Domestic Homicide Review

'Janet'

Died: August 2016

Tony Blockley
Independent Domestic Homicide Review Chair and Report Author
Johnston and Blockley Limited
November 2017

This report is the property of the Vale of Glamorgan Community Safety Partnership. It must not be altered, amended, distributed or published without the express permission of the review Chair. Prior to its publication, it is marked Official Sensitive under the Government Security Classifications 2014

Index

Introduction	4
The Vale of Glamorgan Partnership Against Crime – Strategic governance	7
Establishing this Domestic Homicide Review	7
The purpose of a Domestic Homicide Review	8
Shared principles of the review	9
Terms of reference for the review	9
Scope of the review	12
Methodology	12
Participating agencies	13
DHR Panel Chair and Overview Report Writer	14
The DHR Panel	15
Parallel processes	16
Summary of what agencies knew about Janet and about Adult A (and analysis)	
• South Wales Police	17
• National Probation Service	26
• The Vale of Glamorgan Council – Adult Services	31
• Vale of Glamorgan Council - Housing Department	32
• Vale of Glamorgan Council - Supporting People team	35
• Cardiff and Vale University Health Board	36
• Atal y Fro Domestic Violence Services	44
• Hafod Care Housing Association	45
Interview with Adult A in prison	50
Addressing the Terms of Reference	51
Agency key lessons learned	58
Conclusions	62
Recommendations	63

Preface

'Janet' is a pseudonym chosen by the review panel.

The Vale of Glamorgan Domestic Homicide Review Panel would like to express its profound condolences and sympathy to Janet's family; their loss is still keenly felt.

The panel wrote to and invited Janet's family and friends to be involved in the review. Following a telephone call to the Vale of Glamorgan Violence Against Women Domestic Abuse Sexual Violence (VAWDASV) manager they expressed their wishes that they did not want to take part in the review and the panel respect their wishes. At all times the panel has tried to view what happened through Janet's eyes. We would like to assure them all that in undertaking this review, we are seeking to learn lessons to improve the response of organisations in cases of domestic abuse.

The key purpose for undertaking a domestic homicide review is to enable lessons to be learnt where a person dies because of domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future. Janet's death met the criteria for conducting a domestic homicide review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004. The Home Office defines domestic violence as:

'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional'.

Controlling behaviour is: *'A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.'*

Coercive behaviour is: *'An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'*

The term domestic abuse will be used throughout this review as it reflects the range of behaviour encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

1 Introduction

This is the report of a domestic homicide review (DHR), following the death of Janet on 14th August 2016. It has sought to provide an independent examination of what services were provided or might have been provided to Janet by agencies that may have had contact with her. The review has analysed the service provision, discussing any lessons identified and making recommendations, with the intention of improving the service provided to victims of domestic abuse in the Vale of Glamorgan and elsewhere.

2 A member of the public called the police after Janet had been heard calling for help during the evening of 4th August 2016. The police found Janet conscious, but she had significant burns to her body, which she said had been caused by Adult A. She was taken to hospital by ambulance where she was placed in an induced coma. Despite the best efforts of medical staff, Janet died ten-days later of multiple organ failure and probably sepsis.

3 **Janet**

Janet was 54 when she died. In 1990, she lost her 18-month-old daughter in a house fire, a tragic event that the judge at her trial stated had led to her over-reliance on alcohol, which in turn made her vulnerable to abuse from two male partners. Her life was blighted by abuse from one of them (Adult B) for ten-years to 2007, during which time the police were called on over 40 occasions.

4 Her second abusive partner and the one responsible for her death was Adult A. Between 2007 and the incident that led to Janet's death on 14th August 2016, four significant incidents involving Janet and Adult A were recorded by the police.

5 **Adult A**

Adult A was 62 when he last attacked Janet. He appeared at Cardiff Crown Court on 21st December 2016, where he pleaded guilty to her murder. He was sentenced to life imprisonment, with a tariff of 17-years and four-months. Following the 17-years and four-months, Adult A will be eligible for parole.

6 During the court proceedings, the judge made the following comments:

"There was an intention here to cause serious bodily harm rather than kill…but you left the scene as quickly as you could".

"You had been in a relationship. You were violent with her... In 1990 there was a house fire in which her 18-month-old daughter died…that ended her marriage and she started to drink heavily…she had a great fear of fire".

"Her relationship with you was characterised with domestic violence…the restraining order failed to ensure there was separation".

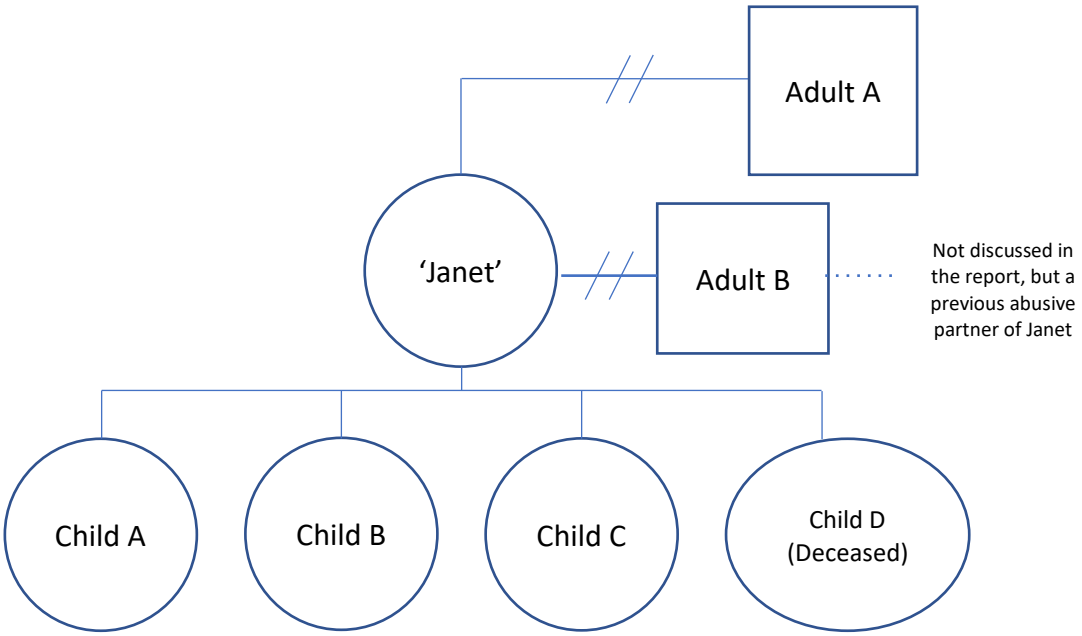
"On August 4 at around 9pm you set her on fire…In her first account to the officer she said you pushed her, told her you were going to kill her, squirted her and set her alight...You did nothing to help her".

7 **Contributors to this review**

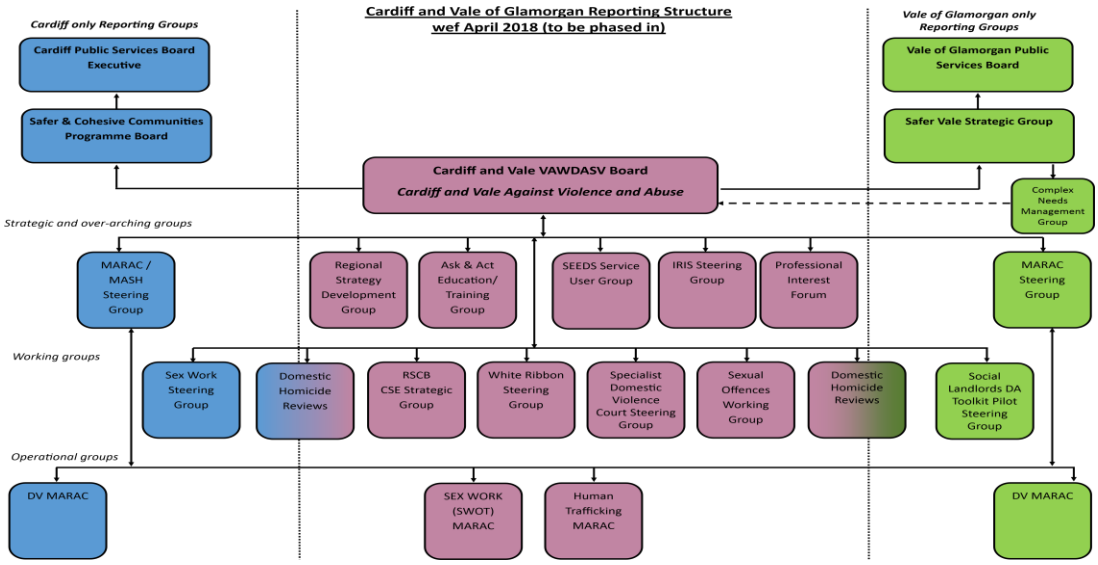
Janet's family and friends, were written to and asked to participate in the review, and/or provide information that could assist the review to gain a better understanding of the events in her life leading up to this tragic event. There was a follow up phone call to a family member who expressed their wishes that they did not want to take part in the review.

Adult A was contacted via the prison office and the offender manager, who had a lengthy conversation with Adult A who stated he did not want to be involved, he also refused to give permission to access his medical records that had been requested on behalf of the panel.

8 Genogram



9 The Vale of Glamorgan Community Safety Partnership



10 Establishing this Domestic Homicide Review

Initially there was an administrative error notifying the partnership of Janet's death. The police contacted Cardiff council, notifying them of the death, however Cardiff council did not notify Vale of Glamorgan. Cardiff council is not the appropriate authority and they should have resent the notification to Vale of Glamorgan, but they did not.

The Vale of Glamorgan was eventually notified on 25th January 2017 and following the decision to hold a DHR, the Home Office were notified on 16th March 2017.

11 The partnership learned that Janet was still conscious when the police arrived and that although she was in great pain, she was able to tell them that Adult A poured lighter fuel over her and set it alight.

