Flintshire Community Safety Partnership- Domestic Homicide Review

Overview Report

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

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2017

Acknowledgement

It is very important for us to acknowledge that in producing such as 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 Marie (pseudonym), their family member, have 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 lessons related to practice, which have been identified during the review of this case, also of course acknowledging that this report will become public as 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.

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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 da 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	Offender Assessment System
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
SS	Silent Solutions
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

Overview Report of the Domestic Homicide Review of the Circumstances Concerning the death of:

Marie, born 24th May 1969

Died 14th September 2014 aged 45 years

1. Introduction

1.1 For the purposes of this review report and in order to protect the identity of those involved the victim will be known as Marie, (not her actual name) and the perpetrator as P1. The reason for the Domestic Homicide review is that Marie was murdered on 14th September 2014.

1.2 At the time of her death Marie lived in her own home in Flintshire, North Wales. Marie was divorced and she was the mother of two children, one a young adult and one still at school at the time. Marie was in a new dating relationship with P1 who she had met only a few weeks previously through an internet dating site. They did not live together.

1.3 On 14th September 2014 at 02:35 hours the Welsh Ambulance Service received an emergency call from a man, now known to be P1, to say that he had found his girlfriend (Marie) unconscious on the floor of her home. P1 reported that she had been drinking and that she was not breathing. The caller was given advice regarding resuscitation and an ambulance was requested.

1.4 A Community First Responder (CFR) was allocated to attend and was the first person to arrive at the address at 02.50 hours, the morning of 14th September 2014. At 02.57 hours the CFR confirmed the patient was in cardiac arrest. After the ambulance arrived advanced life support resuscitation was initiated, however, tragically at 03.09 hours the patient, Marie, was confirmed to be dead.

1.5 The police were informed of the incident and arrived at 03.35 hours. Following initial enquiries P1 was arrested at the house of the victim Marie at 03.44 hours. At 18.31 hours on 16th September 2014, P1 was formally charged with the murder of Marie and was then remanded in custody pending a Crown Court appearance.

1.6 Subsequently on 19th December 2014, P1 appeared before the Crown Court where he pleaded guilty to the murder of Marie and he was sentenced to life imprisonment with a direction from the Trial Judge that he must serve at least seventeen and a half years in prison, before he is considered for release.

1.7 In compliance with Home Office Guidance, the North Wales Police provided written notification of the death to the statutory Community Safety Partnership for Flintshire and on 17th September 2014 a Superintendent from North Wales Police confirmed the requirement for a Domestic Homicide Review (DHR) in this case.

1.8 On 26th September 2014 Flintshire Community Safety Partnership convened an extraordinary meeting, which was attended by most of the invited statutory agencies. The meeting agreed unanimously that the circumstances of the death of Marie met the criteria for a DHR and that a review should be conducted in accordance with Home Office Guidance and the guidance developed by Flintshire Community Safety Partnership.

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

1.10 It is very important for us to acknowledge that in producing such as 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 have 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 lessons related to practice that have been identified during the review of this case, also of course acknowledging that this report will become public as required by the Home Office.

1.11 Additionally, and perhaps unusually we have contacted and/or interviewed past partners of P1 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.

2. Purpose and Scope

2.1 The Domestic Violence, Crimes and Victims Act 2004 Section 9(3), which was implemented with due guidance on 13th April 2011, establishes the statutory basis for a Domestic Homicide Review.

2.2 The process is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —

- A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or
- A member of the same household

2.3 The purpose of a DHR is to:

1. 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;
2. 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. Apply those lessons to service responses, including changes to policies and procedures as appropriate; and
4. Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and interagency working.

2.4 It is important to state that a DHR is not an enquiry into how a victim died or into who is culpable, as those matters are for Coroners and criminal courts to determine.

DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges during the course of a DHR, which indicates that disciplinary action should be initiated, then the established agency disciplinary procedures should be undertaken separately to the DHR process.

2.5 The purpose of Individual Management Reviews was laid out in the Flintshire Community Safety Partnerships Terms of Reference for the DHR as:

- Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.
- 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.
- Whether there were opportunities for professionals to 'routinely enquire' as to any Domestic Abuse experienced by the victim that were missed.
- Whether there were opportunities for agency intervention in relation to Domestic Abuse regarding the victim or alleged perpetrator that were missed.
- 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.

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.

3. The Domestic Homicide Review Panel

Independent Chair

3.1: The Review was chaired by Ms Jenny Williams, Strategic Director of Social Care and Education Services, Conwy. Ms 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.

Report Author

3.2: The independent author of the report is Susan Maskell whose career as a Social Worker extends over thirty years, originally in the field of direct social work, later as Head of Children and Family Services in Local Government, she now works independently. Susan has experience of commissioning serious case reviews, completing Internal Management Reviews, both as an independent person and as a local authority employee. Susan has written serious case reviews for children and participated as second reviewer in an Adult Protection Review. Susan had no involvement of any kind in this matter prior to the DHR.

Administration

3.3: The administration and management of the review process has been carried out by Ms Sian Jones and Ms Michelle Edwards of Flintshire County Council Community Safety Partnership.

Panel Members

3.4: The members of the Panel are from the key statutory agencies that had no direct contact or management involvement with the case subject to this DHR and are not the authors of individual management reviews. The members of the Panel are:

- Welsh Ambulance Services NHS Trust, Safeguarding Specialist
- Solicitor Flintshire County Council
- Detective Inspector North Wales Police
- Educational Social Worker Lifelong Learning Flintshire County Council
- Associate Director Safeguarding, Betsi Cadwaladr University Health Board
- Domestic Abuse and Sexual Violence Coordinator Flintshire County Council
- Deputy Head of Public Protection, National Probation Service Wales
- Independent Domestic Violence Advisor Flintshire
- Community Safety Manager Flintshire
- Senior Manager- Children's Lead, Flintshire
- Administrator Community Safety Flintshire
- Community Safety Manager, North Wales Fire and Rescue Service

3.5: It should be noted that as matters developed additional agencies were required to contribute to the DHR but the Panel was not expanded to include them, not least due to the fact they were geographically distant. However, they have been fully consulted and have each signed off the report.

Independent Management Reviews

4. IMRs were received from the following agencies who were involved with Marie and/or the alleged perpetrator.

Agency	**Date IMR sent for**	**Original IMR received**	**Final version addition/received**
National Probation Service	27/03/15	15/05/15	
Betsi Cadwaladr University Health Board (BCUHB)	27/03/15	25/01/16	10/03/16
Aneurin Bevan University Health Board (ABUHB)	27/08/15	First response received on 07/09/15, second response received on 30/11/15	Final received 20/01/16
Wrexham Local Authority Children's Services	February 2016	08/04/16	
The Royal British Legion (TRBL)	31/07/15	19/08/2015 and 28/09/2015 and 26/11/2015	04/04/16

Due to the limited involvement with Marie and/or P1, chronologies were obtained from the following agencies

	Information requested	**Original Information received**	**Additions/reviews**
Welsh Ambulance Service	27/03/15	26/05/15	
North Wales Fire and Rescue Service	27/03/15	22/04/15 Nil involvement	
North Wales Police	27/03/15	05/05/15	Reviewed 28/09/15

Employer One	27/03/15	22/04/15	25/01/16
Employer Two	27/03/15	15/04/15	
Flintshire County Council Social Services	27/03/15	01/05/15	Revision after further questions 17/02/16

4.1: Further information was requested from the following as the Panel became aware of the limited involvement following a past domestic abuse event concerning P1 and another partner.

AGENCY/ORGANISATION	INFORMATION REQUESTED	INFORMATION RECEIVED	FINAL INFORMATION RECEIVED
Sand Bach Health	27/08/15	Received on 15/09/15	

4.2 Methodology, Quality and Timeliness of Independent Management Reviews

In a sense there are three distinct parts to this DHR.

- The first relates to the main focus and purpose of the review, the homicide of Marie, for which offence of murder P1, was convicted in February 2015.
- The second part relates to a child protection case conference, which the Panel only gained access to at the latter stage of the process and just prior to the drafting of the report. This delay was due to challenges, which persisted over several months, in clarifying information and obtaining the consent of V3, the mother of the child concerned. The matter was thirteen years old by the time of the homicide of Marie.
- The third part relates to the information received as a result of the victims who came forward after they heard about the tragic death of Marie.

In respect of the death of Marie, which is the reason for and main focus of the DHR, prompt requests were sent out by Flintshire Community Safety Partnership for IMR reports.

Three were received:

One was from the National Probation Service in the form of a letter with chronology and recommendations in table form as requested.

The IMR from Betsi Cadwalader University Health Board (BCUHB) was only received on 25th January 2016 and was discussed at the Panel meeting on 4th February 2016. This resulted in a request for further clarification. The final version, after clarification, was received by the report author on 10th March 2016.

A third 'IMR' in respect of an incident in July 2013 involving V5 was in the form of chronology and recommendations, but without a written report and that information was received from Aneurin Bevan University Health Board.

Subsequently, IMRs were also requested from The Royal British Legion (TRBL) and Wrexham Social Services, both of which were received in April 2016. Wrexham's response was swift given they were the last agency asked to contribute.

5. Sources of Information upon which this Review has Relied

5: This review has relied upon the following information as evidence for the production of this report:

- The Internal Management Reviews provided to the DHR Panel by the agencies described in the above tables
- Statements to North Wales Police made by the women who came forward after the killing of Marie.
- An interview with a family member
- A subsequent meeting with Marie's ex-husband and father of her children
- The interview that took place with the offender P1
- The interviews which took place with three of the previous partners of P1
- A telephone call with a further partner of P1
- Contact made with a former wife of P1 and the consent to use the case conference report in respect of her children who were subject to case conference in Wrexham CBC.
- The case conference report from 2001
- A transcript of Sentencing Remarks of Mr Justice Wyn Williams at the trial of P1
- The police information on the enhanced transcript of a 999 call made by the victim
- Information from various web sites on internet dating and safety
- The Ministry of Defence web site section on Domestic Abuse.
- The knowledge and expertise of Panel members

6. Background to this Homicide

Family and Relationship Background

6.1: The victim, Marie, was 45 years old and had been married but was divorced. Marie lived in her own home and she had two children, one of whom had attained adulthood and the other was still a school child. The children spent time both with Marie and with their father. Neither of Marie's two children was present at the house when the incident leading to her death occurred.

Marie has other family members, specifically; her mother and her siblings, and her siblings own children, who lived in the local area, though not the same village, and she was in regular contact with them. So Marie was a mother, a sister, a daughter and an aunt. Marie was employed by a local company where she had worked since May 2014.

Marie lived in rural Flintshire in a small village; she had lived there for approximately twenty years. The population of the county of Flintshire is mainly White Welsh and it is an area where both Welsh and English are spoken.

6.2: P1 lived in the principal town of the area. He lived close to his mother. He had two adult children from his first marriage to V2. P1's children were raised principally by their mother (V2). Then in their later teenage years, first one and then the other young person lived for a time with P1.

In terms of employment P1 was registered with a local recruitment agency and from December 2013 he obtained work through the agency as a Production Operator at a local company, he was employed by the company until his arrest and subsequent conviction. He did not have any prior criminal record when he first registered with this local recruitment service in 2002, at that time he only completed one weeks work before he obtained employment elsewhere. He returned to the local recruitment service in April 2014. At the time of his return he did not disclose the conviction, which had occurred in the meantime. No issues were reported by the agency in respect of the employment that P1 carried out whilst registered with them.

Equality and Diversity

6.3: Flintshire is predominantly a White Welsh Community where both Welsh and English are spoken in the area; the main business language is English.

Local statistics are for Flintshire and Wrexham and state that both counties have reasonable employment rates, with 71% of its inhabitants employed, and 46% employed full time. Incomes are moderate in this region, with the gross weekly income for 2015 at £483.35 per person. Disposable income is also moderate at £16,112 per household for the year. Flintshire and Wrexham have fairly low house prices when compared to the UK as a whole, with the average house sale in 2015 amounting to £138,500. Rent, however, is fairly high at £74 per person, per week.

6.4: Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it

- foster good relations between persons who share a relevant protected characteristic and persons who do not share it

6.5: The review has not established any issue relating to Marie that would demonstrate that prior to her meeting P1 she had any specific needs relating to victimisation, discrimination or disability. Marie was not receiving services from any agency, outside of that which is usual, for instance the health service.

6.6: The review gave due consideration to all of the potential characteristics under the Equality Act and found that P1 had in fact sought help briefly relating to his mental wellbeing, he had also had some other health problems but neither affected him in terms of mobility or employment. It would be difficult to establish, on anything other than the offenders own report, that the Mental Health issues constituted a disability as defined by the Equality Act 2010, especially as he was not in treatment and had not reported problems to his GP for some time. We did not find any evidence of any issue regarding P1's mental health that affected his actions.

7. Chronological Sequence of Events

7.1: Information received from the individual agencies and professionals involved with the family of Marie and also with P1 were collated into a chronology at the request of the DHR Panel. It is important to note that prior to the homicide of Marie there was no contact with any agency that could be said to be anything other than normal. That is, contact was with school and employment and was routine; and none of it would have caused any person to become alert to anything seriously amiss in Marie's life. This lack of any exceptional contact is not surprising as Marie had only recently met P1.

7.2: There was no report of any issue/exceptional incident regarding P1 and Marie from the time when they met, during the period July 2014 to the date of Marie's death on the 14th September 2014. The only information Panel has, is about P1 prior to the time he met Marie. This information will be covered in the sections that follow the chronology concerning Marie.

7.3: During the course of the police investigation it was established that Marie had only recently met P1. 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.

7.4: On 13th September 2014 Marie had been out to a public house in a nearby town with her nephew and P1 joined them there. It was stated by a family member that on this day Marie had mentioned that P1 was a jealous man and possessive, it is thought by her family that Marie had intended to end her relationship with P1. So, given that view of the family, it

is interesting that although P1 had joined the family at the public house. Marie then returned without him to her home, being taken there by her nephew in the early evening. Marie was due into work the next day. It appears though, that shortly afterwards P1 arrived at Marie's home.

7.5: A 999 call was made from the mobile phone of Marie after her return home from the public house. The telecommunications operator told the police that 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.

7.6: The police told the report author that after Marie's death a transcript of the 999 call was made by NWP. This transcript could only be made from a significantly enhanced audio and even after 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 in the transcript to indicate that Marie was asking for help during the call.

7.7: P1 attacked Marie sometime on the evening of 13th 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 judges summing up at the sentencing hearing. P1 also confirmed unsolicited, when he was interviewed by the report author for the purpose of this DHR, 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 02.50 hours
- At 02.57 hours the CFR confirmed that Marie was in cardiac arrest. After the ambulance arrived advanced life support resuscitation was initiated, however, tragically at 03.09 hours Marie was confirmed to be dead.
- At 03.11 hours the police were informed of the incident and arrived at the address at 03.35 hours.
- At 03.44 hours, following initial enquiries; P1 was arrested on suspicion of the murder of Marie.
- At 18.31 hours on 16th September 2014, P1 was formally charged with the murder of Marie and was remanded in custody, pending a Crown Court appearance.

7.8: 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 seventeen and a half years before he is considered for release. In his sentencing address Mr Justice Wyn Williams said that Marie had died as a result of asphyxiation and strangulation and she had been severely beaten in a ferocious attack.

8. Family and Friends Involvement

8.1: 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 DHR Panel with the Home Office leaflet attached. The communication led to the author of the report meeting with Marie's sister. Although a meeting had initially been arranged with him, the ex-husband of Marie did not attend an arranged interview but he, and through him, his children were offered a further opportunity to do so. He asked though to meet with the author when the report was completed and this meeting did take place.

8.2: It was agreed with the sister of Marie that if other family members wanted to participate that could be arranged and she agreed to pass this on to them and she was given further leaflets to enable the family to understand the process and purpose of participation in the review.

8.3: The adult children of P1 were also offered an opportunity to participate. This approach was facilitated through their mother. They both declined.

8.4: As stated above, after the report of the tragic death of Marie, a number of women came forward and provided information to North Wales Police. This led to seven charges being made, to which P1 pleaded not guilty. These charges were 'left on file' after P1 pleaded guilty to the homicide of Marie. With the agreement of the Chief Crown Prosecutor for Wales three of the women who came forward were interviewed, two by the author accompanied by a Panel member and one by the author alone. One other woman was spoken to on the telephone by the author and a further woman was contacted through the police, resulting in her giving her consent to use the information she had given to the police within this DHR, she was later spoken with briefly by the report author. Additionally, for the purpose of the DHR she gave permission for the Panel to access the minutes of a child protection case conference for the purpose of the DHR.

Information from Marie's family

8.5: Of Marie's closest relatives it was established that those family members who had met P1 were her mother, her children, her nephew and her former sister in law. Marie's mother was introduced to P1 by Marie but we were told that she met him only once. Marie's nephew and former sister in law were with Marie during some part of the day on 13th September. It is acknowledged that given that the family believe the relationship was only

four weeks old, most adults are unlikely to introduce new partners widely to family members so near to the start of a relationship.

Silent 999 Calls

8.6: The author heard that the main issue that the family wished to bring forward was the fact that Marie had made a 999 call that no one acted upon. They found it extremely distressing to know that Marie was afraid enough to telephone for help but no one came to her aid. The call went to a BT helpdesk from Marie's mobile phone but was not passed on. The details of this call are detailed above in the chronology section.

8.7: The family said the call was classed as silent, this means that after BT asked the usual questions of the caller about which service is required there was no answer. It is usual practice that when no response is given the call is ended. The family say that the Police told them that they had obtained a copy of the 999 call from BT and had had the call enhanced and that a man's voice could be heard in the background. The author heard that it is a commonly held view that if a person dials 999 seeking help, then if they cannot speak they will be traced. The family feel that Marie would believe that someone would come and she would get help but no one came.

8.8: The family state that they have approached BT by letter, according to Marie's sister, BT initially said they did not have the letter and so the family approached the press. BT's response was that they get hundreds of silent calls every day and have been told by the police not to put them through. BT said they would raise the matter the family brought to their attention, at their next strategic meeting with the government. This issue was the subject of a press report seen by the Panel; the press report was dated 21st April 2015.

8.9: The issue of meeting new people through internet dating was discussed with Marie's sister but she was of the view that although people may present a false picture of themselves on line they may equally do so if you met them in any social setting, for instance in a pub, or at an evening class. The author was told that no one in the family knew about any concerns regarding P1 at the time Marie met him.

8.10: The family made a statement at the court hearing, telling of their devastation and heartbreak and saying how kind hearted and loving a mother, sister, aunty and friend to many Marie was.

