# Domestic Homicide Review

## Executive Summary

**William**

**January 2016**

**Report Produced by Martyn Jones BSc (Hons)**

**Independent Chair and Author**

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## Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 59 years old man on the 10th January 2016. His daughter the perpetrator (known as P) was arrested and charged with his manslaughter. P appeared before the Crown Court in March 2017 and was found not guilty by reason of insanity. P was however, sentenced to a hospital order under the Mental Health Act.

P was 27 years of age at the time of the incident, she was well known known to statutory agencies.

During the early hours of Sunday, the 10th January 2016 the emergency services were summoned to an end of terrace dwelling house where it had been reported smoke was seen escaping from a top floor window. It was quickly established by the fire service that this was a house fire. The victim along with a family dog were found deceased in the bathroom area and the seat of the fire was discovered to have been deliberately started in a cupboard under the stairs. P was found at the scene. P was initially conveyed to hospital however she declined hospital treatment. On being discharged from hospital P was initially arrested under section 39 of the Mental Health Act however following the discovery of her father's body she was arrested for his murder.

The Domestic Violence Crimes and Victims Act 2004 Section 9 (3), which was implemented with due guidance[1] on 13th April 2011 and later revised in December 2016 establishes the statutory basis for a Domestic Homicide Review.

Under this section a Domestic Homicide Review means a review of the circumstances in which the death of a person age 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death

In compliance with the Home Office Guidance,[2] on 24th March 2016 South Wales Police notified the circumstances of the death in writing to the Cardiff Partnership Board. The Board accordingly notified the Home Office on the 18th May 2016 of the circumstances of the incident and the intention to conduct a Domestic Homicide Review.

### The Domestic Homicide Review Panel

The review was carried out by a Domestic Homicide Review Panel made up of representatives of agencies who were involved in delivering services to the family of the victim. It included senior officers of agencies that were involved. The professional designations of the panel members were:

- Safeguarding Manager – Welsh Ambulance Service National Health Services Trust.
- Policy & Development Manager – Cardiff Council.
- Domestic Abuse Co-ordinator – Cardiff Council
- Safeguarding Nurse Advisor – Cardiff and Vale University Health Board

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Home Office Guidance page 8

- Head of Safeguarding – Cardiff and Vale University Health Board.
- Operational Manager – Adult Services Cardiff and Vale University Health Board.
- Service Manager, Safeguarding and Review Children's Services – Cardiff Council
- Independent Protecting Vulnerable Person Manager – South Wales Police
- Senior Operational Manager- South Wales Fire and Rescue Services.
- Manager – Community Rehabilitation Company.

None of the panel members had any direct dealings with the Perpetrator or her family.

The Panel was chaired by an experienced Independent Chair who compiled Overview Report and this Executive Summary. The Chair and Author did not have any dealings with the P or her family prior to being involved with this review.

**Time Period**

It was decided that the review should focus on the period from 1st January 2008 up until the time of death of the death of the victim on 10th January 2016, unless it became apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended.

The review also considered any relevant information relating to agencies contact with the Victim and Perpetrator outside the time frame as it impacts on the assessment in relation to this case.

**Individual Management Reports**

An Individual Management Reports (IMR) and a comprehensive chronology was received from the following organisations:

- Cardiff Council Children's Services
- Cardiff Council Housing
- Cardiff Council Adult Services
- South Wales Police
- Cardiff and Vale University Health Board
- Welsh Ambulance Services Trust
- Wales Community Rehabilitation Company.

**Process of the Review**

Home Office Guidance[3] requires that DHRs should be completed within six months of the date of the decision to proceed with the review.

There were extenuating circumstances that contributed to the review being unable to be completed within the six-month time frame. There were multiple parallel investigations that provided unique and challenging situations, to the review panel, especially in terms of sharing of information and the management and coordination of individual agency reviews.

These parallel investigations can be outlined as follows;

- The Review was commenced in advance of criminal proceedings having been concluded.

[3] Home Office Guidance 2013 page 15

- South Wales Police had self-referred an internal issue to the Independent Office of Police Complaints regarding their initial response prior to the house fire. The Independent Office of Police Complaints advised South Wales Police to conduct an in-house review by their Professional Standards Directorate.
- Cardiff Council in accordance with Welsh Government policy carried out a multi-agency Extended Child Practice Review.
- The Welsh Ambulance Service Trust conducted an internal investigation into their initial response to events prior to the house fire.
- The Wales Community Rehabilitation Company conducted a serious case review regarding their involvement and support to P prior to the homicide.

The Home Office was regularly updated and accepted the situation.

**Terms of Reference for the Review**

The aim of the DHR is to essentially;

- 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;

- 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;

- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and

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

**Family Involvement**

Home Office Guidance[4] requires the family, friends and colleagues who have details or knowledge of the victim or the Perpetrator to be given the opportunity to contribute to the review process. In this case, despite written correspondence and partnership support the family members decided not to participate in the review.

**Summary of Key Events**

There is very little information known about the victim other than he once owned a family butchers' business and was well known in the Cardiff area. He was estranged from his wife the mother of P. He was not known to statutory authorities.

P described her relationship with her father as great, she described herself as a "daddy's girl, her father would take her to watch football. He never treated her badly and was never aggressive.

[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Home Office 2011 Revised 2013 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*

During the course of a pre-trial interview with a Consultant Forensic Psychiatrist P admitted during her teenage years to smoking cannabis and dabbled in taking class A substances. P denied a history of alcohol abuse and explained that apart from occasional feelings of depression she never saw herself as having a mental health problem.

The first recorded partnership intervention with P is dated May 2009 during the birth of her daughter Child A.