12 The police arrested Adult A in the early hours of the morning on the 5th August 2016 for the murder of Janet and he said "Yeah, o.k. yeah" he was subsequently

interviewed and charged with the murder of Janet. When he appeared at court he pleaded guilty to her murder.

13 The purpose of a Domestic Homicide Review

14 The purpose of a Domestic Homicide Review is to:

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

b. 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;

c. Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

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

f. Highlight good practice.

15 Shared principles of the review

The Terms of Reference that will be addressed in the Individual Management Reviews are underpinned by the shared principles articulated in the Vale of Glamorgan Community Strategy 2011-2021, which are the agreed ways of working to reduce the impact of domestic abuse on victims, families and the wider community and ensure that help and support are available. The intended outcomes are:

- A reduction in repeat incidents and increase in early reporting and enhancing safeguarding
- Increased community awareness and access to support
- An increase in the available support and help for victims
- Perpetrators have access to an effective programme to address their abusive behaviour

These will be achieved by:

- The provision of special support and advice to those victims within the criminal justice system
- Ensure effective working relationships between providers of domestic abuse services
- Work closely with substance misuse and alcohol services to identify future collaborative programs to tackle domestic abuse

16 Terms of reference for the review

The review has:

- Invited responses from agencies or individuals identified through the process and requested Individual Management Reviews (IMR's) from each one that was involved with Janet, and/or Adult A (See 'Individual Management Reviews' section below)

- Considered each agency's involvement with Janet and Adult A between 1st July 2011 to 4th August 2016, subject to any information emerging that prompted a review of any earlier incidents or events that were relevant. (See 'Scope of the Review' below)

- Sought the involvement of Janet's family and friends and Adult A, to provide a robust analysis of what happened

- Determined how matters concerning family, the public and media should be managed before, during and after the review and who should take responsibility for it

- Taken account of coroners or criminal proceedings (including disclosure issues) in terms of timing and contact with Janet's family and friends to ensure that relevant information could be shared without incurring significant delay in the review process or compromise to the judicial process

- Considered whether the review panel needed to obtain independent legal advice about any aspect of the review

- Ensured that the review process took account of lessons learned from research and previous domestic homicide reviews.

17 The review has addressed:

- Whether the incident in which Janet died was an isolated event or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence

- Whether there were any barriers experienced by Janet or family/friends/colleagues in reporting any abuse in The Vale of Glamorgan or elsewhere, including whether they knew how to report domestic abuse should they have wanted to

- Whether Janet had experienced abuse in previous relationships in the Vale of Glamorgan or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died

- If there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Janet that were missed

- Whether Adult A had any previous history of abusive behaviour to an intimate partner, a relative or a co-habitee and whether this was known to any agencies

- If there were opportunities for agency intervention in relation to domestic abuse regarding Janet and Adult A or to dependent children that were missed

- If there are any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the region

- Whether there are any equality and diversity issues that appear pertinent to Janet, Adult A and any dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

18 Scope of the review

After discussion, it was agreed to review each agency's involvement with Janet and with Adult A from 1st July 2011 to 4th August 2016, the date of the incident from which Janet died 10-days later.

The 1st July 2011 was chosen as this was the date of an incident involving Janet and Adult A prior to the incident which resulted in him being incarcerated for a significant period of time for an assault upon her.

19 As well as the Individual Management review (IMR), each agency was asked to provide a chronology of interaction with Janet and with Adult A, including what agency decisions were made and what actions were taken. The IMR's considered the terms of reference and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from the perspective of their own organisation and to make recommendations, if appropriate. In addition, they were asked to include information that came to light after Janet's death that might identify learning for the future.

20 Methodology

This overview report has been compiled from analysis of the multi-agency chronology and the information supplied in the IMRs The findings of previous

reviews and research into various aspects of domestic abuse have also been considered, these include:

- The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Call an End to Violence Against Women and Girls – HM Government (November 2010)
- Barriers to Disclosure – Walby and Allen, 2004.
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007.
- DHR Case Analysis Report / Standing Together, November (2016)
- Key Findings from Analysis of DHRs (Home Office, December 2016)
- Preventing Domestic Violence and Abuse: Common lessons Learned from West Midlands DHRs (Dr Lucy Neville and Dr Erin Sanders McDonagh, 2014)
- Southend, Essex and Thurrock Domestic Homicide Review Case Analysis January 2017 (SET DHR Thematic Review Sub-Group)
- The panel Chairs independent research (2017)

21 Participating agencies

The following agencies were asked to give chronological accounts of their contact with Janet and with Adult A during the scoping period:

- South Wales Police
- National Probation Service
- Vale of Glamorgan Council – Adult Services
- Vale of Glamorgan Council – Housing Management
- Vale of Glamorgan Council - Housing Solutions Team
- Vale of Glamorgan Council - Housing Rents
- Vale of Glamorgan Council – Supporting People
- Cardiff and Vale University Health Board
- Atal y Fro Domestic Violence Services
- Hafod Care Housing Association

Other agencies were involved in the review but did not hold any information

- South Wales Fire and Rescue Service*****
- Vale of Glamorgan Children and Young People Services*****
- Wales Community Rehabilitation Company*

22 DHR Panel Chair and Overview Report Writer

The Vale of Glamorgan Community Safety Partnership commissioned Tony Blockley to chair the review chair and to author the overview report. Tony has no connection with Vale of Glamorgan, has never worked or been involved with any agencies included in the review and is independent for the purpose of the review.

He is a senior lecturer at Derby University and is also completing a PhD in domestic violence and abuse, with a focus on risk identification and analysis. He is chair of the multi-agency child sexual exploitation strategic group within Derbyshire, the vice-chair of a domestic violence and sexual abuse services charity and the victims-lead on the advisory board for 'No Offence' CiC. Previously, he was responsible for a

police department that included all aspects of public protection. He devised and delivered training for specialist services that included safeguarding and multi-agency working.

Tony has no connection with Vale of Glamorgan, has never worked or been involved with any agencies included in the review.

23 **The DHR Panel**

The review panel was made up as follows:

24

Name	Organisation
Tony Blockley	Chair/report author – Johnston and Blockley
Julie Grady	VAWDASV Manager
Deborah Gibbs	Community Safety and Partnership Team Leader
Sue Hurley	Independent Protecting Vulnerable Person Manager.
Hannah Williams	National probation service
Vaughan Jenkins	South Wales Fire and Rescue Service
Kay Quinn	Director, Atal Y Fro domestic violence service
Miles Punter	Chair, Director Environmental & Housing
Victoria Harris	Community Rehabilitation company
Yvette Tyndle	Hafod care
Linda Hughes-Jones	Cardiff and Vale University Health Board
Deborah Davies	Children's services
Linda Woodley	Adult services
Helen Jones	Supporting People Manager
Mike Ingram	Head of Housing

25 The review panel met on the following dates:

27th June 2017	31st July 2017
8th September 2017	29th November 2017

26 **Parallel processes**

There was a thorough police investigation into the circumstances of Janet's death and subsequent court proceedings, which resulted in the conviction of Adult A for her murder.

27 Janet's death was referred to the Coroner, who opened an inquest and then adjourned it because Adult A had been charged with her murder.

As there was a full trial and the circumstances of Janet's death were discussed in the court, the coroner in line with the Coroners and Justice Act 2009, did not hold a formal inquest.

28 **Summary of what agencies knew about Janet and about Adult A**

The next section of this report will detail what each agency knew about Janet and about Adult A before the dreadful events of 4th August 2016. An analysis of the involvement of the agency will also be included.

29 ## South Wales Police

30 ## What South Wales Police knew about Janet

During the evening of 2nd July 2011, Janet telephoned the police from a neighbour's house saying Adult A had assaulted her. She added that she had argued with him after he had set-off the smoke alarm whilst he was cooking; he had then grabbed her by her throat, but she had been able to break-free. Janet also said that Adult A had stolen her mobile phone.

Comment: *Manual strangulation is a recurring theme in domestic abuse and it often indicates either an ongoing pattern of abuse or it foreshadows escalating violence. The act sends a message to the victim that the perpetrator holds the power to take the victim's life, with little effort, in a short period, and in a way that may leave little evidence of an altercation.*

31 Although Janet didn't have any visible injuries, the police arrested Adult A for assault. Janet told them that she and Adult A had been drinking together all day and that they were both drunk. She also said that Adult A had been smoking cannabis.

32 Janet declined to make a statement to the police about what had happened; saying all she wanted was for him not to visit her home again. Adult A was interviewed, but he chose not to answer any questions and was released without being charged.

Comment: *Janet will have known through experience that the police would respond swiftly to such incidents and it is probable that she used this tactic to stop the immediate violence or threat of it. Once a volatile situation has been diffused, despite support that is sometimes offered, it is another recurring theme of domestic homicide reviews that victims will call the police to come to their aid in times of crisis*

and then not support a prosecution; it is often a safer option than not involving them at all.

33 The police attempted on several occasions to arrange to take a statement from Janet and they visited her on 5th and 13th July to check that she was okay and to ask again about her making a statement. She said that Adult A was now her 'ex-partner' and reiterated that she did not want to take it any further. The officer gave her contact details for the police domestic abuse unit and Atal –y- Fro (an organisation that helps families suffering domestic abuse – see later).

34 During the visit on 5th July, Janet told the officers that she had been in a violent relationship with Adult A for nine-years. She said he had been sent to prison for four-years in 2004 for assaulting her when he had fractured her skull and cheekbone. She added that she had not given evidence against him on that occasion.

Comment: *The police were aware that Adult A was recorded as a Level 1 MAPPA - Serious Violent Offender.*

It is acknowledged that consideration could have been given for a victimless prosecution however the views of the victim should also be a consideration in any decision around criminal proceedings. In this particular incident Janet was adamant that she did not wish to support a prosecution. Without Janet's evidence and in the absence of any visible injuries to support her initial allegation that Adult A had grabbed her by the throat together with Adult A refusing to answer questions following his arrest it is unlikely that this case would have passed the Crown Prosecution Service (C.P.S) threshold for a victimless prosecution.