Footnote: Following quality assurance of this report by the Home Office, Panel members were made aware of a national scheme called the Silent Solutions scheme, where callers dialling 999 and unable to speak can cough, or tap 55 on the handset when prompted to indicate they are in danger and need assistance. We found that this scheme has been in place for some years, However, after another case, which was investigated by the IPCC, the report being at the end of 2016, we found reports that a national recommendation was made to the Home Office and Metropolitan Police

to review the Silent Solution system. Press reports from January to June during 2017 state that the system is little known about, even though after review of the Silent Solutions system the Deputy Chief Constable of the National Police Chiefs Federation said they were now considering "How best to Educate the Public and Police Officers about the system to make sure those at risk of harm get the help they need.".

Before Publication this DHR report was shared with the Following People

The sister of Marie who also represented the maternal family

The ex-husband of Marie who also represented Marie's children

The three women victims who we interviewed as part of the review

The report was signed off by agencies as follows

AGENCY	Report sent	Signed off
The Royal British Legion	06/07/16	Yes 08/08/16
Wrexham CC	08/07/16	Yes 28/07/16
Fire Service WCBC	07/07/16	Yes 04/08/16
Ambulance WAST	07/07/16	Yes 16/08/16
ABUHB	08/07/16	Yes 07/11/16
North Wales Police	07/07/16	Yes 22/08/16
BCUHB	07/07/16	Yes 18/08/16
Probation NPS	05/09/16	Yes 21/09/16
Flintshire County Council	07/07/16	Yes 15/08/16

9. Criminal Investigation

9.1: There is no evidence that anyone other than Marie and P1 was at the property on the night of the attack that led to the murder of Marie. When the Community First Responder arrived Marie was already in cardiac arrest. Upon the arrival of the ambulance, further advanced treatment was given but it appeared the victim had been dead for some time.

9.2: When P1 called the ambulance he did not say that Marie was dead, however, she must have been dead by that time and he told the report author he waited to call the ambulance for a long time, about five hours in fact.

9.3: At the hearing on 19th December 2014, P1 pleaded guilty to the offence of murder, a plea which was not expected. Had he pleaded not guilty to the murder of Marie, he would have been tried for seven further offences for domestic related actual bodily harm alongside the murder. Given the Guilty plea, these additional seven cases still remain 'on file'.

9.4: The Sentencing Hearing on 24th February 2015 heard that P1 had battered Marie to death. The post mortem found substantial internal and external injuries as well as strangulation. The hearing heard that "*some hours went by before you called the emergency services"*

9.5: The Judge in his summing up stated that there were a number of aggravating features; these were that P1 knew that Marie was vulnerable because she had been drinking, the nature and ferocity of the attack were the Judge said "*Quite appalling*"; the Judge noted that P1 had a previous conviction for 'Battery'. The Judge said that "*I should record the fact that I have no doubt you intended to kill this woman. Your actions on that night are consistent only with that conclusion."*

Inquest

9.6: On 15th September 2014 the Coroner, John Gittins, opened and adjourned and inquest into the death of Marie.

On the 29th December 2014 a Coroners Certificate was issued under Schedule 1 of the Coroners and Justice Act 2009, confirming that the inquest would not resume as criminal proceedings were instituted on a charge of murder. As a result of those proceedings the defendant was convicted. As P1 pleaded guilty to causing Marie's death there was no subsequent inquest.

There are no other parallel investigations in relation to this case.

P1 the Perpetrator

10.1: The report author wrote to P1 to provide him with the opportunity to take part in the DHR process. P1 indicated his willingness and was subsequently visited in prison by the author and a Panel member. During that interview the process of the DHR was explained to P1 and he was told that not all the information he gave may be used. It was explained that the primary purpose of meeting him was to see if he could contribute anything which might help us learn lessons that might prevent future tragedies such as Marie's death. P1 was asked to allow access his health records.

10.2: P1 was born in 1967 and he is an ex RAF police officer. P1 stated that he served for nine and a half years before buying himself out. Since that time he has had a number of jobs sometimes through agencies and sometimes direct employment.

10.3: The Review Panel was presented with evidence that P1 had established relationships with a number of women over time. We obviously do not know about all his relationships but we do know that he was married twice and both marriages ended in divorce. The second divorce was finalised at the start of the DHR timeline in 2005. P1 has two children both are from his first marriage and both are now adults. Despite the fact that P1's first marriage ended in divorce in 1995, he has maintained some contact with his children but

this contact has not always been consistent. Latterly though, they had both lived with him. We were told that P1's eldest child moved to his home when she was about 17 years of age.

10.4: P1 started the interview by saying that he had a mental breakdown several years ago in 2007 when he was diagnosed with PTSD by his GP. He said he was crying and could not go to work. He told us that he was prescribed antidepressants but only took them for a week as they did not agree with him and he felt worse, not sleeping etc. Following an outburst, which he said was not physical; he went back to his GP in 2008.

10.5: P1 alleged to us that as a child he was physically and emotionally abused by his father, this is something he also told to some of the women he met and this is mentioned in their statements to the police. He also alleged that in 2002 he was the victim of Domestic Abuse, he did not state by who but he said that he had telephoned a helpline but they were not interested in helping him, as he was a man.

10.6: P1 made statements to us, which to some extent contradicted the statements of his victims. However, he did state that he was volatile and that women may have been very frightened of him due to that and the fact that he is a big man. He suggested to us that he had not understood the allegations made against him in 2006 and that he had not had support at that time. He described the court process as "bizarre" and that he had not realised he was pleading guilty to 'Battery' at the time. When asked about support to him at the time of his conviction he did not mention his Probation officer or any support he might have gained through that service, had he asked for such support.

10.7: P1 said that he was living with his mother and working part time after his conviction so could 'knock off' the hours of community service quickly.

10.8: When talking about the homicide P1 did not try to blame Marie in any way for what had happened, neither did he deny his guilt. Though he did say he had learned that he should avoid relationships where drinking was part of the social life, as he should avoid alcohol. This was to some extent an admission of the impact of alcohol on his actions. We should note here that the statements of the other women report he would drink heavily and much of his violence followed drinking alcohol, though his controlling nature is a constant and not all the alleged assaults were after drinking.

10.9: The main points that P1 made, which he felt were relevant to the DHR, were about the safety of internet dating and how little anyone could know about a person from a webpage. His suggestion though, of sharing criminal background information on sites, is unrealistic. He also mentioned that he wished he had sought treatment for his Mental Health issues and been more persistent in addressing them, instead of agreeing that he was managing. He stated the Mental Health services were the poor relation.

10.10: P1 said he was the North Wales Representative for the Bikers Branch of The Royal British Legion (TRBL) and that he was elected to that position. He said he was not involved in

the welfare side of the organisation but in attending and helping to organise rallies and fund raising events. He was very defensive when asked by the report author about an assault by him on his then partner V5, at a RBL Rally and he was challenging about this incident and blamed V5.

10.11: So the two main points raised by P1 were about the risks of internet dating and the fact that he did not think that Mental Health issues were given the priority that they should have within the Health Service. When asked, P1 said that he got no support from the RAF or from TRBL but he also added he did not ask TRBL for help.

Health of P1

10.12: The IMR of the BCUHB supports the fact that P1 did indeed report that he suffered PTSD to his GP. The first mention of this is on 22nd April 2004 when the timeline from Health reports that P1 was depressed after splitting up with V3 he was referred to the 'First Access' Team by his GP. There was no formal diagnosis of PTSD, which was self-reported by P1 to the GP. The contact with the First Access Team did not continue.

10.14: In December 2006 P1 was self-reporting irritability and anger and saying he had assaulted his partner (given the date this would be V4 and he was charged with an offence against her at this time). He was prescribed medication and referred to counselling, P1 does not appear to have seen a counsellor at that stage. He was reporting irritability and anger in December 2006 and January 2007, which it appears coincides with the aftermath of his assault on V4 and his conviction for Battery.

10.15: Again on 22nd August 2007 P1 reported PTSD to his GP, this was also self-report and not a recorded formal diagnosis. On four further occasions up to 19th September 2007 he reported symptoms of low mood, depression and anxiety, sleeplessness and angry outbursts. He also mentioned on 23rd March 2009 that he was convicted of a crime he did not commit. He was again referred to the First Access team. We should note the only conviction he had was for the assault on V4.

10.16: Although there are letters from the First Access Team inviting P1 for an appointment in April 2009 the main record from First Access in the BCUHB timeline is in November 2009. It is recorded that P1 was having 'verbal outbursts' but the nurse records "*No physical violence*". P1 also told the nurse that he was wrongly convicted of common assault three years ago and felt bitter about that.

10.17: P1 told the report author that his engagement with the First Access Team ended when he told the practitioner that he was managing his symptoms. He told us that he now wishes that he had been clearer and more persistent in seeking help, instead of agreeing that he was managing. The records do indeed confirm that P1 stated he was managing his stress and there was no evidence of mental health problems or mood disorder.

10.18: There was only one referral for substance misuse and that was in 2001 but P1 did not engage with the Drug & Alcohol rehabilitation service, even though he proactively sought help from the service by referring himself. His GP and hospital records show he stated he drank occasionally, rather than by his own admission to the report author, that he should avoid alcohol, and the reports of several people that he was known to drink heavily.

10.19: At the times P1 sought help from the medical profession he was, it appears from the dates of contact with his GP, usually out of any relationship, indicating perhaps that he sought help as relationships ended. For instance around the time of the incident in December 2006 and the court case in 2007 and after splitting up with V3 his second wife. There is no evidence that at the time of his relationship with Marie that he was having or seeking any support due to Mental Health issues, the last entry on his GP health record being for a physical ailment in July 2013.

11. Summary and Analysis of the Information Relating Solely to the Death of Marie

11.1: It is important perhaps at this stage to state, that had no other women come forward after 14th September 2014, the DHR report would have been very brief. However, the fact of other alleged past victims bringing new information to the attention of police and thus the DHR Panel, gave a significant historical context to the offence of the murder of Marie and led the Panel to ask whether there were lessons to be learned, arising from the contact these women may have had with agencies, prior to the murder of Marie.

11.2: This Section of the Report Relates Solely to the Death of Marie.

The relationship of Marie and P1 was very brief indeed. There was no reported history of any abuse in the short time, four to six weeks, during which they knew each other. The family and extended family of Marie had no prior knowledge of P1. Given the short length of time Marie had known P1 she had only introduced him to her mother, who we are told met him once, her nephew and former sister in law also met him.

11.3: We do know that the perpetrator went to Marie's home, after she had been taken home by her nephew without him. Marie was severely beaten and strangled and this resulted in her death.

Key Issues

Agency Involvement

11.4: There were no reports to any agency of Domestic Abuse during Marie's brief relationship with P1. There was no indication through the normal involvement that people have with their place of work or 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 during Marie's relationship with P1. We did not identify any

trigger that would have caused Marie to communicate with agencies, or ask for help, before the night of her death.

11.5: 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.

11.6: We have established that P1's self-report that he suffered from PTSD was not, according to records, formally diagnosed and he was not seeking, or having any treatment for any kind of physical or mental illness for over a year prior to the death of Marie. His last treatment was for a physical problem treated by minor surgery in July 2013. He had no diagnosis of mental illness or treatment, except a brief contact with the First Access Team five years before the homicide. As far as we can ascertain, he had not been in a permanent 'live in' relationship for a long time, since approximately 2006/7, so any medical issues brought to a medical practitioner would not have resulted in a Domestic Abuse or child protection referral under any guidelines which existed at the time.

11.7: However, it is important to note that in the third biennial review of Child Deaths by Brandon et al, 2009 to 2011, it was found that adult orientated services including Mental Health services failed often to consider the impact of adults' presenting problems upon their families. In this case P1 reported several times that he had angry outbursts and in his own report to his GP he referred to an offence of which he was accused. It is not clear from the Health IMR whether the practitioners who came into contact with P1 at these times actually checked whether his reported problems were impacting upon others. It is also not clear whether current procedures would have caused them to do so and indeed it is also unlikely, if he was not in a current relationship when consulting medical practitioners, that any action they took would have resulted in an intervention. Except that by the latter times of his health consultations his daughter was living with him.

Emergency Calls

11.8: 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.

11.9: 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).

11.10: 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.

11.11: 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.

Internet Dating

11.12: Given this relationship was of a very brief duration and that it had begun through internet dating, the Panel has discussed whether there should be any recommendation made to the Home Office about keeping safe on internet dating sites when meeting new people, which might be included in any new campaigns about Domestic Abuse.

11.13: This seemed an especially important consideration given that five internet sites (not all specifically dating sites), were mentioned in the police statements and by interviewees, as being used by P1 to meet and contact people. P1 himself mentioned the safety of internet dating and said in his experience “*No one was honest, with one exception, and no one could check whether the person they were connecting with had previous convictions or any* other *issues”*. P1 said that no one would know, for instance, of his convictions. However, it is simply not going to be the case, as he suggested, that sites should include such details.

11.14: The importance of keeping safe when using dating sites has been highlighted again to the Panel whilst this DHR was being undertaken; when a man was convicted of raping, or

assaulting, seven women met through a specific dating site. The Judge in that case raised issues about the safety of internet dating.

11.15: The Panel considered the safeguards, which are already in place including Clare's Law; which is the Domestic Violence Disclosure Scheme (DVDS) which was introduced following after the murder of 36 year old Clare Wood killed by her ex-boyfriend. An application for information to be disclosed under the provisions of Clare's Law, can be made by either someone who has become concerned about a partner's abusive behaviour or a by a third party – a mother, father, and friend – who is concerned for someone they believe to be involved in a potentially dangerous relationship. But the information isn't handed out lightly – requests go before the police and agencies; ranging from social services, to the National Probation Service and the NSPCC – and information is only disclosed if there is believed to be an imminent risk of harm. Whilst in most cases the disclosure will be made to the person who is at risk as a result of their involvement in a relationship the DVDS scheme does allow for disclosures to be made to another party (other than the person at risk) if that other party is the person who is best placed to safeguard the person who is deemed to be at risk. The person receiving the information may not divulge it to anyone else – if they do, they can be prosecuted under the Data Protection Act. The scheme does allow the police to disclose information about a partner's previous history of Domestic Abuse or violent acts to individuals entering a relationship with a known perpetrator, should they deem it 'legal, necessary and proportionate'.

11.16: The author searched online for information about safety when dating via the internet and she found there is considerable information contained in any straightforward search about this but sites are not consistent. The advice included meeting only in public places and not giving out personal information and not committing too soon to a relationship, there is also information on internet dating scams and so on.

11.17: Given what happened to Marie and the fact that Marie met P1 through internet dating, suggests that all information and services related to Domestic Abuse should include advice, or links to advice, about internet dating and about keeping safe when making contacts through 'on line' sites whether the sites are dating or common interest sites.

Conclusion of this Section

11.18: 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 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 during Marie's relationship with P1.

11.19: We did not identify any trigger that would have caused Marie to communicate with agencies or ask for help before the night of her death.

11.20: 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 agencies had not received any reports of any incidents or concerns which would have prompted any intervention.

11.21: 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.

11.22: However, in terms of the lessons from the homicide of Marie we made three main findings.

- The first relates to silent 999 calls
- The second relates to the issue of the safety of internet dating
- There also appears to be potential to consider the role of GPs and Health Workers when patients report angry, outbursts and mention allegations of violence against them. Panel noted that this arose in a previous DHR in Birmingham and we recommend that nationally the role of GPs and Health Workers in reporting is considered in terms of both guidelines for GPs and training in this regard.

The Panel has made recommendations below in relation to each of these issues.

Recommendations

Mobile Phones and Calls for Help

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 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)

Internet Dating

11.24: We would recommend that there is a national information advert about the risks inherent in using internet dating sites and personal disclosure online. This should include information on how to meet safely, and how to recognise the first signs of coercive control and abuse and what to do about that. (National Recommendation)

11.25: 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. (Safer Communities Board)

11.26: The Panel will approach Welsh Government about the proposed new series of campaigns about Domestic Abuse and ask that the campaigns include the issues with the use of Mobile Phones for calling help and also include keeping safe on line and when using internet dating sites. (Welsh Government)

GPs and Health Workers

11.27: We recommend that training is provided nationally 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 deal with disclosure from patients about abuse that they indicate they may be perpetrating against their partner. (Local BCUHB and National Recommendation)

11.28: 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. (Home Office)

12. Section Two: Some of the Relationship History of P1

12.1: This section of the report is about the previous relationships of P1 and provides an extensive insight into his history; it also provides a background context for his behaviour towards Marie, which led to her death.

12.2: During the timescale set for the DHR we are aware of eight women who had some involvement with P1. One woman appears to have met with him in July 2014, around the time he met Marie and two months before Marie's death. Some relationships are reported to be very brief lasting for only a month or few weeks. Others lasted six months or a longer, he was twice married. Most other relationships were not 'live in' relationships.

12.3: Five women report having met P1 online, one of these was in contact with P1 having not seen him since her schooldays; this woman, V1, ended the relationship swiftly, after being assaulted by P1 in front of another person. P1 was not formally charged in respect of this particular incident as, due to the nature of the incident, the timescales allowed to be able proceed with a prosecution had expired, the author spoke to V1 on the telephone she did not wish for a face to face meeting. All the women mention that they, not P1, ended the relationship.

12.4: 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 of being emotionally abused by his father. He gave the women various reasons for the alleged PTSD; these range from childhood abuse, to losing his first wife and children through divorce, trauma in service with the RAF and suffering Domestic Abuse himself.

12.5: This DHR will focus upon the five women from whom the police took statements of complaint that led in four cases to seven criminal charges against P1, which were ordered to remain on file following him pleading guilty to the murder of Marie. Consent has been gained from these women to use the information they gave within the DHR. 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. 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.

12.6: P1 entered a plea of not guilty to all the criminal charges which remain 'on file'. This review explores the information given to it and cannot comment on the veracity, or otherwise of the information given, as 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 grateful.

12.7: There are four major areas that this report will now focus upon.

a. A Child Protection Case Conference which resulted from the violence of P1. 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 led to the homicide, persisted and that a child was injured on the occasion that the Child Protection Case Conference covered. (At this time P1 was living with V3, who later became his second wife)
b. That it is reported that serious verbal threats continued to be made to P1's first wife V2, many years after the divorce, some of these threats fell within the DHR timescale. (V2 was P1's first wife)

c. That there was an incident, which took place at the end of 2006 and for which P1 was convicted and sentenced in 2007 (V4 was a partner of P1 with whom he resided at the time of the assault)
d. That there was an incident, which occurred at a Royal British Legion Bikers Rally in Monmouthshire, South East Wales, in July 2013, which resulted in the need for the victim's hospital attendance (V5 was a girlfriend of P1 he did not live with her)

13: SECTION 2: A) THERE WAS A CHILD PROTECTION CASE CONFERENCE WHICH RESULTED FROM THE VIOLENCE OF P1.

