Domestic Abuse and Sexual Advisor, funded by Welsh Government and hosted Newport City Council.

Janice has completed the Home Office Domestic Homicide Training and completed Significant Incident Learning Programme (SiLP: University of Portsmouth). Janice

was a member of the AADFA DHR Network and attended key webinars to ensure understanding of best practice at all stages of reviews.

TERMS OF REFERENCE FOR THE REVIEW

The purpose of this review was to –

- Determine whether decisions and actions in the case comply with the policy and procedures of Torfaen County Borough Council and the Domestic Homicide Review Statutory Guidance 2016.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Establish whether previous relevant information or history about the deceased and/or family members was known and considered in professionals' assessment, planning and decision-making in respect of the person, the family, and their circumstances. How that knowledge contributed to the outcome for the person.
- Review any barriers experienced by the family and/or friends in reporting abuse or concerns, including whether they knew how to report domestic abuse.
- Establish whether the actions identified to safeguard the person were robust, and appropriate for that person and their circumstances.
- Assess whether the actions were implemented effectively, monitored, and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.
- Identify the aspects of the actions that worked well and those that did not work well and why. Evaluate the degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes the person. Establish whether the protocol for professional disagreement was invoked.
- Review advice and learning for wider agencies and professionals in relation to identifying and reporting DA concerns, including estate agents and solicitors.
- Review communication to the public and non-specialist services about available specialist services related to domestic abuse or violence.

SUMMARY CHRONOLOGY

Sue had moved to the area with her first husband, the children's father, but they separated after living there for approximately 7 years. Sue stayed in the marital home and raised the children on her own. Although, due to divorce and subsequent financial difficulties, the house had to be sold and Sue and the children lived in privately rented houses around the area for a while.

Sue had known Bob and they had a short relationship a few years prior to them getting together permanently. When Bob got back in contact with Sue after a few

years he offered to help her and the children, and they moved into his house. When Sue's mother became ill, she moved into their home so that Sue could care for her until she moved into a nursing home and shortly after passed away.

The family shared that approximately 10 years ago their mother's relationship with Bob had started to change, and they noticed that the relationship was not as happy. Bob's circumstances had changed when he retired early and then him losing his driving licence following a medical incident, although he could have reapplied after a year Bob chose not to. Bob's behaviour is said to have changed around this time, and he rarely left the house. It was reported that Bob became more frugal with his money at this time and expected Sue to continue working and contribute to all financial expenses even though he had no financial issues.

Sue sought legal advice as she was concerned for her housing security, as the house was in Bob's name only. Sue had reassured family that she was looking to leave the relationship but that she didn't want to leave her home and start again. Family explained that Sue had struggled with finances when her children were younger but had always worked hard and provided for her children.

Not long afterwards, in 2012, Sue and Bob married, and Bob changed his will to leave half of the house to Sue. Family described a lavish wedding and remembered Sue as being 'over the moon'.

Approximately 5 years later Sue returned to the solicitor for further advice. At this time Sue described a strained relationship with regular arguments about money and smoking. Bob was a chain smoker and insisted on smoking in the house. After the legal appointment Sue was unhappy to return to Bob and went to stay with a friend for a couple of days. Bob sought Sue out and persuaded her to try again and return home with him, he agreed to build an extension to the house something that he knew Sue had wanted to do for some time.

A short while after Sue's return home the arguments and unhappiness within the relationship returned, so they started to live separately in the same house. Sue was so unhappy she returned to the solicitor approximately 2 years ago and started divorce proceedings.

During this period family refer to Sue as feeling low and spending more time with them at the weekends etc. Sue spent many hours driving around with her daughter looking for alternative accommodation. Sue did not want to start over again building a new home and life for herself, but felt she had no choice due to the poor relationship she had with Bob.

When the lockdown occurred during the initial phase of the Covid Pandemic, it meant that her usual escapes to family and out and about in the community were no longer a viable option.

On the morning of Sue's murder, she was in her own bed upstairs, Bob entered and murdered her by stabbing her repeatedly while she was in bed.

After murdering Sue, Bob called the police to tell them he'd stabbed his wife and that they should also arrange an ambulance.

KEY ISSUES ARISING FROM THE REVIEW

Coercion and Control - The overarching theme identified during the review was that of coercion and control, which has informed the learning points from this review.

Missed Opportunities for intervention and support - Escalation and the reporting of this is a key learning point identified in this review. The clarity of the timeline from involved agencies, and through speaking to Sue's family, provides evidence of the escalation of concerns, coercive control, and threats. Bob had made threats towards Sue to a housing association officer, which were reported to the Police, and Bob also expressed these same threats towards Sue to an estate agent who visited the house and to a neighbour. The mechanism for all agencies reporting concerns to the police as intelligence may support the identification of escalation and support safety planning and prevention. Within the chronology, in hindsight there were missed opportunities for additional questions to be asked of Sue using the Ask and Act principles in Wales.

Community awareness - The role of the wider community in addressing and preventing domestic abuse is documented throughout this review. Supporting families, neighbours, and non-specialist services to recognise but more importantly how they can help is a key learning point identified by Sue's family, agencies involved and the authors.

Limited Professional Curiosity - Through analysis of the chronology and agency management information there are situations in which professional curiosity and actions may have been affected by conscious and/or unconscious biases by practitioners.

CONCLUSIONS

By conducting this review and speaking to Sue's family and other agencies it has become clear from the information shared that Sue had experienced coercive and controlling behaviour for many years. It is not possible to say whether she recognised this, although she had sought legal support and raised some concerns with family members.