Since this time South Wales Police have continually strived to improve the way in which they tackle Domestic Abuse. More recently albeit not relevant for this

particular incident because there was no visible injuries they have introduced body worn cameras for response officers. This will enable officers to record the visible injuries at the time for victims and capture their first accounts, which will be used as supporting evidence in those cases where there are reluctant victims.

Despite the fact that Janet did not wish for proceedings to be taken the police still ensured that partner agencies were informed to allow an effective service provision to support Janet.

35 On 9th November 2011, Janet rang 999 to say that Adult A had punched her. She added that he was drunk and that she couldn't find her house-keys and she was frightened he was going to come back to her house.

36 When the police got there, they found Janet to be very drunk and she said she could not remember calling them. She said she had since found her keys and that she had been upset at the thought of ending her relationship with Adult A.

37 On new-year's eve 2011, Janet called the police emergency number to say that her son and his partner were fighting outside her home. The police operator recorded that she sounded drunk and that she said her son's partner was caring for two very young children.

38 It transpired that Janet's son, his partner; Adult A and Janet had all been drinking together when an argument broke out between them. The police were of the view that the mother of the children was able to care for them.

Comment: *Janet's son was later arrested for assault, but there was insufficient evidence to warrant a prosecution.*

39 On 19th June 2012, Janet reported another fight taking place at her home address. She was distressed and said Adult A had assaulted both her and her friend. When the police arrived, they discovered that only a verbal altercation had taken place and that no offences had been committed, even though all the participants were drunk.

40 On 7th July 2012, Adult A was arrested for assaulting Janet after they had been drinking together all day. An argument broke out with Janet throwing food at Adult A, who responded by punching Janet in her face and grabbing hold of her by the throat. Janet's injuries consisted of a cut lip, two loosened teeth, bruising to her neck, mouth and shoulders and a sore throat.

41 Adult A told the police that Janet had been 'winding him-up' about his former wife who had died of cancer and that he had only been defending himself because Janet had attacked him, but nevertheless, he was charged with assaulting her. He remained in custody until October 2012 when he was found guilty of assault and was sentenced to three-years imprisonment. He was also given an indefinite restraining order to prevent further harm to Janet. Adult A was released from prison on 7th January 2014.

42 On 1st of April 2014, a friend of Janet telephoned the police to say she had been at Janet's house the night before when they had seen police outside, who appeared to have been watching the house. It had worried Janet because she thought it might have been something to do with Adult A now he was out of prison.

The police were able to tell the caller that their presence in the area had been nothing to do with Janet or Adult A. Officers visited Janet on 3rd April 2014 and she said her friend had told her the police activity had not been connected to her. She added that she was safe and well and that she had not seen or heard from Adult A since his release from prison.

43 During the afternoon of 10th October 2015, Janet called 999 saying Adult A had punched her in the head. The police log of the incident recorded that Janet was highly intoxicated and was unable to give details of where the assault had taken place. The police eventually found Janet at her home address; she told them that she had been drinking all day with friends, including Adult A. They had an argument and it was then that Adult A punched her in the head causing a small bruise. Janet told the officers that she did not want to make a statement or have her injury photographed, but that she might change her mind later. The police went to arrest Adult A, but he could not be found.

44 The police went to see Janet the following day. She again said she did not wish to make a complaint against Adult A and that she would not support any investigation. She also said that a friend who had witnessed the incident would not provide a statement either.

45 Adult A was nevertheless arrested on 14th October 2015. He told the police that he was an alcoholic and both he and Janet occasionally sent text messages and telephoned one another. He had spoken to Janet on 10th October and told her he was going to watch television with some friends. Janet arrived later, and they then argued about his refusal to give her a cigarette. He said that Janet left the house and that he neither assaulted nor threatened her. He added that his friend would be able to confirm what had happened.

46 **What South Wales Police knew about Adult A**

47 Adult A has 16 convictions for 39 offences spanning from 3rd July 1969 through to 9th October 2012 for offence against the person, theft and firearms offences, drugs and offences relating to Police, Courts or Prison.

His record also contains warnings regarding violent behaviour, a domestic abuse aggressor, Multi Agency Public Protection Arrangements (MAPPA) and that he offends on bail.

Adult A is a MAPPA Category 2 offender, managed at level 1 and therefore he has not been discussed at any MAPPA meetings.

His MAPPA status is as a consequence of an incident In May 2004. Adult A and Janet returned home following a night out and an argument ensued between them. Janet's teenage son intervened and Adult A assaulted him by punching and kicking him resulting in the child (Child A) sustaining bruising to his ears and body. Adult A was arrested and charged with the offence and on 22nd September 2004 he pleaded guilty at court and received 18 months imprisonment which was to run concurrently with a sentence for offences against Janet.

The Category is determined purely by offence and sentence – A schedule 15 Violent Offence that results in a sentence of 12 months or more in custody is automatically a MAPPA Category 2 case. At any one time 95% of MAPPA cases are managed at Level 1 (Ordinary Agency Management) which allows MAPPA Partners to share information but does not involve 'active multi-agency management' i.e. No meetings are required as the Lead agency (NPS) are content with the Risk Management Plan.

For MAPPA Level 1 offenders a higher level of awareness of risk posed is expected of the agency managing the case and the Offender Manager's team manager now

approves a decision on the level of management. The Offender Manager is still expected to consult with other agencies involved but the purpose of a referral to Level 2 is to access resources / information that are not available to the Offender Manager doing the 'day job'.

Adult A has been probation managed throughout the period of the review. A brief history of relevant contacts are included for information

08/12/05	Registered Domestic Violence (DV) perpetrator by the National Probation Service
30/12/05	Registered as Schedule 1 Offender due to assault on boy of 14
5/7/06	Registered DV perpetrator by the National Probation Service
3/5/07	Referral to Multi Agency Risk Assessment Conference (MARAC)
22/8/07	Recalled to custody (Missed appointments)
10/1/08	Released from custody
16/1/08	Referral to MARAC
13/1/09	Registered High Risk of Serious Harm (RoSH), DV Perpetrator by the National Probation Service
25/2/13	Released from custody
13/6/13	Registered MAPPA Category 2, Level 1, High RoSH by the National probation Service
18/12/13	Referral to MARAC
8/7/15	Licence supervision terminated
16/7/15	Registered Medium RoSH (reduced from HRoSH) National probation Service
24/8/16	Referral to MARAC

48 Analysis of the involvement of South Wales Police

49 There was ample evidence of individual police officers being aware of the long-history of domestic violence suffered by Janet at the hands of Adult A. Their responses to calls were prompt and in accordance with recognised policies and procedures.

50 Adult A was arrested when the opportunity to do so arose, even when Janet had declined to support a prosecution, which was in accordance with recognised good practice and indicative of a positive mind-set in respect of domestic abuse related matters.

51 There was also evidence of officers 'following-up' their pursuit of evidence after the event, by making return visits to check on Janet's welfare and to elicit a statement from her. The officers also gave Janet advice about referral to support agencies that were available to her, which she appeared grateful for.

52 Ongoing risk-assessments were appropriate, which resulted in Janet being subject of an action plan created by the safeguarding unit which included a referral to Atal-y-Fro, implementation of 'Police Watch' which included increased police patrols in Janet's street and the inclusion of critical response markers on police computer systems, to alert officers of the risk to Janet of being victim of domestic abuse.

53 The assault on Janet on 7th July 2012 appropriately resulted in an assessment that she was at 'high-risk' and she was therefore referred to the MARAC.

54 The notification of the impending release of Adult A at the end of his three-year sentence for assaulting Janet was received by the police about one month in advance, demonstrating good communication between the National Offender

Management Service and South Wales Police. This allowed for his release to be discussed locally, so that appropriate intelligence and risk management actions could be considered, and all operational policing teams briefed.

55 Although the police arrested Adult A after Janet had complained of being assaulted by him on 10th October 2015, and had then declined to pursue the complaint, they did not consider the restraining order that had been imposed on him three-years earlier. This was an error on the part of the investigating officers. The case was not referred to the Crown Prosecution Service (CPS) for their consideration because it did not meet the threshold for referral, but had the existence of the breach of a restraining order been apparent to the decision-maker, the matter would almost certainly have been referred to the CPS.

Comment: *The appropriate recording systems were available to the officers to discover the existence of the restraining order, but they did not utilise them properly. The matter has been addressed by the officers' line-management.*

Whilst this error is acknowledged it is highly likely that even if positive action was taken and Adult A had been arrested for a breach of the order it is highly likely the he would not have been prosecuted. The rationale being that Janet had approached Adult A whilst he was at his friends address and not the other way around which would have been a clear breach. In the unlikely event that he was taken before the court it is highly probable due to the circumstances as presented he would have been found not guilty.

As previously mentioned it is acknowledged that consideration could have been given for a victimless prosecution however the voice of the victim should be heard and considered in any decision around criminal proceedings. In this particular incident Janet initially stated she had been assaulted and then said it was a verbal

argument and she refused for any photographs of visible injuries to be taken. She was adamant that she did not wish to support a prosecution. Despite her wishes positive action was taken and Adult A was arrested he denied any assault but admitted that both he and Janet had sent texts to each other prior to meeting each other at the friend's house. As a consequence it is highly unlikely that the evidence would have passed the C.P.S. threshold test for proceedings and even if it had the likely hood of a court finding against Adult A would have been highly unlikely. As previously mentioned the use of body cameras could make a difference going forward in a similar situation.

56 **National Probation Service (NPS)**

The NPS provides services to the Courts, principally preparing pre-sentence reports to sentencers and judges in the Magistrate and Crown Courts, recommending sentencing disposals for those convicted of offences. Once sentenced, the offender is allocated to either the NPS or to the Wales Community Rehabilitation Company for supervision and management of their sentence. Those people assessed as having potential to cause serious harm to others are retained and managed by the NPS. This is either through the disposal of Community Sentences or if sentenced to a term of imprisonment throughout the custodial and then licence release parts of the sentence.