13.1: Panel became aware of the case conference from the evidence supplied to the police during their investigation into the death of Marie and after the author had read all the statements of the women who came forward and had compiled the information for the Panel to discuss. Although the child protection case conference occurred much earlier than the timeline originally set for the review, the Panel felt this event was relevant to the DHR, as evidence of the length of time over which the behaviour that led to the homicide persisted, and also evidence of the severity of that behaviour.

13.2: There was delay in gathering the information needed to look at this part of the history of P1's relationships. It was a long time 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, because P1 and V3 who was his then partner (later his wife) moved address. V3 and P1 met, we were told, when they worked for the same company in Wrexham in approximately 1998. That company no longer exists. The minutes were obtained via NWP and the author first had sight of these in January 2016.

13.3: The case conference occurred in Wrexham on 8th October 2001.The minutes stated that during the incident in question, that in addition to assaulting V3, that P1 had also assaulted the infant child of V3. There were three children listed in the minutes of the conference and all three were resident with their fathers at the time of the conference, the two older children lived with their father over the border in England. The child who was the main subject of the conference was aged only 4 years at the time. It was this youngest child who witnessed a serious attack on her mother (V3) and was herself injured during the incident. It was also alleged that in addition to the physical assault upon the child, that P1 threatened to throw this child from an upstairs balcony.

13.4: The police had been called to an address in the Wrexham area at 03.16 hours on 9th September 2001 because of a serious incident of Domestic Abuse. It was reported that P1 had smashed a mirror over the head of V3, which resulted in her suffering substantial blood loss. The conference heard that during the incident P1 was also reported to have been aggressive and threatening to the infant and she sustained an injury to her toe and head, as well, also she was allegedly held upside down over a bannister, thus experiencing terror.

13.5: Following the police attendance at the property V3 was taken to hospital and the child was subsequently video interviewed by NWP. In her account the child said she was woken in the night by shouting and got out of bed. She said she was scared of P1 and Wrexham Social Services Department record that there was a referral about the child on that same evening from the local Accident and Emergency Department. From the video interview with the child it was established by Social Services that the child was injured as a result of Domestic Abuse between P1 and V3. Therefore, for her protection the child was sent to live with her father. Later, when being interviewed by Social Services, the child imitated P1 using his fist, the record does not say the child disclosed against who his fists were used.

13.6: P1 was arrested and subsequently charged with offences of Affray and a Section 47 Assault against the infant. The mother declined to pursue a formal complaint about her own injury and withdrew her consent for proceedings to be continued in relation to the injury to the child. However, the child's father did initially allow use of the child's statement for prosecution purposes. However, later he refused a second interview of the child, as he felt that the child had moved on from the incident and did not want to bring it up again for her. The police recorded that they had no previous involvement with either the family of V3 or P1. The mother, V3, stated that she had been assaulted by P1 before this incident and sustained injuries including a fractured skull. These events she said usually occurred during the weekends and were alcohol related. The children, she said, were usually staying with their fathers at the time of the assaults.

13.7: After the incident of 9th September 2001 the infant went to live with her father, the two older children of V3 were also stated as living with their own father.

13.8: During the course of the conference, according to the minutes it became clear that the mother had contacted her former husband at the times she had concerns about events and injuries she had sustained. V3 told the conference that she would not have P1 back in her house and would not continue her relationship with him. According to the case conference report the longer term future of the female infant was not decided at this time neither was the longer term future of the older two children decided. However, records show that the 4 year old did stay with her father and that he fully cooperated with the social services department.

13.9: The conference recorded that P1 came to the office to see the Social Worker between the date of the incident and the date of the case conference. It is recorded in the conference minutes that the precise reason for his visit was unclear. He talked to the Social Worker about the incident of 9th September 2001 saying he thought he acted appropriately by removing the infant from the room where the violence was happening. P1 talked in the visit he made of wanting V3 to have more contact with the infant. He also requested that he speak with the child's father and this was refused by the Social Worker, who recorded that P1 appeared jealous of the ex-husband.

13.10: The Social Worker reported that P1 did not accept responsibility for his actions and that P1 had implied that his relationship with V3 would resume at some point. V3 told the conference she did not know about P1's visit to the office and his meeting with the Social Worker. The former husband said that he was aware of the Domestic Abuse between V3 and P1 but was loathed to become involved/interfere. However, he reported to the case conference that eighteen months before the 2001 incident, (i.e. circa 1999 / 2000) his ex-wife had sustained a skull fracture and that he had reported that to the police. As can be seen, there are some contradictions, as the police stated they have no previous records of V3 or P1.

13.11: The conference decided not to place the name of the 4 year old child on the child protection register as she was not at risk of significant harm, due to the fact that she was now living with her father. However, there was a plan for support and to '*monitor*' the child's safety. The parents were to ensure the infant's protection and keep her safe from harm. The child's father was not to allow visits to her mother if P1 was there and a '*child protection plan'* was to be created with the parents and "*agreed by all* parties*."*

13.12: The final recommendation was that the conference would reconvene immediately if V3 and P1 resumed their relationship and the safety of the two older children would be considered at that point.

13.13: It has been established during the course of this DHR that after the above assaults P1 was charged with Common Assault contrary to Section 39 'Offences against the Person Act' 1861, this related to the assault on the child. And also with Affray contrary to Section 3 Public Order Act 1986. He appeared at Wrexham Magistrates Court on 9th September 2001 and there were subsequent appearances before the same court on 14th September 2001, 23rd September 2001 and finally 16th November 2001 when the proceedings were discontinued. The reason for the discontinuance is not available due to the length of time since. It is known that V3 withdrew her complaint and neither did she agree to allow her child's evidence to be used. At the time the case conference was called the child's father had consented to the child's evidence being used. It is now known through Wrexham's IMR that he withdrew his consent to continue with a further interview as he was concerned about the impact upon the child's welfare. It appears logical that it is for these reasons the case against P1 was discontinued in 2001.

13.14: It is now known that V3 and P1 did resume their relationship and that the children did have access to their mother's home whilst P1 was there. V3 told NWP that early in 2002 she and P1 moved out of the Wrexham area to the town in Flintshire where P1's mother lived. P1 and V3 married in February 2003. V3 records that the child who was subject of the case conference was living with her at the time and her older children visited her at weekends. Social Services Departmental records state the child's primary residence was with her father and that visits for all three children only took place when P1 was on night shifts. Again there are contradictions here, between what was thought to be happening in

regard to the children's arrangements around the time of case closure or soon after and what in fact the case was.

13.15: V3 obtained work in another nearby town and made some friends there. Two of her male work colleagues, she said, were the only people to whom she disclosed that P1 was abusing her and it was these two colleagues who assisted her when she finally left P1 in November 2003.

Other alleged assaults

13.16: V3 has also reported that she was assaulted by P1 on her wedding day and at scooter rallies. V3 eventually left P1 in November 2003 after he allegedly made threats to her children whilst she was at work, one of her older children said P1 had put his hands around the child's throat. The couple divorced in 2005 and after V3 left P1, she states that he would sometimes try to follow her home from her place of work and if she saw him in public, V3 said he would be verbally abusive towards her.

13.17: V3 reported that she has suffered lasting physical and emotional problems as a result of the abuse she suffered at the hands of P1. Wrexham record that at the time of the incident that went to Case Conference in 2001 that V3 was advised about Women's Aid and she was also given leaflets about other support available.

Analysis of the Period when the Case Conference Occurred and Subsequent Events

13.18: At the case conference it was acknowledged that the assaults against V3 were very serious and that V3's infant daughter had also been injured during an incident of domestic abuse, it is also clear that the child was very frightened of P1 and despite her infancy she was able to make that clear to the social worker. At the case conference, the minutes record that members of the conference knew that V3 had withdrawn her permission to use her statement against P1 or that of her daughter. V3 was not able to proceed towards prosecution and that, it seems, was because the relationship was not at an end.

13.19: Conference stated that the child's father agreed at that point to the use of his daughter's statement in the prosecution of P1. The protection of the child relied on her father who, though no risk himself to his child, had stated that he knew about the domestic violence and previous skull fracture to V3 but the child had nevertheless previously stayed with her mother when P1 was present. So there was some evidence at the time of the conference that he was either not sufficiently aware of the danger to his child, or was unable, without support, to manage any challenge from V3 and P1.

13.20: From Wrexham's IMR it was clearly established that the child's father continued to work well with the department, even after the case was closed. This is because he came to the department to inform them that V3 had re-established her relationship with P1 and moved to another town, out of the county. He was given advice about not allowing contact

while P1 was present and also about how to gain a Residence Order. It appears that the child continued to reside with her father, with contact to her mother only being supposed to take place when P1 was not present. However, those arrangements relied on all parties co-operation. Wrexham's IMR is clear that the social worker continued involvement until January 2002.

13.21: It appears that the conference was not reconvened when the couple reconciled because they appear, from the evidence we have, to have lived apart whilst under the jurisdiction of Wrexham SSD and until they moved across the border to the neighbouring county of Flintshire where P1's family lived. The local authorities in North Wales do not share databases and there is no indication that any further report of Domestic Abuse or child protection was made in Wrexham. Furthermore, the child's birth father remained in proactive contact with Wrexham SSD informing them of the change in V3's circumstances and receiving advice from the Social Worker.

13.22: When the incidents occurred relating to another victim, V4, and the preliminary inquiries were made, P1 would not appear on Flintshire's system because the above incidents (2001) were in Wrexham. Additionally, even had this been another Wrexham family that P1 had joined P1 would not appear on that system either; as at that time searches in local authority databases were restricted to the family and not associated males. Nowadays authorities do have databases, which make links with people entered as 'associated persons' but these are still restricted to individual counties and are not shared across borders unless an authority makes a request during an assessment.

13.23: Prior to 2005 if a person was arrested and charged, but not convicted, there would be no record of arrest/charge in the Police National Computer (PNC). Since then as a result of the 'Bichard Report' details of any arrest or of any charge would appear on the data base. This case conference preceded that change in recording practice.

13.24: The Panel recognises that impact on children of Domestic Abuse can be very serious and can affect their long term development. (See Appendix 3)

It appears that the conference did not know about the level of fluidity in the arrangements for the children, as it was thought sufficient safeguards were in place given they lived with their fathers and so an assessment was made that they would be safe, when in fact we know now that they were not always kept away from P1.

13.25: Although, there was recognition of the level of risk, the conference did not take sufficient account of the visit of P1 to the office and what that visit symbolised. If the relationship was in the past, why did P1 say he wanted V3 to have more contact to the child? Neither was sufficient cognizance given to the fact that P1 stated that the relationship would resume and additionally, it was also known at the conference that V3 was not

supporting prosecution of P1. V3 told the police that she still loved P1 and the relationship was not over.

13.26: The conference relied on the father of the infant to protect her. There is evidence on Social Services files that there was an agreed plan, which was monitored for 4 months. There is also evidence that the father of the child in question continued to cooperate proactively with SSD. The fact the prosecution did not proceed and that the couple moved county and married, meant that any further assaults of V3 and any impact on the children continued outside of the county in which the above case conference took place.

13.27: In terms of good practice, after the case conference the Social Worker from Wrexham remained involved to ensure that the action plan was reviewed. The Social Worker remained in contact with the birth father regarding contact arrangements and attempted to speak to V3 on numerous occasions to review these. The birth father was co-operative and proactive in keeping contact. The case was formally closed on 14th January 2002 after the Social Worker was assured by the parents that the child's safety would remain paramount in any arrangements that the parents made between them for her care.

13.28: It seems very unfortunate, and an oversight, that the conference made no full risk assessment of the danger to the other two children of V3 despite the fact they had staying contact with their mother and their permanent residence had, according to the conference minutes, not been decided, though the Social Work record, according to Wrexham's IMR, contradicted the conference minutes in this regard and suggested their residence was decided.

13.29: Wrexham stated at the close of their IMR, that as the incident, which led to the referral to Social Services, took place fifteen years ago, no formal recommendations are required. The reason given was that passage of time means that practice has developed and improvements, which may have been made, are already implemented. This includes improvements in information sharing and the introduction of risk management tools and better quality audit processes.

13.30: "*The adoption of an electronic case management system has helped to confirm and also evidence that information can and is shared quickly and is stored in an orderly format with workflows in place to ensure that work is overseen by supervisors and additionally evidence based tools are used in everyday practice."* Wrexham state that greater emphasis has been placed on making the Child Protection Case Conference a multi-agency forum with all professionals involved with a child or young person being invited to attend and or share reports as part of the meeting.

13.31: Further Wrexham's IMR states that appropriate checks are made with both police; health and other stakeholders to confirm all members of the household are identified and recorded on the social service case management database, RAISE. This ensures that family

members living inside and outside the household are recorded and linked. Additionally, genograms are considered essential to case records and the presence of updated genograms are part of the department's monthly case file audit programme.

Conclusion

13.32: From the Panel's point of view and as far as the DHR is concerned, the most important conclusion from this section is that all workers, from every discipline, should exercise professional curiosity and carefully risk assess the ability of a victim of Domestic Abuse to protect children when the abuse is severe and there is no clear evidence that a relationship is ended. In this case the Panel's view is that there was evidence at the time of the conference and contained in those minutes that the relationship had not ended. Indeed the father of the 4 year old child informed the county the relationship had resumed. The timescale of involvement was short given the situation and the seriousness of the assaults. It could be argued there was insufficient time to test out the plan which was put in place. Although the Social Worker was optimistic about the parents' cooperation, the grooming and control of the offender was seminal to any full assessment of risk. P1 was still very much still part of the life of V3 at the time.

13.33: 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. The Panel is therefore in agreement with Wrexham Social Services Department about the importance of the use of genograms and thorough information sharing between agencies, but this information should also be shared between counties, as not all the children resided in Wrexham.

13.34: The Panel would observe that risk assessment tools are of course very useful but that there is no substitute for 'confident competent practitioners' who are alert to offenders' attempts to groom and control environments and workers, as well as their victims. P1's visit to the Social Work office prior to the conference was no doubt part of this process.

Recommendations

13.35: 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. (Recommendation to the North Wales Regional Training Consortium)

13.36 The training of frontline staff, who 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. (Recommendation to the North Wales Regional Training Consortium)

14 : SECTION TWO B) VERBAL THREATS

14.1: It is recorded in statements that P1 and his first wife V2 were divorced. They had been living together on an RAF base abroad after their wedding. P1 was a dog handler in the RAF police. P1 told the report author that he bought himself out of the RAF after nine and a half years. P1's and V2's first marriage ended, according to V2, due to the severe violence and coercive control she suffered from P1. V2 described to the author of this report how she was not allowed out freely, she said that the money and resources she had were extremely tightly controlled by P1, to the extent she would have to ask for money to buy nappies and take home the penny change. P1 was described as possessive and V2 described extreme violence, which increased during pregnancy. Indeed the description of the level of violence she alleges was horrifying.

14.2: Although this marriage was lived out entirely on RAF property between 1991 and 1995, V2 states that little support was ever offered to her by the RAF, though she was convinced that everyone knew about how she was treated and this included RAF medical staff. At the time 1991 to 1995, V2 returned to the UK with her children and it is recorded that the violence of P1 was investigated by the RAF police. P1's RAF service record contains details of an investigation that was conducted by the RAF Police following V2 reporting to them that she had been assaulted by P1. P1 has mentioned this allegation of assault to various people over time and he has stated that he was exonerated. During the DHR the police further checked this record and the Panel were advised that the outcome of the RAF investigation was "Insufficient *evidence to justify disciplinary action"*, this does not amount to a complete exoneration.

14.3: V2 did have contact with P1 over the years due to the fact he was the father of her children. Contact to the children was not always consistent and at times it was stated as being really problematic but V2 states that she felt even so, the children needed some relationship with their father. Given the difficulties experienced over contact the author was told that the civil courts were involved in deciding the residence of the children and the result of that was a shared Residence Order was made, though the children lived mainly with their mother with 'staying contact' with P1.

14.4: In 2010/11 the oldest child went to live with her father in Wales at the same address where he resided at the time of the homicide of Marie. V2 told the police and the author that she had wanted to visit her daughter for her 18th birthday and had spoken to her daughter about this. V2 described to the author how she switches her phone off at night, not least because this is when P1 tends to contact people. When she awoke one morning P1 had called her 10 minutes after midnight. P1 had left V2 a message to say that if V2 came to the town in which he lived, or even attempted to enter Wales, he would kill her and bury her under the patio. V2 said that her younger daughter was aware of this call, as she was present when her mother played back the message left by P1.

14.5: The second major threat alleged by V2 to the author of this report, occurred when the Child Support Agency (CSA) 'caught up' with P1. V2 says that P1 had moved about and the CSA had been looking for him for a long time. Having located him, V2 said that the CSA had taken money from P1 at source i.e. from his wages and as a result he was very angry. He called V2 and threatened to break her legs.

14.6: V2 said she had not reported these threats and the author asked her why that was. V2 said that she didn't think that anyone would help, as they had not done so in the past. Another reason V2 gave was that it was 'normal' due to the fact that the threatening behaviour had gone on for so long. V2 recalled that she had injunctions against P1 in the past but his behaviour had never changed or been affected by those orders or by anything else.

14.7: V2 said she had no help from people when things were at their worst, neighbours and workers on the RAF base, including health staff and colleagues of P1 must have heard her distress or seen her injuries she said. V2 did report violence to the RAF police on her return to England and this was investigated but V2 said this did not result in any action. V2 felt it didn't help her situation that P1 was also an RAF police officer and so she questioned whether the investigation may have been compromised by his position.

14.8: V2 also said that given her earlier experience of reporting abuse, which was not adequately or sympathetically dealt with, she only acted subsequently to report anything when she was concerned about her children. When her child told her, after contact with P1 and his new wife (V3), that V3 was not allowed to have her children with her when P1 was present, V2 was very concerned and so she phoned North Wales Police to find out why the children couldn't stay because she guessed something must have happened.

14.9: North Wales Police passed V2 to Social Services; V2 could not recall whether this was Wrexham or Flintshire SSD. V2 was put through to a Social Worker and advised not to let the children go to contact with their father. So after that phone call V2 made arrangements for contact to take place under the supervision of P1's mother.

14.10: V2 states the she was not given any information by Social Services as to why the children should not visit V3. It is unclear, and V2 cannot recall, whether she contacted Flintshire SSD or Wrexham SSD. Connections between the injury to the child of V3 in 2001 do not appear to have resulted in a Child Protection Referral about the risk to V2's children; neither does it appear that V2 was given sufficient information to help her to protect them. During the review no trace of a record of V2's phone call was found in either Wrexham SSD or Flintshire SSD records.