Coercive and controlling behaviour is challenging in many ways; victims may not recognise that this is happening to them. If the relationship is regarded as loving and the behaviour seen as originating from a point of love, they may not see that it is restricting or limiting their life.

To effect change, there needs to be a greater public awareness of how coercive and controlling behaviour and domestic abuse in a wider form can present. More importantly this needs to be presented with information about what families, neighbours and other people involved can do as there is a risk that telling someone to leave may put them at greater danger.

The messages around the COVID-19 pandemic also had an impact on this situation. National messages about those at risk of harm from domestic abuse were able to leave their home, these focused on physical risk more than psychological and relied upon people recognising they are a 'victim' of domestic abuse. Although it is hoped there won't be a need for these messages to be used again, should a similar crisis occur care will need to be taken to ensure fuller understanding and communication from government departments.

LESSONS TO BE LEARNED

Coercive control continues to be an area where increased awareness amongst community members and professionals would be beneficial. In hindsight, there are indications of the coercive control Bob used with Sue, financially, psychologically, and sexually.

In addition to being able to recognise coercive control it is important to ensure referral pathways are clear. In one example Sue had reflected her own situation mirroring a domestic abuse storyline on a soap but there was no evidence she or her family knew how and where to access support or the range of safeguarding measures available including property markers and protective orders.

The Welsh Government VAWDASV National Training Framework is supporting awareness raising amongst relevant authority staff, but it is important this learning is further disseminated among communities and other agencies, including but not limited to housing associations and estate agents.

There were concerns raised by Bob and Sue to different agencies during the timeline period with no obvious referral to specialist support. There is a potential for unconscious bias with older couples. An example of this is the decision not to arrest appearing to have been influenced by Bob's fragility and Sue's unfazed reaction to the threatening comments made by Bob towards her.

Gwent Police report a lack of professional curiosity when speaking to Sue following the report by the housing association although this is in the context of very little domestic violence history reported to the Police. Intelligence reports from other agencies on comments and threats made, along with the escalation of these may have triggered further exploration of the domestic abuse history with Sue, her family, friends, and neighbours may have provided a more detailed picture of the risk involved, and additional safeguarding procedures implemented including options of

Police bail with conditions or the issuing of a Domestic Violence Protection Order and/or an urgent response marker applied to the address.

Even though there is evidence of good practice by the Police attending and speaking to Sue and Bob separately, they didn't fully explore with neighbours or family to fully understand the history and the risk with no record of Sue being asked for her consent to speak to family members about the nature of the threats made by Bob to her.

The importance of utilising opportunities to implement Ask and Ask processes and reporting concerns by all relevant agencies was identified through conducting this review.

The family are clear if they had been informed of the threat to stab Sue by Bob, they would have intervened and removed her from the home. We need to consider how this can be addressed by practitioners and with respect to Sue's confidentiality. Recognising the coercive control that Bob had over Sue and not recognising or prioritising herself or the potential risk she faced requires intervention and sensitivity to enable victims to seek assistance when they are most vulnerable.

During the review process, panel members identified a possible gap in support for people in privately owned homes as opposed to those living in accommodation provided by social landlords. For example, it was highlighted that within social housing organisations there are designated safeguarding teams and domestic abuse liaison officers who would approach both parties separately. They also have positive links to be able to refer into the Multi Agency Risk Assessment Conference (MARAC).

RECOMMENDATIONS FROM THE REVIEW

The following recommendations are based upon information provided by Sue's family, and relevant agencies through information submitted as part of management reports and through discussions during panel meetings.

Recommendation 1

Information and campaigns aimed at community members on domestic abuse at any age and in different circumstances, and especially in relation to coercive control need to be reinforced both on a national and local level. There are some positive examples detailed above but is recommended that the awareness raising and bystander type campaigns are regularly repeated in a way that doesn't lead to them not being impactful.

Recommendation 2

Public Services Board/VAWDASV Partnership to consider sharing this report and recommendations with the Wales VAWDASV National Advisors, and to ask if the National Training Framework could be expanded to include additional agencies

including solicitors and estate agents who are likely to encounter citizens during stressful and emotional times.

Recommendation 3
The local commissioning of older persons specialist staff and the work of the Older Person's commissioner on abuse of older adults to be promoted to aid recognition of domestic abuse within older relationships and referral routes for support. With family consent this report and findings could be utilised as a case study for learning.

Recommendation 4
Ask and Act training to be considered for wider staff within agencies, including NHS employed counselling staff and control centre staff within WAST and Gwent Police with a focus on domestic abuse within all relationships including older adults.

Recommendation 5
Region to consider further training on recognition and referral for those displaying and/or expressing abuse behaviour including mapping of services that support behavioural change and recognition of risk to partners. With consent, this report and recommendations could be utilised to raise awareness of the need to engage with potential perpetrators, with a focus on older and perceived frail adults.

Recommendation 6
Gwent Police are piloting the DARA risk assessment tool alongside the DASH risk assessment due to highlighted concerns in some of the key questions which may result in a lower risk score for older adults (as an example in relation to pregnancy). The region and or Welsh Government VAWDASV team may wish to consider a task and finish group to share learning and good practice.

Recommendation 7
Report and recommendations to be shared with the Gwent VAWDASV and Safeguarding Boards to consider the support available to those who own their own homes, like, and in line with the support available via dedicated safeguarding and domestic abuse practitioners within registered housing associations. This is particularly a concern where couples are assessed as standard to medium risk and therefore not supported via MARAC.