Those on licence release are subject to a number of conditions and a good behaviour condition and can be recalled back to prison should any of those conditions be breached.

57 **Involvement with Adult A**

58 During the time of the review the NPS managed Adult A when he received a term of imprisonment for 36 months. This was from the time of his sentence at Cardiff Crown Court on 9th October 2012 up until his licence and sentence end date on 8th July 2015.

59 The sentence was given for an offence of causing actual bodily harm to his partner Janet. Adult A had assaulted Janet on 7th July 2012 during the course of an alcohol-fuelled argument at her address. He had punched her to the face resulting in the loss of two teeth and cuts to the face. This offence followed a well-established pattern of serious domestic violence against Janet and family members.

60 Adult A had previously been supervised and managed by Wales Probation Trust when he had been sentenced on 9th January 2009 to 30 months imprisonment for an offence of malicious wounding. He was released on licence supervision on 6th April 2010 with his licence period and sentence finishing on 5th July 2011. This offence had occurred after Adult A had been drinking with a number of people in the home of Janet, had an argument with the victim (Janet's adult nephew) before collecting two knives from the kitchen and stabbing the victim to the upper body.

61 Adult A committed this offence when he was subject to licence release having received a 54 month term of imprisonment in 2004 for offences committed against Janet and her then 14 year old son. The assaults occurred after consumption of alcohol.

62 Whilst on bail for these offences, before being sentenced, Adult A breached his bail conditions by contacting and meeting with Janet further assaulting her in the street and stamping, kicking and punching her to the head.

63 There was therefore a long established pattern of alcohol-fuelled violence within the household. Both parties had a long-standing dependence on alcohol and their household was often used as an 'open house' by other established alcohol dependent associates. Arguments and acts of violence occurred over the years, and despite Adult A receiving significant terms of imprisonment he would consistently minimise his offending and responsibilities for his actions

64 During the review, the panel considered the information within the prisons, which Adult A had served his sentence as important. This would allow the panel to ascertain what programmes he had been involved with, which would lead to a wider discussion about the management of Adult A on his release and further engagement with Janet. Unfortunately, the review was not able to ascertain that information.

65 **Analysis of the involvement with Adult A**

66 Adult A was sentenced at Cardiff Crown Court to 36 months imprisonment on 9th October 2012 for the assault on Janet. The court did not ask for a pre-sentence report to be prepared. The court at point of sentence also imposed an indefinite Restraining Order prohibiting Adult A from contacting Janet.

67 The allocated probation officer promptly obtained information relating to this offending from the police domestic abuse unit in the absence of the Crown Prosecution Service documentation usually obtained as part of the pre-sentence report enquiries.

68 There was timely and prompt communication with the offender supervisor in HMP Parc alerting the probation officer to the existence of the Restraining Order. Discussions were had concerning Adult A's negative attitude to this sentence, his

previous refusal to engage in offence-focused work and the unlikely change in this attitude.

69 On 12th November 2012 a sentence planning meeting was held in HMP Parc with the probation officer, offender supervisor and Adult A. Records indicate that Adult A declined to engage in meaningful discussion around his offending behaviour and declined to participate in any interventions to address this.

70 Later that month, Adult A's custody OASys was completed. This document outlined previous and current offences perpetrated against Janet. It was noted that Adult A had previously breached 'no contact' licence conditions with Janet on previous sentence and had resided with her. He was assessed as being a high risk of serious harm in the future to Janet.

> *The probation and prison services across the country use a system called the Offender Assessment System (OASys) for assessing the risks and needs of an offender.*
>
> *Assessing risks and needs is an integral part of the work probation officers do in assessing offenders; identifying the risks they pose, deciding how to minimise those risks and how to tackle their offending behaviour effectively.*

71 Late in November 2012, the probation service Victim Liaison Officer visited Janet, where she disclosed many years of domestic abuse and did not want to resume her relationship with Adult A on his release, acknowledging the indefinite Restraining Order. She requested that additional no contact licence conditions and an exclusion from the local town should be included. From this visit referrals were made to both Victim Support and to Atal y Fro.

72 On 18th December 2013 Janet was discussed at the Vale Multi-Agency Risk Assessment Conference (MARAC). The meeting requested that on release Adult A's licence included an exclusion zone in the town near to where as Janet lived. It was agreed that Vale housing department would accommodate Adult A away from the town at a property in Cardiff, or would assist with private rental.

73 Adult A was released on licence from 7th January 2014 until 8th July 2015, with a focus on Adult A settling into accommodation and employment. By the end of the licence/sentence period he was settled in supported accommodation and through an employment agency was working on a temporary contract as a labourer/grounds man.

74 Overall his compliance with the reporting instructions during the course of his licence supervision was good with only one warning letter being issued.

75 Adult A maintained throughout the licence period that he remained abstinent from alcohol. There was nothing in his presentation, behaviour, or countenance to indicate that he had returned to drinking. Treatment for a liver complaint whilst serving the custodial part of his sentence had been a serious health concern to him.

76 Throughout the licence period Adult A continued to gain support from his daughter and grandchildren; his tenancy support worker also supported him. There was no indication that he had any contact with Janet during this time. A check with the Vale Police Public Protection unit disclosed that there had been no incidents reported between the parties. All indications during the licence period were that Adult A fully complied with the conditions of the Restraining Order.

77 At the termination of probation involvement with Adult A on 8th July 2015 it was assessed that he had displayed a positive attitude towards his licence and

supervision. During the licence period he had been arrested for an offence unrelated to Janet but this matter was later dismissed. He had fully complied with instructions from his offender manager, had for the majority of time attended promptly when required and had been polite and cooperative at all times displaying no anti-social or adverse behaviour.

78 At the termination of his statutory management he appeared motivated to remain offence free and had made significant changes in his lifestyle to facilitate this by being abstinent from alcohol, living in supported accommodation, and maintaining employment and financial stability. There had been no indication that he had sought to resume his previous relationship with Janet during this time.

79 **The Vale of Glamorgan Council – Adult Services**

Vale of Glamorgan Council offers a range of services to citizens of the Vale. The Adult Social Services Department offers support to people who need help to live their lives as independently as possible. This includes the provision of support and services to people affected by mental health and drug and alcohol problems, delivered as part of an integrated service with Cardiff and Vale University Health Board.

The Social Services and Well Being (Wales) Act 2014 (SSWBA) was enacted in April 2016. Part 7 of this act outlines the duties local authorities and statutory partners have to safeguard Adults at Risk. The act defines an 'Adult at Risk' as a person who is 18 years or older who:

(a) Is experiencing or is at risk of abuse or neglect
(b) Has needs for care and support (whether or not the authority is meeting any of those needs), and

(c) As a result of those needs is unable to protect themselves against the abuse or neglect or the risk of it

The Social Services and Well Being Act 2014 also imposes a new 'Duty To Report ' where an employee of the Local Authority or statutory partner has a duty to report any concerns to the relevant Local Authority, regarding an adult who may be at risk. Once reported the Local Authority Under S126 of the SSWBA, has a duty to make Adult Safeguarding enquiries.

In relation to Janet's circumstances, although the legislation was in place for four months prior to her death, the knowledge and understanding of agencies responsibilities regarding 'Duty to report', was not fully embedded into practice. The Statutory Guidance in respect of Part 7 was published after the enactment of the Act and was not available in August 2016.

80 **Analysis of the involvement of the Vale of Glamorgan Council – Adult Services**

Janet was only referred to Adult Services after the incident that led to her death and no direct contact was made with her.

81 The service had no contact with Adult A.

82 **Vale of Glamorgan Council - Housing Department**

The Housing Management Team has the overall responsibility of managing council housing within the Vale, including the management of rent accounts, anti-social behaviour management, resolving tenancy issues, providing sheltered accommodation for older people and general tenancy/neighbourhood management. The department also actions repairs required to properties, provides

money advice to tenants, supports tenants with additional needs, attends regular community meetings such as resident boards as well as risk management meetings such as MARAC, Child Protection Meetings or MAPPA.

83 **Analysis of the involvement of the Vale of Glamorgan Council – Housing Department**

Janet

The Housing Department had regular contact with Janet from 1992 and from 2011 onwards, much of which was in respect of rent arrears. The Housing Management Team is part of the MARAC process and they were aware of Janet's history of being the victim of domestic abuse as well as her complex needs within the family and that support was in place for her from appropriate providers. It is also recognised that rent arrears and debt are also opportunities for an abuser[1]. The review has identified that economic abuse is an ongoing behaviour for many victims and this is recognised by agencies, specifically within the Housing Management Team.

All staff within the Housing Management Team have since completed level 1 domestic abuse awareness training as well as attending more specialist training including the links between domestic abuse and substance abuse in order to better understand some of the more complex issues, such as those that arose in this case.

84 Adult A was in sheltered accommodation. Although he indicated he had friendships outside of the scheme there was nothing to indicate that there were any concerns for Janet's safety other than those agencies were already aware of.

[1] Sanders, C. (2014). Economic Abuse in the Lives of Women Abused by an Intimate Partner. *Violence Against Women*, 21(1), pp.3-29.

85 **Adult A**

Adult A was also subject to the rent arrears procedure, an eviction order was sought at court on 4th August 2016, which resulted in a 28-day possession order, however before this could be executed he was sentenced to a term of imprisonment and the house repossessed. He was also provided with the appropriate support from the Sheltered Scheme Coordinator including reading letters and completing forms. He received regular support plan reviews in line with contractual requirements set by the Supporting People Team (see below).

86 Because of this review, the department recognises that its current methods of recording case notes could be improved to better evidence their information sharing and joint working with other agencies. This has included introducing a case management process to record case notes, contacts and referrals made in relation to tenants. This has enabled the team to better record information as well being able to share this with relevant partners.