14.11: Given this DHR is about preventing abuse in future, the author asked V2 what services or information might help to support victims of Domestic Abuse. V2 stated that support was not advertised enough and it was hard to know what was currently available.

V2 said she would not approach Women's Aid or use a refuge, but when asked, she was not aware of the outreach aspect of Women's Aid.

14.12: V2 said "*There needs to be somewhere you can go and you don't have to wait forever. Help is needed when people are ready to speak. At the GP's you are just a number."*

14.13: V2 said it's not easy to use phone lines "*They watch your phone don't they. They would probably take the phone away from you because its control and psychological, not just physical abuse."* V2 added that *"You may not have credit on your phone."*

14.14: So V2 described how she was watched by P1. V2 also stated that working people are very busy and drop off children and go to work and then pick the children up and get ready for the next day. "*Services are not geared to deal with that lack of space working people have and are only provided within normal working hours".* V2 said that walk in centres should be available as they are for other issues. "*The face to face meeting with someone who really listens is the important thing. It's the relationship with the person you speak to, and it's not the same, it's hard to talk on the phone."*

Analysis of Section 2 b)

The RAF

14.15: The Panel felt the need to be reassured that the severe level of violence that V2 states occurred at the start of the 1990s, whilst P1 was a serving RAF officer, would result in more effective and protective action nowadays.

14.16: In terms of good practice the Panel notes that there is accessible 'on line' information from the Ministry of Defence, which is up to date and contains guidance on Domestic Abuse and a handbook for Civilian Support Services, this information site was dated 23rd February 2015. There is detailed information given on the site about reporting abuse and support services available. There is also good analysis of the concerns that victims may have about reporting and information is given on the site, in order to assure victims that their concerns will be dealt with and so examples are given as to how that will be done. The site is easy to navigate. We also noted the following statement;

"*Domestic Abuse is not tolerated within the Armed Forces. The main policy document for the Armed Forces is Joint Service Publication (JSP) 913, Tri-Service Policy on Domestic Abuse and Sexual Violence (this policy is currently under review). JSP 913 details the responsibilities of the chain of command and the procedures for military welfare provision. The key policy documents for the RAF are: Air Publication (AP) 3392 Volume 2 Leaflet 2414 (Domestic Abuse Practice Policy); AP 1722 Part 3 Leaflet 3528 (RAF Police Procedures for Domestic Abuse, Sexual Violence and Child Protection; RAF Internal Briefing Note (IBN)*

49/14 (Dealing with Domestic Abuse in the RAF) A number of additional tri-service policies that may be relevant to cases of Domestic Abuse are outlined in the document."

14.17: NWP told the Panel they have established that there is no national protocol/ arrangement on 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. The police reported they had identified that there are some local protocols including a protocol that has been developed in the south of England between Thames Valley Police, Hampshire Police and the various armed forces police services (Ministry of Defence Police / Royal Navy Police / Royal Military Police / Royal Air Force Police).

V2

14.18: The interview we undertook was very upsetting indeed for V2 and it was clear to see that trauma from Domestic Abuse lasts a very long time indeed; in that sense it is life changing and all the women victims spoken with directly or by telephone had not been able to simply leave the attacks behind, they were affected emotionally and physically many years later.

14.19: It is clear that listening in an open, empathic, supportive and non-judgmental way when people come forward to report abuse is essential. The practice maxim "*What starts well goes well and what starts badly goes badly"* is true here. Women are unlikely to report again if they are not responded to appropriately on first contact.

14.20: The same applies to the ability of women to follow through with complaints; insufficient support and protection at the time will lead to withdrawal of complaints or not making them at all. Although this is well known already, it seems to the Panel that it cannot be emphasised enough how much this matters.

14.21: This interview showed that the behaviour reported by women who P1 met after his relationship with V2 had ended, persisted over a very long period, some twenty three years.

14.22: A further overall discussion of forms of support for victims is described later in this DHR but we note here that it is important that women are given enough information when they contact services to enable them to make sound decisions about how they can protect their children and whether they need support to do that. In this case inadequate information was given when V2 phoned the police and SSD. Although the advice from Social Services was sound, without clear information, the position of a woman refusing contact, when a court has already made a decision in favour of contact, and in this case of residence too, is compromised.

Conclusion

14.23: One of our aims was to ensure that should incidents of this nature occur on an RAF base today that the response resultant from such incident would be one of proactive action and protection for victims. The Panel found that there is no national protocol/ arrangement

on 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, now or in future and the North Wales Police and Panel also recommends that this protocol should be a national requirement.

14.24: There is moving evidence that there are clear practice issues which need to be followed up in training. These 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 make those contacts with services and the fear they have of doing so. Not forgetting that violence and control will increase if the perpetrator becomes aware of the contact.

14.25: The Panel also notes the very important issue of giving parents and carers sufficient information with which to protect their children.

Recommendations 2 B

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

14.27: We recommend that nationally, consideration is given to developing protocols between police and military police services across the British Isles where they do not already exist. (National Recommendation to the Home Office)

14.28: 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 all workers keep at the forefront of their minds the courage that it takes to ask for help or report abuse. (North Wales Regional Safeguarding Board)

14.29: We recommend that all 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. (North Wales Regional Safeguarding Board)

14.30: 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 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 (DVDS) or Claire's Law as it is also known, and the Child Sex Offender Disclosure Scheme (CSODS).

CSODS 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 also those individuals who pose a risk of harm to children. These may include persons who are convicted of other offences such as serious domestic violence. (North Wales Regional Safeguarding Board)

14.31: We recommend that training 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. (North Wales Regional Safeguarding Board)

15: SECTION 2 c) Incident in 2006 V4

15.1: P1 had a significant relationship with a woman known hereafter as V4, which began after his second marriage (which was to V3) ended and around the time the Decree Absolute for that marriage was finalised in 2005. The couple met after being introduced by mutual friends and they attended a scooter rally together. P1 had an interest in scooters and later in motorbikes. Of the women who came forward, most had been taken to rallies by P1 or met him at a rally.

15.2: V4 entered into a relationship with P1 and he began to live with her and her children. At certain times his children would also stay at the house, V2 confirmed this. When V4 met with the author and another Panel member, V4 told them that P1 was an angry and violent man and he showed a tendency to these behaviours when she entered into a 'live in' relationship with him, V4 said "he would become very critical quite quickly". V4 said that this behaviour was not constant but his aggression would usually be sparked off by very minor events. V4 was aware that P1 was married twice before as he told her this during their relationship. V4 said they moved in together very early in their relationship.

15.3: V4 said she was embarrassed now, because at the time she had believed that P1 could change and she had sympathised with him because he told her he was abused by his father and suffered PTSD due to military service. V4 was reassured by the author and the Panel member that she was no different to other victims who also believed their partners could change; but this reassurance was not really accepted by V4 because she felt she had failed to recognise in herself, that which she would have recognised in others. This she put down to the level of emotional and environmental grooming, which often takes place with, or leading up to physical abuse.

15.4: During her interview V4 described horrific assaults on her that she hid from her family and friends, these assaults she said would often result in injury which was also hidden. V4 was not only assaulted at home but also, like other women P1 met, at a scooter rally. V4

said that the children were in the house when 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. These alleged assaults on V4 are horrific in their detail, aimed significantly at her head and eyes and allegedly including kicking her body with P1's feet encased in work boots.

The Offence in 2006

15.5: There is one specific incident that the DHR will concentrate on and the details of that follow here. On 18th December 2006 P1 visited the pub, later that evening V4 had joined him there and then P1 left the pub, which is near the house to return home. P1 started smashing things up, tearing down curtains and the Christmas tree because he could not find the remote control. P1 telephoned V4 to ask where the remote control was and as a result of his call she went home. P1 then proceeded to assault V4, particularly about her head and she left the house and called the police from the pub nearby. V4 commented that he would bang her head against the wall and so the injuries would often not be apparent due to her hair covering them. V4 felt he was used to doing this and he knew the evidence was not obvious after the assault.

15.6: Police records show that when the police first arrived, V4 and P1 were outside the house; V4 showed them the damage to the house stating that the property had been damaged by P1. According to police records V4 did not disclose the assault upon her at that point. V4 agreed with the police records when we interviewed her, she said she did not tell the police that she had been assaulted on their first visit but reported the damage to the house. The Police did not arrest him due to the fact they were told that the damage was only to property that he owned, P1 left the house but only to go to a nearby location, so he was apprehended by the police but not arrested, thus enabling him to return after the police had left. It is agreed that shortly after the police left P1 did indeed return to the family home and further assaulted V4, removing her glasses so she could not see properly, he severely attacked her.

15.7: The police were called again to the property by V4's daughter who was in her room and could hear the assault. The police arrived and P1 was arrested and charged with common assault on 19th December 2006.

15.8: North Wales Police reported to the DHR that on 19th December 2006, P1 was arrested for physically assaulting his partner by hitting her to the face and kicking her to the leg. Initially, during police interview P1 did not admit or deny causing the injuries to V4, stating he could not remember what had happened. P1 was charged with an offence of a domestic related Common Assault and appeared before the Magistrates Court where he pleaded guilty. He received a sentence of four months imprisonment, which was suspended for two years.

15.9: P1 mentioned the charge relating to this offence when the report author and Panel member visited him in prison. He described the court process as bizarre and said that he did not realise that he pleaded guilty to "battery" at the time. He admitted that V4 would have been very frightened of him and mentioned how big he would be compared to her; but he also significantly minimised the offence and in doing so ensured he made an attempt to undermine V4's allegations by partially blaming her.

15.10: P1 said that after the offence he was living with his mother whilst he found work again and commented that he was fortunate in this circumstance, as he could work part time and quickly 'knock off' the hours of community service. This appears to show that he did not view the punishment as meaningful but something to be got out of the way.

15.11: P1 was supervised by the former North Wales Probation Area (now the National Probation Service) between 5th February 2007 and 4th February 2009 when he was subject to a Suspended Sentence Order following conviction for an offence of Common Assault upon his then partner. He was sentenced to a Suspended Sentence Order with two requirements – two hundred hours Unpaid Work and a twenty four month Prohibited Activity Requirement for him not to approach the victim, her home address, or her place of work for twenty four months. P1 duly completed his 'Unpaid Work' hours. There were no reported breaches of the Prohibited Activity requirement during the term of his Suspended Sentence Order that came to the attention of his Offender Manager.

15.12: The pre-sentence court report that was prepared for court was no longer available to the DHR due to the 'destruction of records policy' of the NPS. However, the NPS IMR letter states that it appears from other records that the NPS recommended in their pre-sentence report that P1 be made subject to Community Supervision with a requirement to undertake the Integrated Domestic Abuse Programme known as IDAP. This programme is an accredited programme designed to address the thinking and behaviour of perpetrators of Domestic Abuse with the intention of reducing and eradicating that behaviour. In this case the court did not follow that recommendation but made a Suspended Sentence Order and two requirements (described above) were attached to the order.

15.13: NPS said that they were confident that the court was aware of previous concerns about P1's behaviour but this was P1's first recorded offence. Due to the nature of the sentence no offence focused work was carried out with P1 as NPS did not have the legal mandate to intervene in such a way. The NPS report that "*This was further exacerbated by P1's minimisation of the seriousness of the matter for which he had been convicted and his general reluctance to address criminogenic attitudes which underpinned his behaviour.*" This latter statement of NPS was manifest during the report author's interview with P1 who continues to minimise this offence.

15.14: The DHR attempted to gain the court records hoping that the court might have retained a copy of the NPS pre-sentence report and that we might see the reasoning behind

the court not following NPS recommendations. However we were not successful as the same situation pertains to the court as to NPS in that all the court records have been destroyed.

15.15: NPS report that P1 completed his unpaid work and there were no breaches of the Prohibited Activity Requirement during the course of his Suspended Sentence Order.

After the Offence in 2006

15.16: However, one of the main foci in interviewing V4 for the DHR arose out of her statement to North Wales Police made after the death of Marie; when she stated that the Prohibited Activity Requirement made in respect of P1 had been breached by him. Therefore, the report author asked V4 about the circumstances of this.

15.17: V4 told the author and Panel member that P1 would usually phone very late at night, (she is not the only woman to state this). V4 said that she would be awoken and feels that people are in a vulnerable state at that time and not thinking straight and are likely to be more afraid. (V2 also reported this). P1 had continued to make threats to V4 and she alleges these threats included not only V4 but her female friend. V4 alleged that P1 threatened to cut her throat and set fire to her friend's house.

15.18: V4 decided, at his request, to meet P1 away from the immediate area thinking that if she did so it would reduce the danger to others. V4 considered that if she did not meet him he would come to her home anyway and to that of her friend. V4 also thought that her contact with him would stop him contacting her "*at all hours*". So V4 met with P1, at first this seemed ok but then P1 stated he wanted her to withdraw what she had said in her statement to the police. This request made her realise that he would never change and so she did not continue to see him.

15.19: We asked V4 what help had been offered to her at the time and we found that there was no offer of additional home security, which in 2007 to 2009 would have been available.

15.20: When we asked if the Prohibited Activity Requirement was explained to her, V4 told us that no one visited her after the court case to go through this requirement with her and explain to her what it meant. V4 said that she had not really understood what areas the requirement was able to control and she felt she could not report the harassment of P1 after she had gone herself to meet with him and this was due to her thinking that she would now be in trouble under the terms of the requirement. V4 also said any information about the Prohibited Activity Requirement did not click at the time and she now felt that if she'd had a link person to call, that would have helped her. Had V4 contacted Victim Support or had a visit from the Police or Probation or the Social Services Department; then the requirement upon P1 not to visit or approach V3 might have been explained to her. However, none of these agencies visited after the court hearing and none it seems had a specific duty at the time to do so.

15.21: The DHR Panel are aware that V4 received a letter from Victim Support, so we asked her about that. V4 said she did not think she needed that help at the time. When asked about support to her and her children V4 said that she thought support for the children would have helped as it took at least a year to get back to normal. "*Looking back I think the kids could have done with some support."*

V4 said; "*All the help is out there but if I don't see myself as being in that situation I am not likely to use it. I wouldn't tolerate that behaviour now."*

15.22: V4 said that she thought that the grooming and control of victims and emotional abuse was less well understood by people. She went on to say that she was always the 'helper' regarding others, so it was very difficult for her to make the mental shift and see herself as in need of help, she struggled to see herself as a victim of abuse.

15.23: V4 said that neighbours and others would have been aware of what was happening but people don't report. V4 said: "*People worry about getting involved and it backfiring on them."*

The Agencies Involved

Flintshire Social Services

15.24: A referral was made by NWP to Flintshire Social Services. The referral was made on a CID16 by NWP the same day as the arrest of P1 in regard to an incident that was first recorded on the night of 18th December being the first call made to the police and it lasted into early hours of 19th December 2006. The CID16 was completed in accordance with guidelines contained in the All Wales Child Protection Procedures. The CID16 was done to refer the family to SSD and contained information, according to Flintshire County Council's chronology, of the two calls to V4's home relating to Domestic Abuse. The first attendance by the police was in response to a call from V4. Upon arrival at 23.20 hours this incident was recorded as damage to property and P1 left the home and handed V4 the key and the police left the property. Later that same night V4's daughter called the police as P1 had returned to the house and was carrying out an assault on V4. The children were in their rooms and could hear what was happening. This second incident was reported to NWP at 01.55 hours on 19th December 2006.

15.25: A further referral was made to Flintshire SSD on 19th December 2006 about the same incident by the Senior Nurse for Child Protection this was due to the fact that V4 had attended A and E with facial bruising and grazes and bruises to both legs. In this referral it was reported that V4's daughter called the police on her mobile phone because the land line had been disconnected by P1.

15.26: Flintshire Social Services record that the matter was referred to the Domestic Abuse Panel after consideration by SSD. This Panel consisted of the range of agencies that would

be concerned with children and their welfare and it was a system developed to manage consideration of the large volume of Domestic Abuse Referrals received by the

Social Services Department This system was not exclusive to Flintshire and it was used in other North Wales Counties at the time.

15.27: The Domestic Abuse Panel met promptly on 20th December 2006 and the Panel decided that there would be a single agency visit by Flintshire Social Services to the family home. The record of the meeting does not record which agencies attended the Panel and there is no record of the considerations or rationale behind the decisions the Panel made. The CAADA DASH risk assessment (A tool designed to measure the seriousness of Domestic Abuse and subsequent risk) was completed at the time.

15.28: There was no record that the Panel considered referring the case to MARAC, however the CAADA DASH risk score when completed was relatively low, scoring three risks, so the likelihood is they decided not to refer to MARAC as the case did not meet the threshold for high risk. We should note that the Panel had no information we know of that would have highlighted the earlier serious assault in Wrexham or the assaults against V2. After the Domestic Abuse Panel, Flintshire SSD record that the case was allocated for a single agency visit on 5th January 2007.

15.29: The Social Worker received supervision on 6th February 2007. The Social Worker said at that time that a letter had been left for V4 at her home address. It is recorded that an agreed action arising from the supervision session, which in Social Work amounts to a direction from the supervisor; was for the social worker to check the welfare of the children with the schools. The diary note of the Social Worker dated 6th February 2007 the same day as the supervision session, also refers to P1's children and says they are not living in Flintshire. Flintshire SSD's chronology also records that on 6th February 2007 that someone contacted Flintshire SSD to say that P1 had been bailed not to approach the family but that V4 had sent messages via friends to P1. The record confirms that P1 had been bailed not to approach the family or the area. We do not know the source of this referral.

15.30: It is also noted that P1 disclosed that his first wife was not living in Flintshire or locally and that she had accused him of Domestic Abuse but he had been exonerated by the RAF. P1 had no previous convictions. P1 was asked about his alcohol consumption but was reluctant to answer questions about that. Concern was expressed in notes about P1's own daughters with whom he had holiday access. P1 said that he did not know their address and had not harmed children. We are not clear to whom P1 made these statements but possibly they were made to Probation as the Social Worker did not see P1 as far as we can ascertain.

15.31: It is recorded also in Social Work records that on 6th February 2007 Probation were involved with P1 and that P1 informed Probation that he was no longer in a relationship with V4.

15.32: A further note in Flintshire SSD's chronology states that in a file audit on 7th June 2007 it was noted the Social Worker involved in the case had left the authority and there was agreement with Senior Management to close the case.

15.33: MAPPA and MARAC were both in existence at this time and Flintshire SSD record that P1 was not referred to either Panel. A check was also made with Flintshire Substance Misuse Service and Mental Health Service and P1 was said not to be known to either.

Analysis of the 2006/07 Assault and Subsequent Actions by Agencies

Analysis of FLINTSHIRE SOCIAL SERVICES Involvement in 2006/7

15.34: The case in question is some nine years old and, inevitably, processes and practice has changed over this time. The Domestic Abuse Panel is not in operation now and was de-commissioned in 2015. All referrals that are received from North Wales Police via a CID16 are checked by the Protection of Vulnerable People Unit and cases where the risk has been identified as 'high' are shared with Independent Domestic Violence Advisors and Risk Assessment Graded rated before being sent onto Children's Services. CID16s where risk has been identified as 'medium' are assessed by Domestic Abuse Officers. On a daily basis these referrals are overseen by a manager within Social Services and a management decision made as to whether there should be a strategy discussion with appropriate multi-agency involvement and subsequent processes. Whilst there have been changes in practice since 2007, Flintshire SSD acknowledge that there are areas for learning and improvement from this DHR, specifically:

- There is no recorded information to reflect sufficient consideration of the welfare of the children in this matter either the children of V4 or P1's own children.
- There was no recorded initial assessment in the case and the home visit recommended by the Domestic Abuse Panel and confirmed in supervision did not take place.
- There is no record of consideration for a MARAC referral arising from the Domestic Abuse Panel. However, the identified risks indicators as part of the DASH referral are low in the number (3 out of 24). However, it is unclear whether the risk assessment was undertaken face to face with V4 and if it was not, this would make it unreliable.
- Recording is not sufficient within the case records to understand why or whether actions did or did not occur:
- The Domestic Abuse Panel did not record which agencies were present/involved in the discussions or record the key decisions made apart from the decision that there should be a 'single agency visit'.
- There is no recorded evidence of the social worker visiting/seeing the children, or of the outcome of the direction in supervision for the Social Worker to make

checks with the children's school, or of the contents of a letter recorded as being left at the address. So the focus on the children is not sufficiently apparent and their views were not ascertained and there is no evidence that actions were in fact carried out.

- A referral from a partner agency is recorded by the professional referrer's individual name. Social Services have not recorded the referrer's role or agency and the information that the referrer gave does not appear to have influenced decision making even though it indicated the relationship had not yet ended.

15.35: So the latter mentioned referral; (see above) raised concern about the safety of the birth children with whom P1 had contact. In the records it is mentioned that the perpetrator stated he did not know his biological daughters' address however this was not verified by anyone. It would have been appropriate for Social Services to ascertain whether P1's ex-wife, V2 knew of the current circumstances, particularly as he stated that his ex-wife, V2, was also a victim of Domestic Abuse. Even if it was known that the children of V4 had suffered no injury, the level of seriousness of the incident should have been seen as risk of significant harm from a child protection point of view. It is well known that bail alone is not a protection for a family and a home visit would have established what the needs of the family were under Part Three of the Children Act 1989, even if Section 47 was not implemented. Furthermore, at the time that the case was put for 'no further action' a phone call had been received indicating the relationship with V4 was not yet over.

15.36: Also P1 disclosed at the time that there had been previous allegations of Domestic Abuse made against him indicating that this was part of a pattern of behaviour. Additionally, we know that P1 was in regular contact with his children and that they had stayed at V4's house. Had a home visit occurred and an initial assessment been completed there is every chance this could have been established with V4 and that contact with P1's ex-wife (V2) about the safety of her children would have revealed the level of risk P1 continued to present.

15.37: It appears that the case was closed by Social Services following a period of inactivity and after a record stated that P1 was being granted bail with a condition that he resided at an address that was outside of the area. There is no evidence of consideration of the family's current situation before case closure. Flintshire SSD state that cases are now audited on a regular basis and a system now operates that would determine that no cases are left "hanging" without intervention.

15.38: As a result of the completion of the Flintshire IMR, the county have made a number of recommendations, which the Panel accepts and these are attached to this report in a group of internal agency recommendations.

15.39: Flintshire SSD's recommendations include maintaining a focus on the impact of Domestic Abuse on children. Updating procedures for managing cases of Domestic Abuse

including a review of 'the disclosure of information policy' with North Wales Police in order to better share intelligence and support victims and so as to reduce risk. Given the difficulty in looking back and fully understanding the actions taken at the time and the reasons behind the decision making there should be a review and updating of the recording policy in Flintshire Social Services Department. The recommendations include a review of the requirement for a Police National Computer check.

15.40: In addition to the recommendations that Flintshire Social Services has made, Panel has made a recommendation regarding supervision of fieldwork social workers and the importance of supervisors carefully recording the instructions given to workers during supervision and then checking that they have been carried out.

Analysis of National Probation Service Involvement

15.41: From the information that we were given in the interview that took place with P1 it seems clear that the punishment that P1 received from the court did not impact on him in terms of any adjustments to his behaviour. From P1's expressed view it seems he saw the unpaid work as something to, in his words, "*knock off*". He continued to minimise the offence according to the offender manager and we now know he did not heed the Prohibited Activity Requirement but continued to threaten his victim, though this was not known to the Probation or any other service at that time. We should note that the Probation Service states they would have checked with the police periodically to ensure the order was not breached and there were no reports of breach; though we expect that NWP would have informed the Probation Service were there any breach of the requirement.

15.42: The sentence of the Court did not include the requirement for P1 to attend Integrated Domestic Abuse Programme (IDAP) a programme that is specifically designed to reduce Domestic Abuse. The Court would have passed sentence based on this being P1's first conviction for such an offence and on the seriousness of that offence.

15.43: The author checked with the National Probation Service DHR Panel representative about how much the service had known about the case that had resulted in charges being brought against P1 in 2001. There is no information on P1's records to indicate that the North Wales Probation Area were aware of the incident in 2001. There was a change in P1's Offender Manager in October 2008. On completing his final sentence plan on 16th January 2009, there is reference to checks being made with Wrexham SSD Safeguarding team regarding the case but no feedback was received by the time the Order was then terminated on 4th February 2009. Probation reported that there is no information on his case records to suggest that this was in relation to a specific query and such checks are routine practice. However, we note that not all the records of this matter are available to the DHR due to the record destruction policy.

15.44: In terms of the current method of managing such cases the National Probation Service point out that the offence predates the establishment of the Wales Probation Trust and the Transforming Rehabilitation Reform Programme, both of which have led to significant changes in Probation practice and have led to the establishment of the new National Probation Service in June 2014. At the time of the offence in 2006 the National Probation Service was not in its current form and the service was known as North Wales Probation Area. Therefore, this review needs to be seen in the light of significant change in recent times.

15.45: It is important to note that in carrying out any analysis of the involvement of the Probation Service with P1 as a result of the 2006 assault, the records of the court were not retrievable, due to the court's destruction policy and the probation records were also minimal due to lack of contact with P1 because there was no supervisory requirement in the court order. Similarly, Probation has a relatively short record retention policy, so not all records were available. The Probation electronic records are limited in content due to the nature of the court order and requirements to which P1 was sentenced. The electronic case records are available but the paper file is not, due to the paper records retention policy of the then North Wales Probation area. This meant it was not possible to establish all of the detail of that period of involvement with P1.

15.46: A pre-sentence report was requested and prepared for the Magistrates Court the report is no longer available but it appears from the North Wales Probation Area records that in view of the assessment regarding the risk he presented, the author of the pre-sentence report proposed P1 be made subject to community supervision with a requirement to undertake the Integrated Domestic Abuse Programme (IDAP). This is an accredited programme for Domestic Abuse perpetrators designed to address their thinking and behaviour. However the Court did not follow this recommendation and he was sentenced to a Suspended Sentence Order with two requirements – two hundred hours unpaid work and a twenty four month Prohibited Activity Requirement for him not to approach the victim, her home address or place of work for twenty four months. Due to the lack of court records, we have been unable to establish why the court seems not to have followed the recommendations of the North Wales Probation Area in terms of sentencing. The sentence given by the Court meant that P1 did not attend any course to address Domestic Abuse which is potentially a missed opportunity to bring about change in P1's behaviour. It must however be noted that the Court will have passed sentence based upon the seriousness of the charge before them and the fact that this was P1's first conviction for such an offence. In view of P1's minimisation of his offending and his limited acceptance of responsibility, it is unclear as to whether his attendance on this programme would have led to changes in his behaviour.

15.47: Due to the nature of the court sentence, the North Wales Probation Area were subsequently not able to undertake any offence focussed work with P1 as they did not have

the legal mandate to intervene in such a way. This was further exacerbated by P1's minimisation of the seriousness of the matter for which he had been convicted and his general reluctance to address the range of criminogenic attitudes which underpinned his behaviour.

15.48: It is acknowledged that periodic contact with P1 to review his circumstances could have improved the quality of the Oasys risk assessment reviews undertaken. However, any involvement would have been tempered by the nature of the court sentence and contact would have to be proportionate with this sentence. Checks were made with North Wales Police in respect of P1's Prohibited Activity Requirement who confirmed there had been no reported breaches.

15.49: There have been significant improvements to Domestic Abuse Policy and practice during the period between the 2006 offence and now. For instance offender managers now ensure they take a clear multi-agency approach to the management of such cases with a strong emphasis on MAPPA and Domestic Abuse MARAC processes.

15.50: Protocols have been established to ensure that Probation Court Staff and Offender Managers have improved availability of access to information from North Wales Police so as to inform assessments and to strengthen the referral and sharing of information in relation to Child Safeguarding. Probation officers have already been reminded of the importance of using this facility to check for previous offences and matters that have come to the attention of the police, prior to writing pre-sentence reports.

15.51: Since the offence in 2006 NWP and the National Probation Service have been actively involved in implementing the Welsh Government's 10,000 Safer Lives standards. It is acknowledged that there is a need to remind staff of the continued importance of this approach to work, as a conclusion of this DHR process.

15.52: The National Probation Service is of the opinion that practice and policy developments since 2008 have led to a significant improvement in the management of Domestic Abuse perpetrators. The introduction of Professional Judgement and the new National Standards emphasise the requirement for reviews to be triggered by significant events rather than timescales which have improved the quality of risk assessments.

Analysis of North Wales Police Involvement

15.53: In terms of good practice: NWP attended a Domestic Abuse incident and as a result of the investigation carried out P1 was prosecuted. The police immediately referred the case to Flintshire Social Services using the communication required, the CID16. This was clearly good practice as the offender was charged and brought to court and Social Services were alerted to the presence of children during the incident.

15.54: The police also attended the Domestic Abuse Panel, which was the management arrangement between agencies at that time; again this multi-agency liaison work was good practice. However, we cannot establish if they were able to share any information about previous concerns about P1, because at the time there was no structure to the Panel's documentation or storage of the Domestic Abuse Panel minutes.

15.55: We found that no face to face support was arranged after the assault of V4 and no offer of home protection was made, though a letter was sent from Victim Support. Having regard to the history of P1, had that history been accessed or known about at the time, such protection may have been suggested.

15.56: No direct explanation was given to the victim about the court requirement which prohibited P1 having contact. Again had this occurred V4 may have been better protected and more likely to report P1's breach of the order. This was a missed opportunity to offer a victim protection and it is something that no single agency appeared to have specific responsibility for.

15.57: The Panel are aware that there is now an IDVA Service, which would mean that had the risks been identified as high, V4 would have had been offered support from an IDVA and that the Prohibited Activity Requirement would have been explained to the victim. It would also have given her the opportunity to report that P1 was in breach of that requirement. If the risk was graded as medium, then such contact, advice and support would now be provided by a specialist Domestic Abuse Officer (DAO) from the PVPU.

Further Issues from Section 2b

Previous Incidents Regarding Children

15.58: As a result of the DHR we have identified that P1's first wife (V2) made allegations of Domestic Abuse against him, we are told that these increased when she was pregnant. It appears that P1 told the Probation Service about this part of his past, though he said he was exonerated. NWP told the report author that the police officer attending the Flintshire Domestic Violence Panel on 20th December 2006 planned to take information about previous concerns with them to the meeting. As stated above we do not have full recording of the meeting and so we cannot establish with certainty what information was shared at that meeting.

15.59: We are also aware of the fact that in 2001 there was a case conference in a neighbouring county as a result of serious domestic violence against V3 and that this also involved injury to a child for which charges were initially brought but then dropped. Again we cannot establish with certainty why they were dropped. In 2007 P1 denied having caused any child any harm in the past.

15.60: We know that it was a child who rang the police about assaults to her mother in 2006. We have also been told by V4 that P1's own children were present at times when abuse occurred. If Flintshire SSD had visited V4 maybe they would have discovered that P1 was not truthful about access to his own children.

15.61: In considering the history of P1 he has, it seems from interviews, statements and records, adversely affected the lives of a number of children as well as their mothers. There is no firm evidence we could find, that the history of Domestic Abuse by P1, where children were present or involved, was known to the agencies at the time of the CID16 referral by NWP on the 19th December 2006 excepting that V4's children were present at that time.

Transmission of Information about Past Assaults etc.

15.62: We must be concerned about the transmission of information about the past violence of those who perpetrate abuse of any kind. Complete knowledge about the full scale of P1's violence or alleged violence does not appear to have been gathered into one place when incidents occurred. Partly, this seems to be because P1 moved about geographically, between England and Wales and within those countries, crossing county boundaries. He also lived abroad during his RAF service. We are aware that the Police National Computer would not produce information about previous allegations/charges that did not result in convictions prior to the Bichard recommendations in 2004 and the implementation of those recommendations in 2005.

15.63: For the purpose of this matter though, in 2006/2007 the MARAC would be embedded in practice. This case did not come to MARAC and given the serious nature of the assault, with children present, it is difficult to understand why, unless we question the way the CAADA Dash tool was used. Clearly the risks were much higher than identified on the risk assessment tool and so this appeared to have reassured practitioners that the risk was lower than it actually was. There was no home visit and so either the tool was used by the police under the conditions when they arrested P1 or by the Panel later but not by interviewing the victim face to face.

15.64: Practitioners from all agencies should be aware that tools do not negate the need to use professional judgement of the facts. It is also the case that where information is unclear and missing it should not be assumed it does not exist. As Lord Laming said the exercise of professional curiosity is required. The DASH risk assessment tool (Now Safe Lives) isn't a definitive assessment of risk but is part of the whole assessment that should be made considering the level of the incident, past history, other family members affected and the information provided by the multi-agency network.

15.65: The DHR Panel is of the opinion that a referral to MARAC should have resulted from the Domestic Abuse Panel in December 2006.

Communication and Services to Victims of Domestic Abuse

15.66: It is very disappointing that there is no evidence of any kind of visit to explain to V4 that she could have gained counselling and support after her experiences. It is not likely, in the view of the report author, that a letter will elicit an adequate response at the point when an incident has occurred. We heard from the victims we spoke to of the importance of face to face contact. We also heard that it is not always in the immediate aftermath that help is required but this may be needed later, when the actual events are over and things have settled a little, giving the victim time to reflect. It is clear that information is not always 'taken in' at the time when people are still shocked and highly distressed.

15.67: It is a serious omission that the Prohibited Activity Requirement was not explained in a face to face meeting with the victim. V4 clearly did not understand the controls it brought and indeed it seemed to inhibit her reporting further harassment as she was not sure she would not be in trouble. Fortunately, there is now a post of Independent Domestic Violence Advisor (IDVA) and this would now mean that V4 would receive a visit and have support through the criminal proceedings and have all processes explained to her if the risk was assessed as High. This case illustrates the importance of having such a service.

15.68: The IDVA would also be able to advise victims of abuse about access to home security for their future protection. V4 said that it would have helped if she had a link person to speak to, nowadays dependent on level of identified risk, this would be the IDVA or the Domestic Abuse Officer from the PVPU.

15.69: The other services which could have been arranged were support for the children. As a result of no agency visiting the family after the events of 19th December 2006 this support was not forthcoming.

Emotional Abuse Grooming and Control

15.70: V4 is not the only person we spoke to who mentioned to us that emotional abuse and coercive control are less understood by the public. V4 said that people found it more difficult to recognise when this was happening to them or their relative or friend.

15.71: Since beginning this DHR new legislation aimed at tackling controlling or coercive behaviour has been added to the statute books under the provisions of section 76 of the Serious Crime Act 2015. This piece of legislation makes it an offence where a person causes someone to fear that violence will be used against them on at least two occasions, or generating serious alarm or distress that has a substantial effect on their usual day-to-day activities.

15.72: Victims can be frightened of the repercussions of not abiding by someone else's rules and this was mentioned by most of the victims who came forward in this matter. Often people fear that violence will be used against them, or suffer from extreme psychological and emotional abuse.

15.73: The Director of Public Prosecutions said in December 2015 "*Being subjected to repeat humiliation, intimidation or subordination can be as harmful as physical abuse; with many victims stating that trauma from psychological abuse had a more lasting impact than physical abuse."*

Conclusion of this Section 2C

15.74: There is from December 2015 a remedy in law which did not exist throughout the period when evidence shows that P1 was abusive and controlling of a number of his victims. The Panel notes that a national advertising campaign is currently raising awareness about 'Coercive Control', which should be a core element of all training across the multi-disciplinary network in North Wales and elsewhere.

15.75: The new Violence Against Women, Domestic Abuse & Sexual Violence (Wales) Act 2015 requires 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 will raise awareness of gender based violence, Domestic Abuse and sexual violence, change attitudes and improve the nature and quality of support provided to victims. The police though are not included in this requirement for training, so local police forces will need to ensure their PVPU officers access it.

15.76: The Panel notes that the events described above, illustrate 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 sensitivity to the level of fear and trauma suffered.

15.77: There were failings in 2006/7 and in summary these were;

- The court did not, it appears, follow Probation's recommendation, 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 Prohibited Activity Requirement had been breached.
- A failure by the social worker to carry out the home visit recommended by the Domestic Abuse Panel and 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.
- It appears that there was some knowledge of the Wrexham assaults probably by Probation at least. It is not clear that this was passed on in any way which would have assisted the assessment of risk by Social Services and the Domestic Abuse Panel.

15.78: 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 agencies. At this stage in the development of national awareness of Domestic Abuse and the level of access to reporting helplines which now exists, it seems reluctance to report is as strong as ever.