The Housing Management Team has ensured regular attendance at MARAC meetings; this enables the team to share information as well as being involved in the risk management process. Following these meetings the team is implementing a process of ensuring all victims and perpetrators within Vale Homes properties have an indicator flag added to the address on the Housing Management database. All staff within Housing Services has access to this database and are aware of the marker system.

The review has also highlighted where as a landlord the department can highlight potential risk factors and adapt responses based on these. For example when taking eviction action against a tenant who is known as a perpetrator of domestic abuse,

including when they do not reside with the victim, this information is relayed to the Housing Management Team. Safeguarding measures can then be put in place for victims including notifying the police via the 101 process, referring cases into MARAC for review giving the increased risk and sharing information with specialist support providers such as Atal Y Fro.

87 **Analysis of the involvement of the Vale of Glamorgan Council Housing Solutions Team**

The Housing Solutions Team provide housing related support, advice and assistance to households who may be threatened with or who are homeless. The team offer support to help households, where appropriate, to be able to remain in their home thus preventing homelessness where possible. The team also assist with identifying and securing alternative suitable accommodation, including in the private rented sector. Many of the households who require our support are vulnerable and often require referrals for additional support and advocacy offered via The Council Supporting People Service.

88 **Janet**

In June 1998 Janet who at the time declared that her household consisted of herself and three young children (Child A, Child B and Child C) made an application. She also said she had a male lodger. The application was cancelled in August 1998, following an offer of permanent social housing for the family.

89 **Adult A**

Adult A first presented as homeless 2007 and then again in January 2014. He was placed in temporary accommodation and then permanent social housing was

provided to him in June 2014, where he remained until his incarceration for murdering Janet.

90 All advice and support provided to both Janet and Adult A was in keeping with internal policies and processes in accordance with legislation.

91 **Vale of Glamorgan Council - Supporting People team**

The Supporting People Team manages referrals for vulnerable clients seeking housing related support. This can include vulnerable families and people experiencing domestic abuse. They monitor the support clients receive, but do not directly deliver support themselves.

92 **Analysis of the involvement of the Vale of Glamorgan Supporting People Team**

Janet

Janet was referred to Taff Housing Association from July 2011 to June 2012 for housing related support as a vulnerable older person. Her issues included domestic abuse, mental health, alcohol, chronic illness, criminal justice issues and physical mobility.

93 Janet was then referred to Hafod Care Housing Association (see later) from January 2013 to October 2015 for financial support and debt management, alcohol use and mental and physical health issues. Within Janet's records there was historic information concerning domestic abuse and this was an opportunity to gain further information and be aware of the fuller picture.

94 **Adult A**

Adult A was supported by Taff Housing Association from June 2014 to March 2015, having been referred for being homeless, having difficulties, criminal justice issues, chronic illness, physical mobility and mental health issues. He was also supported by Redlands Warden Scheme from June 2014 to September 2015 and by Vale Community Alarm Service during the same period.

95 **Cardiff and Vale University Health Board**

Cardiff and Vale University Health Board provide health services to residents and visitors within Cardiff and the Vale of Glamorgan. General Practice (GP services) is provided under the General Medical Services Contract 2004, which sits adjacent to the Primary Community and Intermediate Care Board of Cardiff and Vale University Health Board. As an agency the services provided by health professionals are diverse and cover all medical specialties; most people are known to health services from birth to death, thus generating considerable recorded material.

96 **What Cardiff and Vale University Health Board knew about Janet**

Within the scoping period, Janet first presented to the Emergency Unit with a broken wrist on 30th September 2011. She attended three follow-up appointments to review her injury, with the cast being removed at the last one, which revealed that the fracture had healed; her GP was notified accordingly. Appointments were also set for her to attend the physiotherapy department, but she did not keep any of them.

97 Janet's GP visited her at home on 6th March 2012 and noted that she was 'an alcoholic and frail' and that she said she was drinking three to four bottles of cider per day. The GP's plan was to refer Janet back to Newlands Drug and Alcohol Centre,

which is part of the Community Addictions Unit (CAU) at the Cardiff and Vale University Health Board. At 9pm on the same day, Janet visited the Emergency Unit with a nosebleed, which she said was the second time it had happened within the past two-days.

98 Six-days later, Janet saw her GP again who notes that she 'was doing really well'. She said she had stopped drinking a week ago and had suffered no ill effects and that she had refused the input of Newlands**.** She did say, however, that she was having problems sleeping, so she was prescribed night sedation on a short-term basis. The GP also offered specialist medication to help ensure she did not start drinking alcohol again, but Janet declined to accept it.

99 On 7th July 2012, Janet was brought into the Emergency Unit by ambulance; she said she had been strangled and punched in the mouth by her partner. She had a wound to her upper lip and an abrasion above her top lip. Her bottom teeth were loose, and Janet said her right shoulder was painful. Once her injuries had been reviewed, Janet was discharged home with her son. The notes indicate it was safe for her to go home.

100 The next time Janet saw a health professional was on 24th January 2014, when she attended the GP surgery. She told the GP that her ex- partner, who has been physically abusive in the past, had been released from prison a week ago. She said there was a restraining order in place, but she was "terrified' that he would 'come onto her'. She said she had thought she had heard knocking on her window and that she had told the police who were on 'fast track', should anything happen. She added that she was not sleeping well because of it. They discussed the prospects of her going to stay at her daughter's home, but Janet said it was not an option.

101 On 8th May 2014, Janet saw another GP and reported having 'blackouts' and possible seizure activity. She was referred to the neurology department at the University Hospital of Wales.

Comment: *Janet attended numerous neurology appointments over the following months from where she was referred also to a cardiologist. The neurologist was concerned about Janet's alcohol consumption and told her categorically that she needed to reduce it. The neurologist speculated in a letter to the GP that the cause of Janet's blackouts might be alcohol related phenomena.*

102 On 19th June 2014, Janet attended the GP surgery complaining of pain in her chest saying she had fallen when drunk about two-weeks previously. She also had pain to her right side, bruising down her leg and she said her ribs hurt. She was examined, but the doctor didn't feel that medical intervention was required.

103 Janet's next visit to her GP was on 28th August 2014. She was with a support-worker and said she had fallen over but couldn't remember doing it. No medical intervention was required.

104 Few-days later, Janet was taken by ambulance to hospital. A friend had witnessed her blackout and fall over and then lose consciousness for a few minutes. After tests, Janet was discharged home the following day. It was documented in her notes that she was alcohol dependant, and that she had drunk alcohol prior to the event. The name of the friend was not recorded.

105 **What Cardiff and Vale University Health Board knew about Adult A**

The Cardiff and Vale University Health Board will not disclose health information about Adult A for this safeguarding review, without his prior consent. They have requested his consent, but to date he has not given it.

106 The chair of this review impressed upon the University Health Board that the review panel is not interested in conducting a 'fishing exercise' into Adult A's medical records, but is interested solely in any information that may be directly relevant and proportionate to the aims of the domestic homicide review. They were asked to apply professional judgement to ensure that only personal data that is adequate and directly relevant to this review is disclosed and that any excess information, for example about routine or personal medical matters, should not be included.

107 It is the view of the review panel that the processing of the data is necessary for the exercise of the obligations under an enactment, namely Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004, for the exercise of any functions of the Crown, a Minister of the Crown or a government department, and for the exercise of any other functions of a public nature exercised in the public interest by any person.

108 Included in the information provided in the IMR template for the review, was the following excerpt from the Home Office statutory guidance:

'The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles'. Data protection issues in relation to DHRs tend to emerge in relation to access to records, for example medical records. Data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those

held by solicitors and counsellors. In the case of a living person, for example the perpetrator, the obligations do apply. It is recognised that some local areas have faced resistance from clinicians and health professionals when seeking release of medical records on perpetrators.

The Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and, where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:

a) *The review team should be informed about the existence of information relevant to an inquiry in all cases; and*

b) *The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.*

The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set-aside in the greater public interest.

The Department of Health recognises that DHRs have a strong parallel with child Serious Case Reviews. Guidance advises doctors that they should participate fully in these reviews. It goes on to say, "When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent." The

Department of Health believes it is reasonable that this should be the principle that doctors should follow in cooperating with DHR's. This action was further supported by recommendations in the Department of Health document 'Striking the Balance' (2012)' (Web address supplied).

109 The review panel fully understands the difficult position health service providers find themselves in when it comes to disclosing medical information about people who have not consented to its release. A recommendation emanating from this review will be that government should seek to provide clearer direction about the issue.

110 Analysis of the involvement of Cardiff and Vale University Health Board

Janet presented to health services on 24-occasions during the scoping period of the review. On two of those she disclosed being the victim of domestic abuse at the hands of her partner. The first of those was when she was taken to hospital by ambulance in December 2012; the police were involved, and her partner was arrested. She was discharged home with her son (an adult) and her medical notes indicate it was safe for her to do so. Staff did not appear to know whether her partner was still in custody or what measures may have been necessary to ensure it was safe for her to go home. There is nothing in the notes to suggest that Janet was asked whether it was the first occasion she had been a victim of domestic abuse and there is nothing documented to say she was given any information about support services for victims of domestic abuse.

111 Anyone in Janet's position, who is seen in the emergency department nowadays, would be identified as a victim of domestic abuse and offered support from appropriate services. Section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 introduced the principle of 'Ask and Act' to

target routine enquiry for violence against women, domestic abuse and sexual violence. Relevant Emergency Unit staff has received awareness raising training and follow the process when it is safe to do so.

112 In addition, since October 2016, a Health Independent Domestic Violence Advocate (IDVA) has been appointed and is contacted when anyone in a similar position to Janet attends the department, so that arrangements may be made to meet to discuss the patient's needs.

113 The second occasion Janet mentioned domestic abuse was when, in January 2014, she told her GP that her physically abusive former partner had recently been released from prison and she was 'terrified' he would 'come onto her', despite there being a restraining order in existence. She was not sleeping well and there was some discussion about sleeping tablets and alcohol being only short-term solutions. There is nothing to indicate there was any discussion about Janet's immediate safety and safeguarding measures, or referring her on to an appropriate support agency or to MARAC.