Recommendations for Section 2 C

15.79: Panel notes there are a series of improvements that have already been made by the agencies but there are also additional recommendations from NPS and Flintshire County Council Social Services resulting from the findings of the DHR and these recommendations and action plans are attached to this report. In addition to the recommendations made by agencies the Panel makes the following recommendations:

Flintshire County Council

15.80: Flintshire Social Services should ensure that during the supervision of fieldwork social workers supervisors carefully record the instructions given to 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. (FCC)

Recording of Decisions

15.81: 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. (North Wales Regional Safeguarding Boards for Children and Adults)

Courts Sentencing and Record Retention

15.82: 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 offenders 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. (Home Office)

15.83: 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. (Home Office)

The Importance of Assessment and the Use of Tools in Domestic Abuse Work

15.84: 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. (North Wales Regional Training Consortium)

15.85: 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' (previously CADDA DASH) 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. (North Wales Regional Training Consortium)

15.86: 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/she is, 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 perpetrator's circle of contacts to ensure the safety of all other vulnerable contacts is taken into account. (North Wales Regional Training Consortium)

15.87: 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 five 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. (DHR Panel to North Wales Regional Training Consortium)

15.88: 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 and PVPU officers in Wales do receive training that is commensurate to their specific role (North Wales Police on behalf of the Safer Communities Board)

15.89: 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 comfort practitioners. (North Wales Regional Training Consortium)

15.90: 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. (North Wales Regional Training Consortium)

16 SECTION 2 d) The Incident in 2013

16.1: The Panel decided that the DHR should explore this incident due to the fact that it occurred within the scope of more modern policies and procedures relating to Domestic Abuse. Following the Panel's decision, the woman hereafter called V5, was interviewed at her home by the report author and a Panel member. V5 had already made a statement to North Wales Police to which the DHR had access. V5 like some of P1's other partners did not live in Wales and it is perhaps important to state that P1 managed to make relationships across a wide geographical area, especially latterly, given the advent of social media and internet dating.

16.2: V5 told us that she met P1 through a 'Biker' website. He told her he had suffered childhood trauma and was trained in policing. He was, she stated, 'upfront' about his past, this was something upon which V4 also remarked. V5 told us that P1 was very much part of The Royal British Legion and he told her he suffered from PTSD. We should note here that P1 never lived with V5.

16.3: The focus of the visit by the Panel member and report author to V5 was an incident that occurred in July 2013 and so the report author asked V5 to confirm whether the rally she had attended with P1 (and where the assault had occurred) was a Royal British Legion Rally and she said it was the Wales Rally. V5 stated that each year there is a national rally and it is in a different area each time and that year it was hosted by Wales. V5 confirmed that P1 was the North Wales organiser. The rally she said was massive and well organised, bands, awards, money -raising. It took place Thursday until Sunday, in South East Wales. TRBL have confirmed this rally took place and that it was a TRBL Bikers Branch Rally, the Bikers Branch we discovered is 6,000 members strong.

16.4: V5 said that at the time of the Rally, P1 had had a minor hernia operation, which is confirmed by his medical record and was supposed to take a back seat. His colleagues, according to V5 told him to just come and enjoy the rally but V5 said he liked to be in control. He was allegedly; angry that night after he had been drinking and he said he was going to have it out with the organisers that he had not been involved in organising the rally, he was upset that there was not a North Wales flag. He was said to be angry that his personal activities were restricted due to his recent hernia operation.

16.5: It was after he had allegedly been to 'have it out' with the organisers about him not being included in the organisation of the rally that he returned to V5 and assaulted her. V5 commented "*he hit me like he had done this before, maximum impact least obvious damage. "* P1 was jealous of any attention that V5 paid towards any other man and he would suggest that this was not neutral attention; (this sort of comment by P1 was

something other women made statements about too). He would often express his jealousy, he was also complaining about this at the time of the assault on V5.

16.6: V5 told us that her 15 year old daughter was present for part of the assault and also present when V5 reported the assault to the Rally organisers. V5 said that she recalled there was some discussion about calling the police and that "*they* (the organisers) *were not keen*". P1, she said, tried to minimise the assault. V5 was seen by a nurse at the rally site in one of the organisation's tents. V5 said the nurse, was not happy when she examined V5's jaw and suggested that she should be taken to the hospital.

16.7: V5 said she was given a lift to the hospital by main organiser's wife but by the time she got to the hospital (she thought it was about 02.00 hours) she was worried about the effect of what happened on her daughter and she was struggling to walk. V5 suffers from vestibular dysfunction, which causes difficulty with her balance. This was worse as she was tired and shocked. Visible injuries at that time, she said, were a cut and bruise on the inside of her lip she said.

16.8: V5 said she reported to reception at the hospital and was taken to a room and left alone. V5 said the doctor came and "t*he doctor was fine, and was considerate and not judgemental. In contrast (she stated) the nurses were monosyllabic".*

16.9: V5 said a woman came and gave her an X-ray slip and she was left to go to X-ray alone, along dark corridors in a hospital with which she was not familiar and when she was having difficulty walking. She was then left in another waiting room, alone and was dressed only in her pyjamas as she had retired when P1 assaulted her. V5 stated: "*It was horrible I felt treated like trailer trash"*

16.10: V5 said that she was told that the outcome of the X-ray and the Doctor's examination by a nurse in the corridor. The outcome at that time was soft tissue damage.

16.11: During our interview we established that no one at the hospital had asked V5 about where her partner was now, or about how her safety could be ensured when she left the hospital. V5 was very upset about the attitude of the nursing staff, as she perceived it. V5 felt they assumed her unsteadiness, which was due to her medical condition, was due to alcohol. She told us that in her opinion "*They'd labelled me 'drunken biker' and I wasn't drunk"* The hospital state that there was nothing on record about her being intoxicated.

16.12: The Panel member asked V5 if anyone at the hospital had mentioned the police to V5 and she said "*not at the hospital, no"* V5 said she was not given any advice or leaflets by the hospital and she felt not believed by the staff at the hospital. Additionally, V5 said the diagnosis was not correct, as later she was referred to a maxio facial specialist. V5 reported the injury at the hospital where she worked and said that injury to her face was diagnosed and she was, she said, to have physiotherapy treatment, she declined any involvement by agencies as her experience at the South East Wales hospital had put her off that.

16.13: Following her discharge from the hospital, V5 returned with her daughter to the TRBL camp site. On their return they were left in a tent with a 'walkie talkie'. She needed her house keys from her car and P1 was in her car and he tried to minimise everything. She stated that TRBL members had asked him to leave the site but he had remained on site.

16.14: Several hours after the assault and after leaving the hospital, V5 just wanted to get herself and her daughter home so the next morning she got the train back home, she was taken to the station by the organiser, P1 had her car and he did return the car to V5 at a later date. V5 said that her daughter had witnessed part of the assault and she believed this may have stopped the assault escalating further. (Another woman that the author spoke with by telephone also mentioned that she felt the assault on her was lesser, due to a witness being present.) The daughter of V5 did not want to speak to anyone about what had happened at the rally and this was another reason that V5 did not go to the police when she got home. V5 said "*If health, a so called caring profession, treated me like they did at the hospital, how would the police treat me?"* V5 said she felt that she was just treated like an inconvenience. V5 said that "*The shame and guilt of that hospital visit has stayed with me"*

16.15: I asked who the TRBL people who knew about all this were and she mentioned three people, two from the Wirral. She could not recall the name of the South Wales organiser but said that of course he too knew about the assault as he drove her to the train station.

16.16: Lastly V5 said that when she phoned North Wales Police after the murder of Marie she rang the non-emergency number, 101 and she did not feel that the responder was very sympathetic to her call. However, twenty minutes later the Detective Inspector involved in the murder investigation phoned V5 and "he was really nice ".

16.17: We asked what might help others in similar circumstances and she said:

- *To make them feel believed*
- *Whatever your state you should be cared for*
- *To feel cared for and not put in a dark area (it was not a well-lit place). No comfort, like a cup of tea, was offered after such an event.*

AGENCIES INVOLVED AT THE TIME OF THE INCIDENT

Aneurin Bevan University Health Board (ABUHB)

16.18: The ABUHB were responsible for the hospital that V5 visited and so they were asked for a chronology of their involvement and an IMR in relation to the incident in July 2013. They report that on 27th July 2013 at 01:30 hours V5 presented at A and E claiming that she had been assaulted by her boyfriend and had received an open slap to the mouth resulting

in pain to her jaw and over her teeth. Her history was taken and she was examined and had an X-ray.

16.19: From the medical notes it is clear V5's Vestibular Dysfunction was mentioned to the doctor and there was a query about needing a stick to walk with. Tenderness of base of the neck and both joints between skull and jaw is recorded by the examining doctor. It was also recorded by the examining doctor that V5 was nauseous and shook up. The notes say that V5 was discharged with advice about head injury.

16.20: ABUHB reported to the DHR that no note was made of the fact that V5 was accompanied by a child. The notes record that she was accompanied by a daughter for whom no age related data was recorded.

16.21: There was nothing recorded in notes about any action taken in relation to referrals about the Domestic Abuse. *"No evidence of the use of DASH or MARAC being considered on this occasion. No record* of *any advice given. No nursing notes held."*

16.22: As a result of this DHR and ABUHB's internal management review, a series of recommendations were made by ABUHB. These are attached at the end of this DHR report.

The Royal British Legion (TRBL)

16.23: It was clear that the assault on V5 took place at a national TRBL Biker's rally. P1 is well known in TRBL Biker circles and some members we were told clearly knew of his past too, this was established not only with V5 but also with V4. Friends/members of TRBL had spoken to both women about P1's past. He was, according to V5, an organiser for RBL Bikers Branch, something which P1 confirmed to the report author and Panel member when he was interviewed in prison.

16.24: A request was sent to TRBL for an IMR in relation to this incident. They have been slow at times to participate in the DHR (as mentioned in the table in section 4 above).

16.25: TRBL was, on initial contact, asked about P1's role in the Bikers Branch and they replied that this was not official. "*The Royal British Legion Bikers Branch is a branch of the Royal British Legion and has a defined leadership structure. P1 was not is a position of leadership in the Branch. Instead he acted as a point of contact for the 5 or 6 members who lived in North Wales. He had no responsibility for these members, or any others, and did not have a formal role in the branch.* However, according to P1 he was elected to his role, he stated this when asked about it during an interview with the report author.

16.26: As part of the police investigation, following the statement made by V5 after Marie's murder, a statement was taken from the representative of the Wales Region of the Bikers Branch. This statement also confirmed that P1 was the North Wales rep (albeit that he resigned on the morning after the incident at the Rally, but then he took up the role again in May 2014, when no one else was found to take the position.)

16.27: The assault on V5 at the rally was known to the organisers of the rally because V5 reported the assault. TRBL initially said they had no information about the incident. Later they reported that: "*The member who was on duty in the control room at the time was called to the incident, which he reported simply as an argument. Although there was an allegation of assault, our information is that the alleged assault took the form of a slap, which would not be deemed a serious assault in criminal law. By the time the duty member had arrived, the argument was drawing to a close and both parties agreed to separate. Therefore the duty member felt no external agency action was required."*

16.28: TRBL went on to state that *"Later on that night the woman who had been involved in the argument went to the control tent and reported that she was in pain. As a precautionary measure she was taken to the hospital. The woman was then kept separately from P1; including being driven to the train station so she was not in the same vehicle as P1. (*In fact the vehicle belonged to V5 and not to P1.)

16.29: TRBL has been asked about their child protection policy given a child was present. They responded as follows:

"*With regard to the presence of the child, children were allowed at the event only if accompanied and looked after by their parents. The child accompanied her mother to the hospital and was then taken home by her mother."*

TRBL state; "*Therefore, there was no evidence at the time that this was a serious assault. All that was seen by the member on duty was an argument, but the duty member did not see a physical altercation."*

16.30: Given the initial responses of TRBL the Panel asked for more information from them. TRBL eventually provided a letter with policies attached on 4th April 2016.

16.31:

1. The Panel asked what the reporting procedures for the rally were and for an incident report.

   TRBL responded that the rally in Wales, where the incident occurred was an event run by the Bikers' Branch of TRBL. At the time of the incident, the Bikers' Branch dealt with any issues that arose, and did not report matters back to TRBL's headquarters. This has since been acknowledged as a practice in need of improvement and there is now greater engagement between the Bikers' Branch and TRBL headquarters to ensure incidents are reported in a timely manner.

   TRBL stated that at the rally in question, a control tent was in place and there were a number of designated roving patrols, all of whom would have been available to consider reports from any incidents. Any such incidents would then, as appropriate,

have been reported to the main rally organiser who could deploy resource from the main body of rally volunteers.

TRBL told that DHR that the incident took place in June 2013, before such data was automatically electronically saved, and unfortunately no incident report is available. "We have, however, reviewed our retention policies and all incident reports are now filed and kept for an appropriate period."

16.32:

2. The Panel asked what the TRBL policies were regarding child safeguarding.

TRBL enclosed a copy of the TRBL Youth Policy which was in force at the time of the incident in 2013. However, the Panel consider that since this was not a Youth Event it would be highly unlikely that organisers would refer to it at the TRBL rally.

It was clear from the response that TRBL do not appear to have specific safeguarding policies and procedures for use at events, which covers Domestic Abuse or the protection of vulnerable adults. If they have, they have not supplied it.

16.33:

3. Given that P1 was a volunteer the Panel asked what the volunteer training programme consisted of.

TRBL responded that TRBL has a significant number of volunteers and there is therefore not one single volunteer training programme. We can confirm that appropriate volunteers receive training in how to deal with children and vulnerable adults, or where to get advice, as follows:

a. All branch officers receive training in how to complete risk assessments, which now includes information on the specific requirements for vulnerable adults and children. At the time of the incident the advice was more general, as shown in the CRO Handbook and Branch Management Course Workbook

b. The County Youth Officers are provided with comprehensive training on the subject of how to manage children. The relevant County Youth Officer training is attached.

c. Recruiting Officers and Recruiting Advisers are provided with training in event planning. This training is set out in the CRO Handbook.

16.34:

4. Given the Safeguarding policy first provided by TRBL the Panel asked how contact details for the policy were provided to the organisers of the rally.

TRBL responded that TRBL headquarters point of contact was the District Secretary, based at Haig House in London and a telephone number was provided for contacting the District Secretary.

16.35:

5. The Panel asked who the nominated safeguarding lead for the event was.

TRBL said that at the time of the incident it is unlikely the Bikers' Branch would have nominated a safeguarding lead but they were aware that matters of concern would be passed through the District Secretary. TRBL headquarters now ensures events like this have a nominated safeguarding lead.

16.36:

6. The Panel asked if there was a risk assessment for the event.

TRBL said that the risk assessment for the rally was destroyed in accordance with the Health and Safety Executive policy guidance, at a time when it was believed the document was no longer relevant after the event. Retention policies for these documents have now been reviewed, and they are kept for a longer period.

16.37:

7. The Panel asked what arrangements were in place should something happen to a member responsible for a child.

TRBL said in the event a member was incapacitated such that they were unable to look after a child in their care, the control tent would organise suitable care.

16.38:

8. The Panel asked for an explanation of how TRBL checks that the people responsible for the health and safety of others at TRBL events are safe individuals who can make the right decisions in terms of safeguarding others.

Response: *Branch officers receive appropriate training in accordance with the Branch Management Course Workbook which they enclosed. All events are now reported to the County or District in advance, who can assist with this assessment, although in 2013 this was, unfortunately, not always the case.*

16.39:

9. The Panel asked for details of what services are available to assist people suffering from Domestic Abuse, and details of any policies in this regard.

Response: The individuals would be referred to the Operations team for assessment and assistance if possible, or signposting to other services. There are no specific policies in this regard. TRBL added that the training of TRBL volunteers in positions of authority and/ or where they run large events is under constant review. TRBL training materials are reviewed by subject matter experts to ensure that we comply with relevant laws and policies.

Analysis of this Section

16.40: This assault on V5 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 have never met or spoken to each other. The assault described by V5 was said to be a very forceful open handed slap to the head, that V5 says was maximum impact, least visible damage; a description that fits entirely with the statement made to the report author by V4. P1 had again been drinking and alcohol is a frequent factor when P1 attacked his partners, though the report author has been told that this was not always the case. P1 denied the level of the assault, and his responsibility for it, when he was interviewed for the purpose of this DHR.

TRBL

16.41: V5 reports that there was reluctance by the organisers of the Rally to involve the police. TRBL disputed this and say this was a minor assault and an argument. It is hard to see how the slap, which caused V5's head to ricochet back, causing her pain to her neck, could be minor. P1 is big man V5 is a small woman. P1 exerted considerable force when he assaulted V5 and any assault to the head is a cause for considerable concern. The Panel is of the view that the police should have been called.

16.42: Furthermore, V5's daughter was present and was under 16 years of age and she remained upset about this incident to the extent she did not want to discuss it again after they returned home. TRBL state that no incident report for the rally is available and at the time no such data would be electronically saved. Although TRBL have provided their youth policies to the DHR an event such as the Biker's rally would not surely be seen by the organisers of the rally as a 'Youth Event'. We note though that TRBL state that organisers now have training in safeguarding of vulnerable adults and children and we would urge TRBL to ensure that these policies are closely adhered to and that a Domestic Abuse Policy is in place.

16.43: Although TRBL say that children are only allowed to events if accompanied by their parents their Child Protection Policy is clear about their commitment to child safeguarding. There was no apparent consideration at the time of the incident of the implications of this event for the young person involved.

16.44: Although after the incident P1 resigned as North Wales' representative he was later reinstated. Such an action could be seen as condoning his behaviour and though reform should always be allowed for; there is no evidence that this was the case with P1. Therefore, Panel urge caution when investing any power or influence in someone who demonstrates violent and coercive behaviour.

ABUHB

16.45: The treatment of V5 at the hospital she attended was an experience described by V5 as unsympathetic and judgemental. This added to V5's distress and influenced her decision not to go to the police when she got home. V5 said that if a caring profession like Health were not sympathetic towards her, then her expectations of others would be for even less empathy. V5 remains upset by her treatment at the hospital.

16.46: No consideration was given to V5's safety in the hospital or upon her departure. In the hospital she was left to find her way to X-ray alone and left alone in a room. V5 was returning to the rally camp where the perpetrator was still present and the hospital would know this. V5 received no advice on the help or protection she might access after the assault.

16.47: No consideration appears to have been given to child protection procedures; her daughter was 15 years old and witnessed some of what happened. From our interview with V5 we know that her daughter was affected by what occurred and this is one reason that V5 did not report the matter and wanted to put it behind them. There should though have been a check on the age and welfare of the child and a referral to the Social Services of the area in which V5 resided.

16.48: The treatment V5 experienced has stayed with her and she states it still impacts upon her now.

16.49: ABUHB acknowledge that processes which they have in place were not followed in the early hours of 27th July 2013. In the intervening time, Domestic Abuse training has been provided to staff and a dedicated Domestic Abuse web based site has been established for staff as a resource and as part of an awareness raising campaign. Going forward recommendations, which are appended to this report, focus upon the implementation of the 'Ask and Act' guidance across the organisation. Outcomes will be monitored through Health Board procedures and the Regional Statutory Violence Against Women, Domestic Abuse and Sexual Violence Board; on which ABUHB has senior representation.

CONCLUSION OF THIS SECTION

16.50: 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 failed to assess the level

of impact and seriousness of such abuse. The trauma has had a long lasting impact on V5 and her family.

16.51: The ABUHB quickly acknowledged that processes which were in place at the time were not followed and they have made recommendations which will support the experience of those using health services after a domestic abuse incident.

16.52: The situation with TRBL is rather more complex. The rally organisers did to some extent deal with the situation taking V5 to the hospital and train station and separating P1 from her. However, 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. TRBL is a much respected, indeed revered organisation in British life; they need to ensure that their organisation at every level has a zero tolerance of Domestic Abuse and follows procedures laid down. 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.

16.53: In the light of the above information the Panel refers the reader to the action plan of ABHUB and also makes the following recommendations.

Recommendations

16.54: 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. (TRBL, to be monitored by Flintshire Community Safety Partnership FCSP)

16.55: 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. (TRBL, FCSP)

16.56: 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. (TRBL FCSP)

16.57: 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.

17. Summary of Learning from the Interviews with Witnesses and the Statements made available to the DHR.

Learning about the Behaviour of P1

Hiding Offences in Plain Sight

17.1: As a Panel we learned 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. He would temper his revelations by explaining that he suffered from PTSD. P1 would also allegedly state that he was accused of assault by his first wife V2 but exonerated. The reasons he gave to partners for suffering PTSD were varied, military service was one reason and he told the report author he had served in Northern Ireland; abuse by his father was another reason given and the fact of his first wife V2 leaving him was another. The IMR from BCUHB shows that before the offence of homicide P1 had no recorded diagnosis of PTSD. Furthermore, NWP could find no record to support PI's statement that he had served in Northern Ireland after searching his RAF record as provided by the RAF.

17.2: This tendency to self-revelation by P1 led to the people around him thinking that his behaviour was explicable and that he was changing, or would change. We found 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 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 was hiding his violent behaviour in plain sight and this was a common theme throughout this review and no doubt part of his grooming technique.

Alcohol Use, Abuse and Violent Behaviour

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

Minimising Offences

17.4: As stated above P1 did not hide his past he talked openly about it. This had the effect of women knowing about his past usually before anyone else told them; therefore they thought he was being honest, open and was reformed. P1 told the report author and Panel member, when he was interviewed, that he too was a victim of Domestic Abuse. He also made well controlled and almost disguised disparaging remarks about victims. 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 innocent. In this he totally minimised his own responsibility for his behaviour.

17.5: He was able though to admit he was a big man and that women would be very afraid of him when angry. He also made no attempt to diminish his responsibility for the murder of Marie.

Assaults on Parts of Body where Injury is Less Evident

17.6: The pattern of assaults on victims was fairly consistent with the head being usually the target. This would often mean that injuries were hidden by hair. Several women commented they were hit like he'd done it before. Other injuries were in areas more likely to be clothed and so practitioners should be wary of making assumptions when they do not immediately observe physical injury when attending Domestic Abuse situations.

Use of the Telephone Late at Night

17.7: 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 his victims were 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.

17.8: 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 is simply to reduce the possibility of late night contact by having a social media and phone curfew and so only answering when rested and when others are more easily contactable.

Recommendation

17.9: We have made recommendations in regard to dealing with perpetrators of domestic abuse above, but here we would add:

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. (Safer Communities Board)

LEARNING FROM THE WOMEN WHO CAME FORWARD

Trauma Lasts

17.10: The strength of feelings about the abuse that had been suffered was still palpable in the women we met and spoke to. This applies even to long distant events. Some of the women sought counselling after the death of Marie due to the shock of what had happened and the impact upon them given that the memories they had suppressed were brought again into sharp focus with the realisation of what Marie had suffered and knowing how

frightened they were in the past. To suffer such abuse or to lose a loved one through it is a life changing event that is hard to recover from, even with the passage of time.

Reporting Domestic Abuse

17.11: We found that there were many alleged assaults and also behaviours, amounting to emotional abuse perpetrated by P1 that were not reported. From this we have learned that there is a very long way to go before victims of abuse feel sufficiently confident to come forward, not only to make initial disclosures to agencies but to also follow through investigations as far as prosecution.

17.12: Grooming and control of victims is less well understood than physical abuse and the women described how they found it hard to believe this was happening to them. This was especially hard for the women who saw themselves as strong and independent, it was as if the abuse did not fit with their idea of who they were. One woman remarked that this is what happens to other people. When the realisation of what was happening came to them they would end the relationship.

17.13: Although many advances have been made in terms of understanding the impact of Domestic Abuse and although training has been delivered and services have been established and information provided, it is clear that we have a long way to go in order to increase the chances of the majority of abuse being reported. This homicide was the very worst of the abuse P1 committed but it was part of a pattern that existed for at least twenty three years and which has left a trail of fear and anguish in its wake.

Using Medical Services

17.14: The women usually did not seek medical attention for their injuries even though they were often in considerable pain and discomfort. Neither did most of them seek counselling support and advice at the time of the offences.

Phone Line Support

17.15: Given what is stated in the above paragraph it is perhaps important to restate here what one of the women said: *"It's not easy to use phone lines, they watch your phone don't they. They would probably take the phone away from you because its control and psychological not just physical abuse."* she added that "*You may not have credit on your phone."* This indicates that other types of access to help are also needed. At the time of writing the government is reviewing land line charges in phone tariffs due to their lack of use. Given the ability of perpetrators to monitor use of mobile phones due to the display functions, and also the issue of access to help when rural signals are still very poor in Wales, adds up to some inbuilt vulnerability in Domestic Abuse situations from lack of land line availability or usage. (We note in the case of V4, that P1 had disconnected the land line.)

17.16: Panel also notes that 'Live Fear Free' is an All Wales helpline, accessible 24/7. It is a bilingual free service for any individual experiencing Domestic Abuse or sexual violence and does not show up on any telephone bill.

GPs as Support for Domestic Abuse Victims

17.17: The same woman said that help via GP surgeries was not useful due to the difficulty in getting appointments and where she lived there were often language barriers. She would prefer a walk in type facility where face to face contact was possible and staff had experience in dealing with victims of Domestic Abuse.

First Contact

17.18: When someone reports an incident, the way the first person deals with that report affects the ability and motivation of the victim to further report the abuse or to go on to give evidence. This applies whether it is a worker who answers the phone or a person on reception; through to Volunteers at events and Nurses in A and E. V2, V4 and V5 report that they did not proceed to ask for help again because first responses were inadequate, ineffective or disparaging.

The Children

17.19: From the information in the case conference in 2001 to the incidents in 2006 and 2013 we have been told that Domestic Abuse terrifies children across the age range and therefore needs to be sensitively dealt with. It is recorded that in 2001, the then infant child of V3 did not want to talk about the incident to the Social Worker, except to say she was afraid of P1. This was also the case with the daughter of V5 who did not want to go over what had happened. V4 also said that her children took a long time to recover from the assaults on her due to overhearing and witnessing them. The mother of P1's children, (V2), also talked about the extensive impact on her children.

17.20: There are several lessons here.

- Firstly that a great deal of sensitivity is needed in intervention with Domestic Abuse cases where there are children involved.
- Secondly, those children are expressing a great level of fear that takes a long time to diminish. (See appendix).
- Thirdly we heard that the reluctance of the children to 'go over' events or to talk about them at all, influenced the mothers who felt they too must move on, rather than get help at the time. The outcome being that neither the direct nor indirect victims received enough help and support.

Why Neighbours Friends, Relatives and the General Public do not Report?

17.21: It was clear when we spoke to the women and read their statements that neighbours, friends and occasionally relatives knew of the Domestic Abuse but did not report it. The women themselves thought that this was largely due to people fearing for their own safety should they report. Whatever the reason, it seems from what we have seen and heard during this DHR, that there is still a very long way to go in terms of public confidence to report incidents of Domestic Abuse.

17.22: We were also told that P1 had friends who 'knew what he was like' however; they did not report him; or for instance at The Royal British Legion Biker Rally call the police. They did though sometimes warn women about him. It was stated that P1 would threaten others at times, so for instance he allegedly threatened to burn down a friend's house.

17.23: It is likely that in order to increase reporting, that it is not only victims but also witnesses that need to be fully supported, with those services such as home security and a key named officer for reassurance, that are currently offered to victims also being made available to vulnerable witnesses. Given the reduction in services across the board, Panel are left wondering how realistic such a service would be despite what we have found to support the need for such services.

Internet Dating

17.24: We are aware of eight women in addition to Marie who knew P1 and had a relationship with him. Some very brief others longer term. Of these eight, four had met P1 for the first time through the internet and one, (V1), met him again that way, having had no contact with him since adolescence.

17.25: The sites mentioned are Facebook, My Space, Biker Match, Plenty of Fish, and My Yearbook. P1 mentioned in his interview that people with one exception were not honest about themselves on these sites and there is no way of checking people out. We have established that dependent on the given circumstances, that there are opportunities to make use of the DVDS or CSODS schemes to address this. However, for most cases it is necessary to follow the advice online and be careful not to share much information or contact details early in these relationships and of course only to meet in public safe places. We have made a recommendation about including internet dating in safety advice in domestic abuse literature and information, including links to more detailed advice online.

Recommendations

17.26: 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. (Community Safety Partnership)

17.27: 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. (Community Safety Partnership)

17.28: The Panel will request that the new 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. (DHR Panel to Welsh Government)

17.29: We recommend that national discussions about further developments aimed at the prevention of Domestic Abuse includes how family, neighbours, friends and the general public can be encouraged and supported to report abuse. (Welsh Government and Home Office)

18 Good Practice

This report did not find examples of good practice beyond that which would normally be viewed as best practice.

19 Flintshire DHR Report Summary and Conclusion

19.1: This is an unusual and long 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 reasons for delay are laid out in the main body of the report and in tables about the timeliness of responses from the various agencies who were asked to contribute to the review.

19.2: This concluding section of the report will first focus on the murder of Marie, which was the main purpose of the Domestic Homicide Review. We will then look at the conclusions of the wider review that was undertaken and the lessons learned from that work.

19.3: The purpose of a DHR as stated at the start of the report is to:

1. 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;

2. 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. Apply those lessons to service responses including changes to policies and procedures as appropriate; and

4. Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and interagency working.

19.4: The reason for the Domestic Homicide Review in Flintshire was to consider the above issues in relation to death of Marie a 45 year old woman who was born on 24th May 1969 and died on the 14th September 2014. Marie was a divorced woman with two children; she lived in a small rural village and had never lived with the offender (P1). Marie met P1 only a few weeks before her death, in July 2014, through an internet dating site. Marie was a much loved family member she was a mother of two children and she also had a mother, siblings and nieces and nephews, who all live in the local area and with whom Marie would have regular contact. So Marie was a mother, a sister, a daughter and an aunt. Marie lived a stable home life and worked for a company in a nearby town.

19.5: The tragic death of Marie occurred at some point during the evening of 13th/14th September 2014; the emergency services were not called by P1 for some hours after he attacked her. The emergency services arrived at Marie's home at 02.50 hours on 14th September, and Marie was confirmed dead at 03.09 hours.

19.6: In regard to the first three purposes for DHRs 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 any 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 offending behaviour would not be apparent to anyone, unless Marie or a third party

who was concerned or 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 advise Marie of any risk 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. they involved child protection / domestic abuse issues may also have be recorded on the Police National Database (PND) ,if the force where the incident occurred had an electronic record of the incident on their systems.

19.7: If there is one thing we have learned it is that recording offending behaviour really matters. 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.

19.8: In regard to the fourth purpose of the DHR, the prevention of further domestic homicides and domestic abuse, we made three main findings.

Silent 999 calls

19.10: The first finding relates to silent 999 calls. We found, that like Marie, the public perceive that they gain security through carrying and using a mobile phone in a situation where there is a need to get help, and though people may try to seek help via a silent 999 call, that will not guarantee help arriving. We have asked each other as a Panel and the author has asked all the people she interviewed and others, during the course of completing this work, whether they believed help would come through a silent 999 call, most, but not all, thought they would be traced and someone would come to their aid. We have established that is not guaranteed to be the case and so relying on a silent call may prevent people getting help from more reliable sources. The Panel has made a recommendation in this regard, which follows the conclusion. The Panel also takes note of the Silent Solutions scheme which appears, during the winter and spring of 2016/2017, to have resulted in some considerable debate in the National Press as to how well known the scheme was. So, we recommend that much more training and awareness raising, as well as advice to the public is given, in regard to Silent Solutions.

Internet Dating

19.9: The second relates to the issue of the safety of internet dating; the Panel recognises that there are risks associated with meeting any new partner but these 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.

GPs

19.11: There was some evidence that P1 had from time to time sought help, firstly he sought help of his own volition, from a substance misuse service in 2001, and he was offered an appointment, which he did not attend. He then sought help from time to time through his GP. We also found that he did not follow through in terms of his engagement with services, which led to case closure, when he told staff that he was managing. He has stated that he now regrets that he was not insistent that he needed help. He is also adamant that he suffered from PTSD but we found no evidence of formal diagnosis other than self-report by P1 to his GP and to the women he met.

19.12: So the Panel concluded that there is potential to consider the role of GPs and Health Workers when patients report to their GP that they experience angry outbursts and mention that allegations of violence have been made against them. Panel noted that this issue arose in a previous DHR in Birmingham and so recommend that nationally the role of GPs and Health workers in reporting potential Domestic Abuse is considered in terms of exploring the legal and ethical limits which may constrain reporting and developing guidelines for GPs and Health staff and GP and Health staff training in this regard.

19.13: 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 seventeen and a half years in prison.

Conclusion for the Remainder of the Report

19.14: The remainder of the DHR was about 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.

19.15: During the timescale set by the Panel for the DHR, which was the ten years before Marie's death in September 2014, the Panel became aware of eight women, in addition to Marie, who had some involvement with P1. One woman appears to have met with him in July 2014, around the time he met Marie and two months before Marie's death. Some relationships are reported to be very brief lasting for only a month or few weeks. Others lasted six 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 timeframe.

19.16: Five women report having met P1 online, one of these was in contact with P1 having not seen him since her schooldays. This woman, V1, ended the relationship swiftly, after being assaulted by P1 in front of another person. All the women mention that they, not P1, ended their relationships.

19.17: 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 of being emotionally abused as a child by his father. He gave the women 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. We found no evidence that PTSD was ever formally diagnosed and according to medical records PTSD was only ever a self-reported condition. At any rate it is not an excuse for violent behaviour.

19.18: This report illustrates that 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. P1's offending behaviour it seems, stretches over twenty three years and in that time we found information that indicates that he has 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 in at least four cases, a conviction for assault in 2007 and eventually to Marie's tragic death.

19.19: The DHR focused upon the five women from whom the police took statements of complaint that led to the seven charges in respect of four of them, which 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. 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, 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.

19.20: P1 entered a plea of not guilty to the additional seven assault charges made against him. Following his guilty plea to the murder of Marie these charges remain 'on file'. This review explores the information given to it and cannot comment on the veracity, or otherwise of the information given, since as stated 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.

19.21: From the evidence gathered during the DHR there were four major areas that the Panel and now this report have focused upon:

19.22: The first area explored by the DHR Panel was a Child Protection Case Conference in 2001

a) There was a Child Protection Case Conference, which resulted from the violence of P1 in 2001.

19.23: 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 that led to the homicide persisted and in particular because a child was injured on the occasion the Child Protection Case Conference covered.

19.24: It must be acknowledged 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. From the Panel's point of view, and as far as the DHR is concerned, the most important conclusion from this section was that all workers, from every discipline, should exercise professional curiosity and carefully risk assess the ability of a victim of Domestic Abuse to protect children, when the abuse is severe and there is no clear evidence that a relationship is ended.

19.25: In this case the Panel's view is that there was evidence at the time of the conference and contained in those conference minutes that the relationship had not ended even though the mother, V3, was not living with P1 at the time of the case conference. The protection arranged for the child who was injured was that the child went to live with her father and the child was supposed only to have staying contact when P1 was not present. This plan relied on V3 to tell the child's father that P1 was not present and the plan did not take account of P1's ability to groom and control V3.

19.26: The father of the child that suffered injury during domestic abuse did work well with Social Services and informed the social worker in Wrexham that the relationship of P1 with V3 had resumed, albeit in another county. This would make any monitoring of the child's arrangements more difficult.

19.27: 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. 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 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. The children certainly stayed at the family home when P1 was present, though we have no evidence that this occurred before the case had closed, 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.

19.28: 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, and not all the children in this matter resided in Wrexham. Children of Domestic Abusers from previous relationships should also be considered and their parent/carer, informed of any risk to them as a result of recent investigations.

19.29: The Panel would observe 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 are alert to offenders' attempts to groom and control environments and workers, as well as their victims.

The Second Area Explored by the DHR Panel

B Verbal Threats Against V2

19.30: 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.

19.31: V2 married P1 and lived in RAF accommodation with him at the start of the 1990's. V2 told us she suffered a severe level of violence, which began straight after the marriage and whilst P1 was serving in the RAF. 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 in it had in the past. We found that there is no national protocol/arrangement on 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 recommends that such protocols should be a national requirement.

19.32: There was moving evidence 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 that there are clear practice issues about attitudes to victims which need to be followed up in training. These 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 will increase if the perpetrator becomes aware of the contact.

19.33: 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 she knew something must have occurred and so being concerned about the safety of her children V2 contacted the police and social services. The Panel are of the opinion that V2 was not given sufficient information with which to protect her children when she made that call. So the Panel concluded that parents and carers should always be given sufficient information to assist them to protect their children when they make enquiries due to concern about the risk an abusive person may present to their children.

19.34: We also learned a great deal from speaking to V2 about the lasting impact of trauma on families and the difficulties in seeking help, detail of this is in the main body of the report.

The Third Area of the Second Part of the DHR Concerned the only Criminal Conviction of P1

19.35: There was an incident, which took place at the end of 2006 and for which P1 was convicted and sentenced in 2007.

19.36: 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. These reported assaults reported by V4 are horrific in their detail, aimed significantly at her head and eyes and allegedly including kicking her body with P1's feet encased in work boots. 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.

19.37: There were failings in 2006/7 and in summary these were;

- 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, which 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.

19.38: Panel noted that there is, from December 2015, a remedy in law which did not exist throughout the period when P1 was 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.

19.39: 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 local police forces will need to ensure their PVPU officers access it according to their responsibilities.

19.40: 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.