114 Some GP surgeries within the Cardiff and Vale University Health Board have been involved with the IRIS (Identification and Referral to Improve Safety) programme that is a general practice-based domestic violence and abuse training support and referral programme. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. An advocate educator is linked to general practices and based in a local specialist domestic violence service. The advocate educator works in partnership with a local clinical lead to co-deliver the training to practices. This programme began at the end of 2014.

115 When Janet went to see her GP on 1st April 2014, the issue of domestic abuse she had previously disclosed was not brought up by the GP. Given how scared Janet said she was, there was an obvious opportunity to review how she was and if she had experienced any further abuse or difficulties from her former partner ex- partner and if she required support.

116 There is a strong relationship between alcohol and domestic abuse and violence, and throughout many of Janet's contact with GP's, hospital staff and consultants, the fact that she was alcoholic dependent was well known. Apart from two-occasions when her GP discussed with Janet the need for her to get support to address her alcohol consumption (which she declined), there is no record of her being offered support services to help her address it. There were several missed opportunities by health staff that were aware of her alcohol dependency, but did not consider that it increased her vulnerability emotionally and physically and made her more vulnerable to be the victim of domestic violence.

It is recognised that Janet's alcohol use were managed from a medical perspective, but it is also recognised that victims of domestic abuse use alcohol as a means of coping with abuse, or that the abuse causes the addictions[2]

117 Janet attended health settings with injuries on several occasions, for example, with a broken wrist, a nosebleed, and when she had fallen and had blacked-out. Staff did not appear to have considered they might have been caused through domestic violence, even though she had disclosed she had been a victim of domestic violence in 2012. There now exists a flagging system on patient notes when a victim has made a disclosure of domestic abuse. This ensures that if victims attend in the future, staff will be alerted so that they may 'Ask and Act, when safe to do so.

[2] Rice C, Mohr CD, Del Boca FK, Mattson ME, Young L, Brady K, Nicklass C. Self-reports of physical, sexual and emotional abuse in an alcoholism treatment sample. Journal of Studies on Alcohol. 2001; 62:114–123.

118 **Atal y Fro Domestic Violence Services**

119 Atal y Fro Domestic Violence Services is an organisation dedicated to the elimination of domestic violence and abuse. In addition to refuge and individual support provision, developing domestic and sexual violence/abuse services for the 21st Century has been its driving force. Its key aim is to act to improve services and deliver better outcomes for service users. Over the last nine-years, Atal Y Fro has developed a range of early intervention, prevention and education services that are unique in Wales.

120 **What Atal y Fro Domestic Violence Services knew about Janet**

Atal y Fro involvement with Janet was through the IDVA via the MARAC between July 2012 and October 2012, which was the period between Adult A's arraignment and committal to Crown Court after he had been arrested for assaulting her.

121 **What Atal y Fro Domestic Violence Services knew about Adult A**

Atal y Fro has no direct contact with Adult A.

122 **Analysis of the involvement of Atal y Fro Domestic Violence Services**

It is not known why an initial assessment was not carried out in respect of Janet, but staff has said she typically did not engage with services; some knew her and said she had a very troubled life. In hindsight, Atal y Fro feel it might have been appropriate to pursue her to encourage her to engage with their service or to make better contact with other agencies such as Social Services /substance misuse, to see if a more pro-active joint approach to helping her manage her situation could have been found.

123 The fact that Adult A had been jailed many times for assaulting Janet rang warning bells and should have flagged a POVA approach on such a vulnerable person. If this had happened, then other agencies would have had to be involved and maybe that integrated approach would have had a more positive impact. Also, the IDVA at the time of the first MARAC should have used this as an opportunity to refer Janet to the wider Atal y Fro services.

124 The IDVA missed an opportunity when she was providing the court support, to refer Janet to the wider support services of Atal y Fro, which would also have linked in to other services. The current IDVA Service (now known as the Advocacy Support Team) is a vast improvement on what existed at the time it was involved with Janet, in that it works closely with the police daily to pick up PPNs as quickly as possible and make immediate contact. Working together with the Court Based Advocate ensures that all other services are accessed.

125 **Hafod Care Housing Association**

Hafod Care Housing Association is a charitable, 'not-for-profit' organisation, which offers personalised care and support and provides a wide range of housing, care and support services to people across South and West Wales. It helps the most vulnerable people in society, to enable them to maintain their independence and well being for as long as possible in their own homes, supported housing or in its residential care homes.

126 **What Hafod Care Housing Association knew about Janet**

The first time Hafod Care Housing Association was involved with Janet was in January 2013. At the time, Adult A was still serving his three-year prison sentence for assaulting her; Janet was concerned about contact from him and was assessing

support from Atal y Fro for specialist advice. There was also discussion around compensation for the assault. They completed an Initial Contact Assessment which has been summarised as follows:

Family and relationships

- *Janet's ex-partner was in prison for domestic violence; there was an order in place that no contact can happen, no contact by phone/letters etc. To set up proper protective measures.*

Life skills

- *Janet suffered from blackouts and because of this there was a risk to doing day-to-day tasks.*

Employment

- *Janet was on Employment Support Allowance (support-group) and was not working*

Domestic Violence

- *Janet suffered Domestic Abuse and her ex-partner was in prison on a three-year sentence. He could be released in October 2013 or early 2014. The court had set up specific orders and that there was a no contact restraining order.*

Mental Health

- *Janet suffered depression and being on her own causes her anxiety and panic attacks. The GP was aware of it, but Janet was not on medication.*

Alcohol

- *Janet was a registered alcoholic and drank strong lager every day. She had stopped for three-four- month periods. She said she might contact Newlands Drug and Alcohol Centre in the future.*

Physical Health

- *Janet experienced problems walking due to breathing difficulties and problems with her legs. Janet Mentioned blackouts on a regular basis, but there was no involvement from other services.*

Chronic Illness

- *Janet said she suffered from asthma and was struggling with breathing daily, but had not been diagnosed. She also mentioned blackouts.*

Housing

- *Janet discussed having to have her house adapted and that there was damp and condensation throughout the house. She also mentioned changes to her housing benefit and how it would impact her tenancy.*

Other agencies involved

- *Janet mentioned her GP surgery and*
- *Her initial Support worker from Hafod Care Housing Association*

There were regular risk-assessments and reviews up to July 2015, with no major changes to Janet's circumstances. In addition, there were several Personal Support Plans' and reviews, which are summarised as follows:

- 8th February 2013 - *Janet required support around feeling safe as her ex-partner was in prison and she wanted to feel safe when he was released and in the future. The support-worker was to get information from Women's Aid about restraining orders and how they work and personal safety and security in the future. There were also plans to obtain criminal injuries compensation*

- 8th August *2013 – feeling safe work ongoing, speaking to 8th August 2013 – feeling safe work on going, speaking to Victim Support (offering emotional and practical support to people affected by crime) about her ex-partner. Janet to be kept informed as to when Adult A is coming out of Prison.*

- 8th February 2014 - *liaise with Women's aid if needed and advice given to Janet about calling the Police if Adult A went anywhere near the property*.

- 30th July 2014 - feeling safe-goal was achieved- *Janet had liaised with Atal y Fro and the Police and she was clear of the procedures regarding Adult A contacting her*.

127 Hafod Care Housing Association visited Janet at home on 31st January 2013. They discussed her rent arears and agreed to support Janet with her criminal injuries compensation claim. The following week, they went with Janet to the police station to get the relevant information to support the claim.

128 There were regular support contacts with Janet over the following months where the goals she wanted to achieve were discussed as well as support given about debt issues, the criminal injuries compensation claim, pains to Janet's chest, tenancy issues and collection of her medication.

129 On 27th May 2013, Janet was visited at home and the support-worker telephoned Victim Support (offering emotional and practical support to people affected by crime) who said that Adult A had not yet been released from prison. She said she would phone Janet if she got any news.

130 On another home visit on 5th December 2013, the support-worker telephoned Victim Support again to ask about Adult A's release from prison because Janet was worried about him (Adult A) going to her property. She was told to ring the Domestic Abuse Unit (as was) and is now the Public Protection Unit to see if Janet could have a panic alarm installed. The support-worker completed the necessary documentation and was told that Janet was to be discussed at the MARAC on 18th December 2013. The support-worker went to the MARAC where Adult A was

discussed with the result that he was not allowed in [town redacted] unless he had appointments if he was to approach Janet or if she wasn't happy Janet should contact a named worker in the Domestic Abuse Unit who could put a marker on the property.

131 When the support worker visited Janet's home on 26th June 2014, she found Adult A there. She told him and Janet that by being there, he was in breach of the restraining order. Adult A said he had only gone there to collect his clothes; he didn't stay long after the support worker's arrival.

132 Support for Janet came to an end on 8th October 2014, because her support needs had been met. An exit survey was completed in which Janet stated ''*I feel more confident with all correspondences and dealing with my debt*''.

133 **What Hafod Care Housing Association knew about Adult A**

Hafod Care Housing had no direct contact with Adult A other than when he was seen at Janet's house on 26th June 2014.

134 **Analysis of the involvement of Hafod Care Housing Association**

Policies and procedures were followed throughout and there can be no doubt that Janet appreciated the support she received from Hafod Care Housing Association. Generally, Janet was not open to the involvement of support organisations, but she appears to have made an exception with Hafod Care.

135 The administration of the service provided included a comprehensive initial interview that was supported by regular risk-assessments and personal support plans throughout the time Janet was involved with the organisation. Contact sheets

were maintained; detailing on each occasion what had been discussed and agreed. When Janet's goals had been achieved, an exit plan was put in place for her, which again was well documented. Finally, an exit survey was completed which is extremely good practice.

136 During the review the organisation identified some relatively minor omissions within a few contact sheets and they have now re-enforced to their staff the importance of accurate and full record keeping. It should be stressed however, that overall, the standard of the administration of the service was high.