19.41: Lastly it was clear from our interview with V4 that P1 was, we were told, 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 report it seems the reluctance to report is a strong as ever, despite national awareness of Domestic Abuse and the continuing

development of responses to it and despite the level of access that now exists for the general public to reporting helplines.

19.42: 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 NPS and Flintshire County Council Social Services as a result of the findings of the DHR and these recommendations and action plans are attached to this report. In addition to the recommendations made by the agencies the Panel also made recommendations which follow this conclusion.

The Fourth Area Explored by the DHR Panel

d) That 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.

19.43: The assault on V5 which took place in July 2013, 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 have not met or spoken to each other. The assault described by V5 was said to be a very forceful open handed slap to the head, that V5 said "was maximum impact, least visible damage," a description that fits entirely with the statement made to the report author by V4. P1 had again been drinking and alcohol is a frequent factor when P1 attacked his partners, though the report author has been told that this was not always the case. P1 denied the level of this assault, and his responsibility for it, when he was interviewed for the purpose of this DHR by a Panel member and the report author.

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

19.45: The ABUHB acknowledged that processes, which were in place in the hospital at the time of V5's attendance there were not followed and so they have made recommendations, which will support the experiences of those using health services after a domestic violent incident.

19.46: The situation with TRBL is rather more complex. The rally organisers did to some extent deal with the situation taking V5 to the hospital and to the train station and separating P1 from her. However, there was a failure to appreciate the seriousness of such violence and from what we have been told during this DHR, P1's behaviour was known to members of the TRBL Bikers Group. TRBL is a much respected, indeed revered organisation in British Life, the DHR Panel concluded that they need to ensure that their organisation, at every level, has a zero tolerance of Domestic Abuse and follows procedures laid down. 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.

19.47: The DHR Panel have made a number of recommendations relating to The Royal British Legion and TRBL have written to Panel stating that they accept these recommendations. Panel also accepts the recommendations of the Aneurin Bevan University Health Board all of which follow the conclusion of this report. The CS Board have also made a recommendation to WCVA and NCVO about support for Voluntary organisations in writing and maintaining adequate protection guidance and procedure which includes a statement of nil tolerance of Domestic Abuse. Guidance is also needed regarding the involvement of voluntary organisations in DHRs.

Learning about the Behaviour of the Offender from Victims

Hiding Offences in Plain Sight

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

19.49: As a Panel we learned 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. He would temper his revelations by explaining that he suffered from PTSD. P1 would also state that he was accused of assault on his first wife but exonerated. The Internal Management Review from BCUHB shows that before he killed Marie he had no recorded diagnosis of PTSD; the only mention in BCUHB records of PTSD, is of self-report.

19.50: 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.

Alcohol Use, Abuse and Violent Behaviour

19.51: 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 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.

Minimising Offences

19.52: 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 innocent victims. In this he totally minimised his own responsibility for his behaviour.

19.53: He was able though to admit he was a big man and that when angry women would be very afraid of him. He made no attempt to diminish his responsibility for the murder of Marie.

Assaults on Parts of Body where Injury is Less Evident

19.54: The pattern of assault 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 attending Domestic Abuse situations or dealing with victims of abuse.

19.55: 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 his victims 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.

19.56: 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.

19.57: 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. So there is certainly a need for other forms of support.

Learning from Victims

19.58: Much of what we have heard from the women we spoke to, 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'.

19.59: 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.

19.60: Of significant importance is encouraging reporting by victims, friends, neighbours and relatives, indeed the general public 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 and witnesses 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.

Quality of Practice

19.61: In many ways our findings on balance are much more about the 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 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.

Acknowledgements

19.62: The Panel wishes to record its thanks to Marie's family and to all those who contributed to this DHR, in the full acknowledgement that participation was painful for them, we hope we have used the information we were given effectively, to help learn lessons for the protection of future victims of domestic abuse in future. We have made a number of recommendations throughout this report, in addition to the agency recommendations, all of which are appended to this report. In terms of the

recommendations, some are local and some are for North Wales as a whole and others are suggested for consideration nationally across Wales and England.

19.63: We hope that our learning and the generosity of the people who contributed to this Domestic Homicide review, makes a valuable contribution to the pooled learning from all such reviews.

RECOMMENDATIONS

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 Ministry of Justice 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.

Appendix One Bibliography

All Wales Child Protection Procedures (2008) http://www.childrensrightswales.org.uk/

Bichard Inquiry Report; London Stationary Office: published 22nd June 2004

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'Claire's Law' Domestic Violence Disclosure Scheme: Implemented March 2014

LAMING William Herbert: The Victoria Climbié Inquiry: report of an inquiry by Lord Laming Publisher Stationery Office, 2003

LAMING William Herbert: The protection of children in England: a progress report Publisher Stationery Office, 2009,

Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews-Home Office (2011)

New Learning from Serious Case Review 2009 – 2011. DFE: Brandon et al (2011)

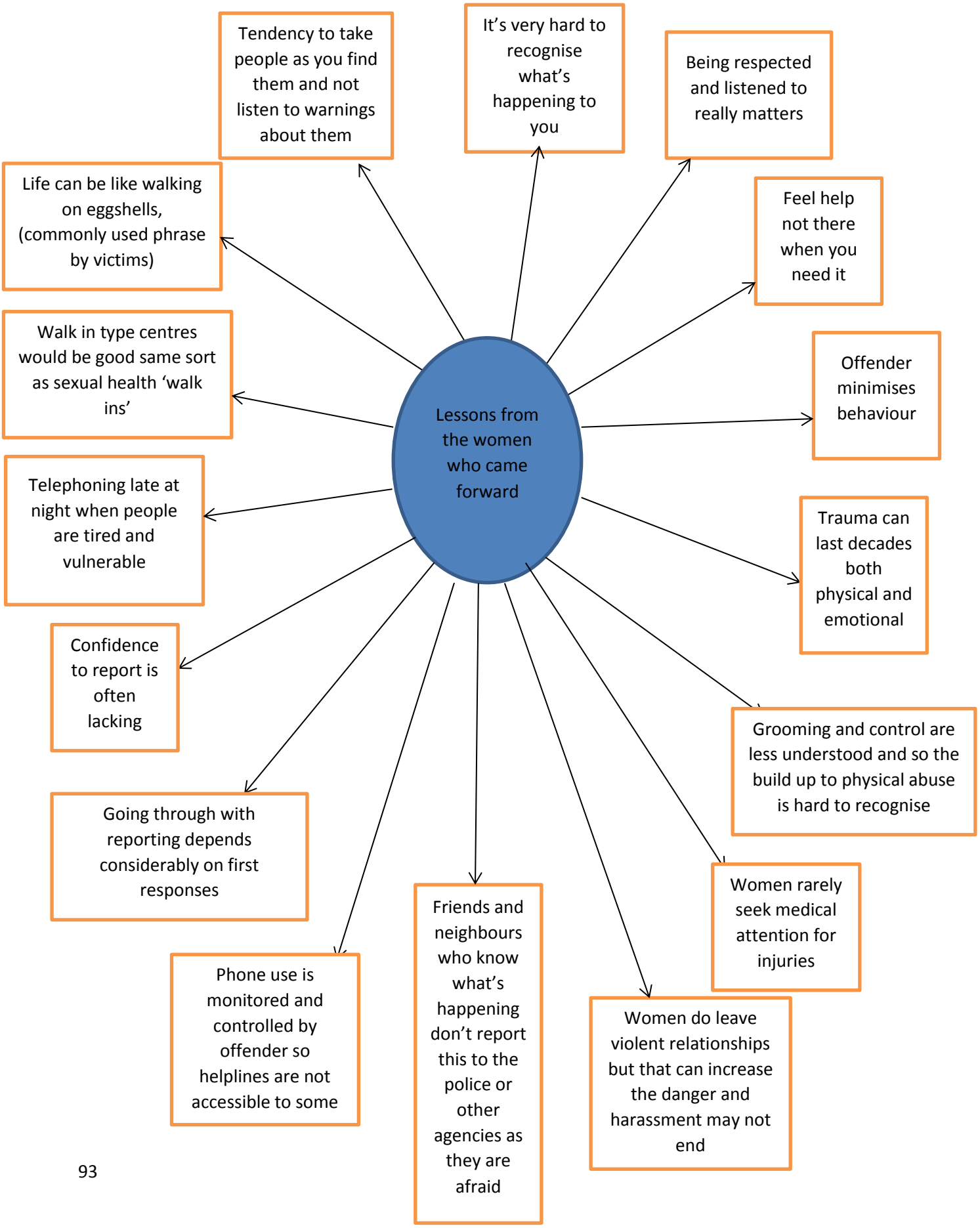
Ministry of Defence Domestic Abuse Guidance and Support: https://www.gov.uk/government/collections/domestic-abuse-guidance-and-support-for-the-armed-forces-community

Serious Crime Act 2015 Section 76 Director of Public Prosecution Alison Saunders CPS.GOV.UK 29.12.2015

Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015.

Appendix 2: Lessons learned from the Women

Summary of Learning from the Women and their Statements



Appendix Three

Impacts upon children of domestic abuse

Effects of Domestic Abuse on children are suggested by researchers to be:

• Increased risk of physical harm or injury—60 per cent of child abuse cases occur in homes where there is family and domestic violence

• Developmental regression—for example regression in language, toilet training etc.

• Emotional/psychological—self-blame, stress, anxiety, depression, maladaptive coping,

(Substance use, self-harm, disordered eating) and post-traumatic stress disorder

• Behavioural—inappropriate use of violence and aggression, trouble sleeping, and children might be withdrawn or hyperactive (Kitzmann, et al., 2004; Moloney, et al., 2007;Osofsky, 1999.

Infants and toddlers are susceptible to even further harm through the impacts of family and domestic violence on parent-child attachment. Research suggests that 60 per cent of infants born into situations of family and domestic violence exhibit insecure and/or disorganised attachment (Buchanan, 2008). This is significant because secure attachment is a strong protective factor, meaning that it buffers the child (to a degree) from adverse situations. Therefore, for children born into an abusive relationship, insecure or disorganised attachment can increase their vulnerability to the emotional and behavioural consequences outlined above. In addition, the attachment style adopted by infants forms the 'template' or basis for their future relationships. Therefore, insecure or disorganised attachment during infancy and childhood might predispose the child to having difficulties with future relationships.

Neurological development is also significantly affected by family and domestic violence. Children who grow up with severe violence and/or neglect are often not provided with the repetition and stimulation in their environment that is needed for optimal brain development. This can 'stunt' brain development in terms of size and connectedness and as a result, cause delays in cognitive and emotional development (Bogat, DeJonghe, Levendosky & Davidson, 2006; Perry, 2007

In addition, the repeated experience of trauma can lead to trauma responses becoming conditioned. This means that whenever the child encounters a reminder of the violence they have been exposed to, it can trigger a trauma response, even in the absence of the perpetrator or a tangible threat. (Bogat, et al., 2006; Perry, 2007).

Compiled by Sue Maskell November 2014

Appendix 4: Terms of Reference

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 14th 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.

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 1st May 2005 and 14th 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 who 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 departments 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 Council.

Appendix 5 – Scope, Process and Timeliness of the review

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 and who reported being the victim of domestic violence related offences committed against them by P1 following the reporting of the murder of Marie.

As a result of the investigations that were conducted into their accounts P1 was additionally charged with seven other charges of Actual Bodily Harm in respect of four of the five 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 these other charges would not be proceeded with and so were ordered to 'lie on file'.

It was agreed in a DHR 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 victims. In order for the Panel to do this, authority was sought from the Chief Crown Prosecutor to include in the DHR those seven prosecution cases that had been ordered to 'lie on file'.

The Chief Crown Prosecutor responded promptly and provided his authority for the cases to form part of the review. During the subsequent initial review of these cases it was identified by the Panel that some of the relationships dated back to 1991.

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 concluded that processes and procedures had changed significantly since 2005 and so the context of the earlier reported assaults would be measured against processes that had by now been significantly changed and so any lessons likely to be learned would in fact already have resulted in changed law, policy and practice.

However, this notwithstanding, there was an exception and this was because after the DHR report author accessed the statements (made by the five women who came forward), she 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, Panel agreed that V2 should be offered an interview as part of this process; an offer which V2 accepted.

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.

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 five and were considered by the Panel to be in the category of additional information, largely since they did not result in any charges being brought as part of the proceedings following the death of Marie.

It was agreed by Panel, following review of all the statements by the report author, that three of the original five women who made statements should be approached and asked if they would be willing to be interviewed as part of the DHR. Of these five women four had made statements resulting in seven 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.

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 report later but she declined that opportunity. A further woman, V1, was spoken to by telephone. No charge was filed in respect of V1 who first knew P1 in childhood; she met him again within the timeframe of the DHR, via the internet.

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 a former wife of P1. (Hereafter, the former wife 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. The minutes of the case conference were, for several reasons, not obtained until January 2016.

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

1. 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 four to six weeks. The fact that the statements made by other witnesses resulted in 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.
2. 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 to Domestic Abuse have changed both in the professions and amongst the general public.
3. 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 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.

4. 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.

Process

On 27th March 2015 formal notifications were sent to agencies asking them to ascertain whether they had any involvement with Marie and her family and if so to undertake a management review of any contact with Marie and P1.

This was the first DHR that Flintshire Community Safety Partnership has carried out and so IMR guidance notes were also drafted, and sent with an IMR template, to the agencies involved this included the employers of Marie and P1.

The guidance notes were specific and stated that agencies that did have involvement with Marie or her family should ensure that the IMR they submitted was signed off by a Chief Officer. The guidance was specific about the content of the report required and also agencies were sent a template for entering chronological information relating to their involvement with Marie.

If the agency had no contact a nil return was requested.

A DHR Panel was established to manage the DHR process and to obtain all the relevant information from the agencies. The Panel's role was to oversee the responses of the agencies in terms of the IMR's submitted and also to ensure the overview report accurately represented the contributions of agencies and met the requirements for DHR reports laid out in the guidance.

An independent chair person was appointed from another Local Authority in North Wales. Two meetings of the Panel took place before the appointment of an independent author. The Panel was made up of a number of representatives from a range of agencies relevant to the case.

At the first meeting it was established that following the murder of Marie, five women had come forward and made statements reporting domestic abuse they had experienced at the hands of P1, therefore the Panel had to consider the information that had been provided. As stated above, some delay occurred whilst the CPS were consulted due to the fact that alleged offences resulted in charges which remained on file, CPS gave agreement to proceed. After the appointment of the Independent Author and during the process of the DHR, substantially more information came to light, leading to the need to send out requests

for further IMRs. In fact it has been a feature of the review that information has come to light as the process proceeded, requiring additional work and clarification.

Terms of Reference were provided to the Panel and as the DHR proceeded these were subsequently reviewed on three occasions during the process. The final version is appended to this report.

In the case of this DHR, which is primarily in respect of Marie, it has been found that there was very little involvement with the victim and none with her children, therefore most contributions from agencies were either a nil return or simply a chronology of contact connected to the incident of Marie's death, for instance, the chronology of the Ambulance Service.

As would be expected for the majority of the general public, both Marie and P1 had contact with the Health Service. However, there were complications in obtaining the Health IMR due to the unwillingness of the GP practice to release information relating to P1 without his consent. Written consent was obtained from P1 during a visit to see him in prison and this was provided to the Health Board in October 2015.

Timeliness of the Review

At first it seemed possible that the review may be delayed by the criminal proceedings and this was recorded by Panel during their meeting on 25th November 2014. The delay was accepted as being necessary in order to ensure that nothing was done to compromise legal proceedings. It was expected that a trial would take place in February/March 2015. However, on 19th December 2014, P1 pleaded guilty to the murder of Marie and the criminal proceedings were concluded on the 24th February 2015 when he was sentenced.

This review has substantially exceeded the six months timeframe specified for the purpose of carrying out a DHR. The delay was not due to a loss of momentum but rather to the complexities that presented themselves to the Panel when a fuller picture of the history of P1 started to become clear.

Delays also occurred due to obtaining necessary consents from CPS and in regard to the women who came forward, in terms of negotiating appointments and completing interviews with the women (referred to in this report as V1 to V5) and in obtaining their written consents to use the information they had provided to the criminal investigation in this DHR. It should be borne in mind that past experiences can be extremely painful to confront, this is true no matter how much time has elapsed and so sensitivity and patience in making arrangements and carrying out interviews was needed. Victims were living across the country in both Wales and England and arranging and carrying out visits took additional time.

During the process of meeting with the women who came forward and in exploring the information obtained from them the Panel decided to request information from other agencies and other health areas, some of which were outside of Wales. Significant delay occurred in this process due to the need to obtain this further information and to the timeliness of some of the responses to requests. Additionally, there was another issue in terms of having to check back the details submitted by some agencies and the need to seek further clarification or explanation of the information received sometimes on more than one occasion.

In accordance with the Home Office Guidance, P1 was also offered the opportunity to engage with and contribute to the DHR process and again letters and arrangements to see him took time. He was eventually visited on 1st October 2015. During the prison visit P1 provided his consent to access his medical records and his consent was passed to the Health Board on that same day. Given the account that P1 had provided to Panel members during the prison visit, it was identified that access to these records was important to the DHR.

A further delay occurred when the Panel requested information from The Royal British Legion (TRBL) who were, at first; slow to fully engage in the DHR. It was the view of Panel that TRBL did not initially understand the importance of a voluntary organisation to participate in and learn from such a process as a DHR. The Panel's view was clear and consistent, in that such a large and well respected organisation at the centre of national life should participate, not least because of its public reach and the number of members that the organisation has. It was not until 4th April 2016 that TRBL provided to the DHR Panel all the required information. The TRBL pointed out that they are a large charity with a great number of volunteers; it was difficult to obtain answers they said from volunteers, due to geographical distance and their limited ability to engage. However, TRBL state that they responded as they were able, taking into account limited resources. This experience has led the Panel to think that there should be specific guidance for Voluntary Organisations who are asked to participate in such a review, currently none exists.

Another delay was due to the format in which some of the information was provided to the DHR. For instance, in one case, information that was provided to Panel was in handwriting (doctor's notes) and simply had to be returned for interpretation and transfer into a typed format. It seemed to the Panel that because DHRs are a new process, that in contrast to the process of carrying out serious case reviews into the deaths of children and adults, agencies have not always understood the requirement placed on them to contribute as promptly and thoroughly as they would in other more established processes.

In terms of good practice though, the employers of both Marie and P1 should be commended for the prompt and comprehensive response to the request to them for an IMR. We should note that they also responded promptly, when further clarification of the information was requested on two occasions.

The final version of the overview report was presented to Panel on 27th September 2016 having been signed off by agencies and to the Flintshire Community Safety Board on 23rd January 2017 when the DHR was accepted by the Board.