137 With the benefit of hindsight, Hafod Care acknowledges that the fact that Adult A had been seen at Janet's home should have been reported to the police. This was an error by an individual, who did not report the incident to her line manager; had she done so, other agencies would have been notified immediately.

138 **Interview with Adult A in prison**

Comment: *Accounts provided by convicted perpetrators are often a useful source of information for domestic homicide reviews, but it should be stressed that invariably what is said is not subject to challenge and there could be any number of reasons why explanations provided may be inconsistent with other known aspects of a case.*

The review chair wrote to Adult A to explain that a domestic homicide review was taking place and to ask whether he would be prepared to participate in it; he did not respond to the letter.

He was also spoken to by probation and the process was explained and again Adult A declined to take part in the review.

139 ## Addressing the Terms of Reference

- **Involvement of Janet's family and friends**

Janet's family and friends were written to and asked to participate in the review, and/or provide information that could assist the review to gain a better understanding of the events in her life leading up to this tragic event. There was a follow up phone call to a family member who expressed their wishes that they did not want to take part in the review.

The panel recognise that their involvement may have assisted in providing a greater understanding of her life and the incidents within it and have striven to view the report through her eyes.

140 - **Determine how matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for it.**

The panel decided that the Vale of Glamorgan Community Partnership would be responsible for all media and communication matters.

141 - **Take account of coroners or criminal proceedings (including disclosure issues) in terms of timing and contact with Janet's family to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?**

As mentioned previously, the inquest into Janet's death was opened by HM Coroner, but was suspended to allow for the criminal justice process to run its course.

As there was a full trial and the circumstances of Janet's death were discussed in the court, the coroner in line with the Coroners and Justice Act 2009 did not hold a formal inquest.

142 Janet's family did not wish to take part in the review and as such there has been no delay in sharing information with them. Once the report has been completed further contact will be made with family members to explain that the report has been completed and provide an opportunity to meet with the Chair, the panel or both to discuss.

143 - **Consider whether the review panel needs to obtain independent legal advice about any aspect of the proposed review.**

No conflicts or issues have been identified that would suggest that independent legal advice will be required about any aspect of this review.

144 - **Ensure that the review process takes account of lessons learned from research and previous DHRs.**

Previous DHRs conducted nationally have been scrutinised by the Chair during this review, to take account of lessons learned.

145 - **The incident in which Janet died was an isolated event or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence.**

Janet's life was blighted by domestic abuse from the mid-1990's. After the death of her baby daughter and the subsequent breakdown of her marriage, she developed a dependency on alcohol that made her particularly vulnerable to abuse by male partners who were also alcohol dependent and who took illegal drugs.

146 She had been in two-lengthy abusive relationships, the first of which lasted ten-years; the police were called to incidents involving them both around 45-times. Since 2007, Janet had been involved with Adult A. There had been several incidents in which he had assaulted Janet and he was twice sent to prison for it.

147 Support agencies and the police knew of her plight and worked together to try to minimise the risk to her, taking positive enforcement action against Adult A when the opportunity arose.

148 Janet was discussed at MARAC on several occasions having been assessed as being at high risk of harm, with the following outcome. A restraining order was obtained but contact was very limited with Janet to a short period following the imprisonment of Adult A.

Atal y Fro commented that the IDVA at the time of the first MARAC should have used it as an opportunity to refer Janet to them. This is the case now where an extremely vulnerable person is going through the criminal justice system, a more 'wrap-around approach to support is provided that includes counselling, more intensive emotional and practical support.

149 There were ample opportunities for health professionals to support Janet, particularly her GPs, but none appear to have considered the continuing risk to her of domestic abuse. She twice disclosed domestic abuse to a GP, but was not offered any support or help.

Janet was repeatedly identified as being alcohol dependent, but she was not offered any support in respect of it; there appears to have been an assumption that she

would have declined it had it been offered. There was no apparent consideration that Janet's alcohol dependency increased her vulnerability.

150 - **Whether Janet had experienced abuse in previous relationships in The Vale of Glamorgan or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died.**

As mentioned above, for at least 19-years, Janet's life was blighted by domestic abuse. During that time, she contacted the police on a number of occasions, no doubt because it was the safest and quickest way for her to stop the immediate violence or threat of it.

151 Janet did accept some support that was offered to her, but the general impression gained by professionals was that she did not like to engage with services other than when she was in crisis.

152 There is nothing to suggest that Janet's experience of the support she had previously been given negatively impacted on her seeking support in the months before she died.

153 - **Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Janet that were missed?**

Janet visited the hospital emergency department on several occasions with a variety of soft tissue injuries, head injuries and fractures. There is no record of any explanations being given by Janet as to how she came by her injuries or of her being asked about them.

154 The GP practice knew of her history of being abused, but there was very little in the way of engaging her in conversation about it to elicit more information with a view

to making safeguarding referrals. Janet had more contact with her GP than with any other health professional and they were best placed to assess her vulnerabilities, but it seems that presentation at the GP surgery was dealt with in isolation.

155 • **Whether Adult A had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.**

Adult A has previous convictions for violence dating back to the late 1960's, but none relate to domestic violence other than those involving Janet.

156 • **Whether there were any barriers experienced by Janet or family/friends/colleagues in reporting any abuse in The Vale of Glamorgan or elsewhere, including whether they knew how to report domestic abuse should they have wanted to.**

There is clear evidence that Janet knew how to report domestic abuse and that she was aware of support mechanisms available to her if she did. It is equally clear though that when she did report it, it was to put a stop to a current violent situation or threat of it and that once the immediate threat dissipated, no doubt through fear of retribution, she tended to distance herself from judicial and support processes.

157 • **Whether there were opportunities for agency intervention in relation to domestic abuse regarding Janet and Adult A or to dependent children that were missed.**

Human error on the part of a police officer meant that Adult A was not arrested on 10th October 2015 for being in breach of a restraining order and similarly, the police were not told by Hafod Care that they had seen Adult A in Janet's home.

158 • **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 in the region.**

The South Wales Police have undertaken to improve service provision to vulnerable people through the implementation of Operation Liberty. This strategic operation aims to highlight the importance of service provision to vulnerable members of the community and has involved ongoing training and resource uplift. For South Wales Police, dealing with vulnerability is now identified strategically as a priority. **Training is now embedded to all south Wales police staff during their probation and continuing service.**

159 The importance of conducting comprehensive intelligence checks on perpetrators of domestic violence is to be emphasised. It is to be brought to the attention of policing departments that are directly involved in dealing with people that are arrested.

160 The Housing Management Team has now completed level 1 domestic abuse awareness training as part of the rollout of the national training framework across Wales. This ensures that all staff are aware of what domestic abuse is, signs to look out for and where to signpost for help. They have a Violence Against Women and Domestic Abuse – Sexual Violence (VAWDA-SV) champion team member, who has taken on the additional responsibility of providing advice to team members in relation to domestic abuse and violence against women.

161 They are also updating their domestic abuse policy and reviewing processes around the recording of MARAC information.

The department are also reviewing internally how they can identify standard and medium risk cases, which would not traditionally be discussed within the MARAC

setting. There is increased emphasis within the service to identify the signs of domestic abuse, including focusing on raising awareness within teams such as maintenance who are often spending the most amount of time in people's homes. This will include ensuring that all staff knows what to do if they suspect domestic abuse, for example reporting it to the Neighbourhood Manager for the area who will then be able to investigate further as required.

162 Safeguarding, including domestic abuse, has been added as a standard agenda item within the Neighbourhood Manager's supervision and team meetings, to ensure the importance of such cases remain at the forefront of their minds. It also creates an opportunity every month for staff to raise any concerns and to seek advice from their manager. Experience has shown that on occasions staff can worry about making referrals to MARAC or safeguarding agencies in relation to sensitive issues, so the process will enable them the time to talk cases through as well as drawing in other relevant information.

163

- **The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to Janet, Adult A and any dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.**

Throughout the review the panel considered all protected characteristics and sought to identify where any of these characteristics could have impacted on decision-making or the manner in which Janet was supported. There were no equality or diversity issues identified during the review.

164 **Agency key lessons learned**

South Wales Police

The police learned that their risk management protocols had been effective and had resulted in swift responses to calls from Janet and appropriate follow-up action being taken.

165 The review has demonstrated that effective multi-agency working practices were in place in the Vale of Glamorgan over the review period, for example officers were able to contact housing department staff to change locks at Janet's premises.

166 The Review has led to a recommendation that an internal review of the compliance in respect of the completion of the mandatory domestic abuse checklist is carried out.

167 There appears to be MARACs that have taken place but that the police may not have a record for. Processes are in place now for storing MARAC minutes, there were issues when the police information and crime recording systems changed to NICHE and there were different systems for retaining minutes.

168 ### National Probation Service

During the course of his licence supervision his management was transferred from a probation officer to a probation service officer as a result of his good progress. Although this would not necessarily be uncommon practice Adult A remained a medium risk domestic abuse perpetrator with a serious long standing offending history against the same person, who had refused to acknowledge or address the underlying caused for his violence and had completed no relationship work.

169 It would have been beneficial to have seen more evidence of structured intervention work undertaken with Adult A, if not directly on focusing on his relationship with Janet given his level of denial, but more generally on healthy relationships and strategies for coping with future conflict and triggers for abusive and violent behaviour. More work on what might draw him into being abusive again within a relationship may have given him better skills in self-control and self management of emotions and behaviour.

170 Within the case recording and assessments there would appear little is known about the whereabouts and circumstances of Janet during the period of Adult A's licence management. Understandably the focus of the NPS is with Adult A as the convicted perpetrator, but maintaining contact with agencies that are in touch with the victim would have provided a greater overview of risk and better informed our engagement with Adult A.

171 There is no evidence that any agencies working long term with Janet were informed of the end of the involvement of the NPS with Adult A in July 2015. This may have helped them to plan their involvement with Janet knowing that his sentence and accountability to the criminal justice system had ended on that date.

172 **Vale of Glamorgan Council – Adult Services**

There were no key lessons learned for the Vale of Glamorgan Council – Adult Services during this review.

173 **Vale of Glamorgan Council – Housing Services**

The learning for the Vale of Glamorgan Council - Housing Services has been the value of all staff members completing domestic abuse awareness training, thus ensuring that everyone feels able to deal with any issues appropriately.

174 The review also highlighted for them that joint working processes within the Vale of Glamorgan, including MARAC, enable them to safeguard tenants to a reasonable level, for example responding to police requests to fit additional window locks and changing the front door locks when required. The review as also re-enforced the importance of maintaining high quality and detailed case management notes.

175 To assist the team to better identify the support needs of those living within their accommodation, they have reviewed their initial assessment process for sheltered accommodation once someone has been allocated a property. They now not only ask the tenant if they have been a victim of domestic abuse, but also if they have ever been a perpetrator of abuse within a relationship.

176 **Vale of Glamorgan Council - Housing Solutions Team**

All Housing Solutions/Options and hostel staff because of lessons learnt from this review has now undertaken domestic abuse training.

177 **Vale of Glamorgan Council – Supporting People**

The learning for Vale of Glamorgan Council – Supporting People is that their service was appropriate for Janet and it enabled them to refer her on for additional support on each occasion.

However it is recognised that there is a need to ensure that the full record of an individual is examined when there is a contact thereby ensuring that staff are aware

of all the issues. On the latter occasion when Janet was referred this did not happen and as a consequence no consideration surrounding domestic abuse was made.

178 **Cardiff and Vale University Health Board**

On many occasions Janet was identified as being alcohol dependent, but only twice was she offered support; there appears to have been an assumption that she would continue to decline it.

179 The Board realised that on two-occasions Janet disclosed domestic abuse, but she was not offered any support. The Cardiff and Vale University Health Board has implemented changes that have significantly improved practice in this regard. There are now several initiatives in place to ensure it will not happen again, such as the implementation of the IRIS project targeted at GP practices. The principle of 'Ask and Act' is firmly embedded across the organisation. There is also a 'flagging' system in place now in the emergency unit to ensure that victims who re-attend are targeted with necessary interventions. The recent appointment of an IDVA will further support staff and victims.

180 **Atal y Fro Domestic Violence Services**

The learning for Atal y Fro Domestic Violence Services was that the IDVA Service at the time of Janet's involvement with them was far from adequate. It has since been greatly improved and now works very closely with the police and the Court-based advocate.

181 Atal y Fro continue to develop and has Introduced an Advocacy Support Team for any gender as well as a Dispersed Housing Project, which provides refuge in individual units for clients such as Janet who have complex needs.

182 The Director reported that the quality of some of their staff (of the time) note-making and reports was disappointing, so Atal y Fro organised compulsory training for the whole team and introduced a new computerised reporting system that appears to have made a significant difference.

183 **Hafod Care Housing Association**

The value of Hafod Care Housing Association's effective administration and compliance was demonstrated during the review, especially its initial contact assessments, risk-assessments, personal support plans and contact sheets. They were able to evidence the support they gave to Janet, for example with tenant issues, debt, health, maximising income, setting up utility bills, legal issues, correspondence, and crisis management. Their interaction with other agencies was well documented as was the fact that their service was service-used lead and outcome focussed.

184 **Conclusions**

Janet died in tragic circumstances at the hand of a man who had been abusive and violent to her over a number of years. Janet had suffered the heartbreak of losing her baby daughter (Child D) nearly 30 years ago in a house fire, something that she never got over and was the causation of her reliance on alcohol. This reliance made her vulnerable and she endured violent and abusive relationships with men.

Janet had two male partners, one of them (Adult B) for around ten years until 2007, where she suffered from violence and abuse, during which the police were called on over 40 occasions

There is no doubt that Adult A was a violent and manipulative individual with a history of multiple offending including violence against women. He had been convicted of violence towards Janet and had served prison sentences for that violence, however he was always able to ingratiate himself back into Janet's life. There were occasions when he was violent towards Janet and the police attended, Janet would not pursue a prosecution. There is recognition that a victimless prosecution may have been available, but there is no reason to believe this would have succeeded given the circumstances.

Janet was supported by agencies and given advice and support but this did not change or effect her actions or outcomes, which in itself is an indication of her vulnerability.

The review is unable to determine why Janet did not want to pursue prosecutions or why she allowed Adult A back into her life, one can only assume it was as a result of her vulnerability, fear, intimidation, threats or the manipulation of Adult A.

Individual agencies have identified points of learning from the review that will develop their services for individuals such as Janet, many have been implemented and others are still in the process.

There is nothing within the review that would indicate Janet would die in such tragic circumstances or that agencies could have done to prevent her death.

185 ## Recommendations

186 ### National

- There should be clarity regarding the accessing and dissemination of health care records relating to the perpetrators of abuse who are within the recommendations of the DHR.

    - At present there is information within the DHR guidance recommending the disclosure of information, however individual agencies and authorities do not have a consistent approach, largely due to the conflicting understanding and advice for which clarity is required from the Home Office.

187 **Community safety Partnership**

- Development and recruitment of PPN coordinator

- More effective sharing of information through the development and implementation of an improved and coordinated IT system

- To review Domestic Abuse referral pathway to ensure that referrals are identified in a timely manner and directed to the appropriate agency

- To review progress made on recommendations at least once every 6 months to provide on-going assessment, including a further assessment on the impact of those recommendations on services within the Vale of Glamorgan

- The development and recruitment of a domestic abuse, assessment and referral coordinator (PPN coordinator)

  (The Vale of Glamorgan has identified that there was not enough emphasis on victims of domestic violence and abuse who do not present as High risk.

This post which will review, risk assess and contact all victims of domestic violence and abuse who have reported to the police to ensure the correct referral is made to the most appropriate agency which will be needs led)

188 **South Wales Police**

- Joint CPS and ACPO Domestic violence checklists that accompany hand on files should be closely scrutinised by Supervisors and any deficiencies in the completion addressed.

189 **National Probation Service**

- Team managers should ensure that in supervision they are discussing unresolved issues of denial in the case of DV perpetrators, assessed as medium risk of harm.

- Team managers encourage practitioners to use a range of practice interventions, e.g. rehabilitative activity requirement workbooks, to address offender denial and rehearse strategies to avoid or cope with relapse into destructive behaviours

- In case of domestic abuse there is more recording of the sharing of offender risk management and sentence plan objectives and progress with those agencies actively involved with past victims. Probation risk management plans are informed by and are responsive to the safety planning and interventions given to victims of domestic abuse

- At the end of licence/sentence management agencies working with known victims are informed of the end of statutory supervision, appraised of the

offender's progress, circumstances and intentions, so that they can consider victim safety planning knowing the perpetrator is now without criminal justice agency oversight

190 **Vale of Glamorgan Council – Adult Services**

There are no recommendations in respect of Vale of Glamorgan Council – Adult Services

191 **Vale of Glamorgan Council – Housing Services**

- Review and up-date its Violence Against Women, Domestic Abuse and Sexual Violence Policy, including:
    - Establishing a central record of MARAC information for Housing Management
    - Reviewing follow-up procedures when cases are discussed at MARAC regardless of other agency involvement
    - To set up a central record of all cases discussed at MARAC including a summary of the reason for referral which can be cross referenced with any anti-social behaviour reports or other concerns that Neighbourhood Managers or other staff members may have

- Develop additional case note recording within its current OHMS database to share information throughout the team more effectively

- Process to be developed to review current "marker" alert system with OHMS for both perpetrator and victims. For example, this may include annual reviews where it will contact a victim to establish if there have been any further incidents. This will better enable them to support and monitor repeat victims of domestic abuse and those who remain in abusive

relationships. It also creates an opportunity to remind the victim of the services available and enquire to if they would like to leave the relationship.

- Ensure that all new staff completes level 1 domestic abuse awareness training. All Neighbourhood Managers will complete level 2 training.

192 **Vale of Glamorgan Council - Housing Solutions Team**

There are no recommendations in respect of Vale of Glamorgan Council – Housing Solutions Team

193 **Vale of Glamorgan Council – Supporting People**

There are no recommendations in respect of Vale of Glamorgan Council – Supporting People

194 **Cardiff and Vale University Health Board**

- All health staff/GPs to undertake the Mandatory Domestic Abuse (Group2) training to ensure that victims of domestic abuse are identified and that health are meeting the needs of the victims particular in EU and at the GP surgeries

- Further Domestic Abuse training to include the links between domestic abuse and alcohol, demonstrating how this increases the victim's vulnerability

- Consideration to be given by Statutory agencies and health for the UHB Safeguarding team to receive high risk victims of Domestic Abuse PPNs. The information would be saved on file in the community and available for staff to view should a victim present in a number of different community health settings such as the Sexual Assault Referral Centre (SARC), the Dept. of

Sexual Health (DOSH), and mental health and substance misuse services. They would be immediately identified as victims and offered an opportunity to consider safeguarding and support.

- IRIS programme roll out to all GP practices across Cardiff & Vale of Glamorgan to be considered and explored
- Health to continue to ensure that EU staff are alert to the identification of potential Domestic Abuse victims and the referral process by introducing a rolling training programme to ensure that all staff are captured.

- Health to continue to develop and expand the IDVA role within the UHB and promote the service provided.

- At each contact with a victim of Domestic Abuse the identification of the perpetrator must be explored and documented. A nil response must also be documented.

195 **Atal y Fro Domestic Violence Services**

- Improve quality of notes /report writing

- Make greater efforts to publicise Atal y Fro services across Vale and Cardiff

- Secure funding for an Education Worker to provide more training in line with the D.V. National Training Framework (Welsh Govt.) to all those working in the region in domestic and sexual abuse

- Ensure better, more intensive preparation of males /couples prior to undertaking any of the programmes to improve engagement

196 **Hafod Care Housing Association**

- To ensure staff record and report information at all times

- To ensure staff are trained in Domestic Abuse and log information appropriately

- To ensure good communication with all agencies and organisations e.g. follow up if information is required.