A Child Protection Assessment was undertaken in relation to concerns that P was agitated and had threatened to leave the hospital with her new born baby. A partnership agreement was made not to progress the matter. However, the assessment identified support mechanisms that were put in place.

In June 2010 P presented herself to Cardiff Council as being homeless. P presented information that she had left the family home due to violence from her mother towards herself and her father. At the time P explained that her father was disabled and that her mother was his principle carer.

Investigations by housing officers revealed that there were counter allegations from P mother. Temporary accommodation was found for P however within a few days P returned to the family home to reside with both her mother and father.

The review identified a pattern of such incidents where various family members made allegations of domestic abuse. There were counter allegations being made within the family group although no information available to suggest these complaints were taken forward. Statutory authorities intervened and offered support with alternative accommodation arrangements and specialist advocacy support.

There is a documented trail of support within Cardiff Council Adult Services, Children's Services, South Wales Police and Safer Wales an independent charity whose mission is to support, protect and empower people often caught up in domestic abuse. These interventions involved timely risk assessments and specialist intervention.

In November 2012 in response to Children's Services support to Child A, a Community Addiction Unit psychologist carried out an assessment of P. This assessment found no evidence of domestic abuse, there were no current concerns regarding P although it was noted P was difficult to engage with.

In November 2013 P whilst in the company of Child A was arrested for shoplifting. This matter was resolved by way of a formal caution for theft.

That same month Police officers responded to a complaint from a landlord that P was involved in drug misuse and in rent arrears. The Police found no evidence of drug misuse and offered advice and guidance in relation to the civil matter of rent arrears.

In December 2013 P was again arrested for shoplifting whilst accompanied by Child A. This matter was again resolved by way of a Police caution. There were concerns regarding the welfare of Child A. A Child referral was made, and a Child Protection Strategy meeting was held the following month January 2014.

During this meeting it was identified that P was being supported by way of Drug Rehabilitation program although there were concerns regarding her attendance record. Adult Services were tasked to offer additional support by way of on-going assessment during home visits. There was also on-going support put in place for Child A.

During the moths of February and March 2014 there were further incidents of family tension where the Police were called, and subsequent inter-agency support was put in place. P was also again arrested for shoplifting. P was reported for summons by the Police however a decision not to prosecute was made by the crown Prosecution Service.

In May 2014 there was considerable Safeguarding activity by Cardiff Council Children's Services in relation to Child A. The child was placed on the at-risk register and there was an agreed Safeguarding plan in place.

There is no information available to suggest that domestic abuse was a contributory factor to this situation.

In November 2014 P made an application to the Police for disclosure of information under the provisions of "Claire's Law" in respect of her then partner. A Detective Officer from the local Public Protection Unit managed the application however P informed the officer she no longer wished to have any disclosure. A further application was made by P to the Police in March 2015 regarding a different partner. Again, the application was managed by a Detective Officer. It is recorded that P again withdrew the application.

Both individuals were known to the Police having previously been involved in incidents of domestic abuse with other partners. These applications and all relevant information were shared in a timely manner with other relevant partnership agencies.

In January 2015 P was arrested for shoplifting. Whilst in Police detention she was drug tested which proved positive for Opiates. P appeared before the Magistrates Court in February 2015 where she was given a conditional discharge and referred to an Integrated Offender Intervention Program.

Despite two appointments P failed to attend the Program. P was arrested and appeared before the Magistrates Court. The Court gave P an absolute discharge.

There followed two further incidents of shoplifting In April and May of 2015 where P appeared before the Magistrates Court. Guilty pleas were accepted, and various community-based sentences were administered. On the basis that P again tested positive for Opiates the court ordered that P work with the Community Rehabilitation Company to support her addiction.

The Community Rehabilitation Company referred P to the Pathfinder Project. This support option brings together existing services such as domestic abuse support, drug abuse agencies and housing in a way that makes best use of services and supports women away from drug addiction and further offending.

Unfortunately, there were persistent breaches by P to comply with the Magistrates Court requirement to work with the Community Rehabilitation Company. This involved non-attendance at Pathfinder appointments.

At the time P received a street warning from the Police for the possession of cannabis.

In July 2015 P appeared before the Magistrates court and sentenced to sixteen weeks imprisonment.

At this time there was a series of meetings within the Children's Services Directorate where multi-agency reviews took place in relation to Child A who was being cared for by her grand-parents. These meetings are all documented and commented upon during the Child Practice review. At this time the Directorate was moving towards a civil care proceedings outcome with a foster care placement. During these reviews incidents of Domestic Abuse were not identified.

South Wales Police were investigating disclosures made by Child A which were sensitive in nature. Both P and her father were witnesses in this investigation. A suspect was identified and interviewed by the Police. Although an initial decision was taken to charge this person with criminal offences, these charges were later withdrawn by the Crown Prosecution Service.

During this process both P's father and mother had made representations to formally foster Child A. A subsequent viability assessment did not support this application.

P was released from custody in September 2015, on licence and subject to a Post Sentence Supervision Order. The licence expired in November 2015.

The Community Rehabilitation Company ( CRC) provided support. It is documented that during initial discussions P disclosed that a previous partner had been abusive towards her.

The CRC worker identified this as potential domestic abuse and arranged for P to attend a supportive program called Safety Trust and Respect ( STAR).

The STAR program is designed to assist victims of abuse with the provision of a toolkit of knowledge and resources that are designed to prevent them entering a domestically abusive relationship.

P did not attend the first appointment for the STAR program. The CRC support worker issued P with a written formal warning.

In October 2015 officers from Cardiff Council Anti-Social Behaviour Unit on receipt of complaints from residents were dealing with incidents of anti-social behaviour at P's home address. The complaints were in relation to allegations of excessive noise and drug dealing. The information provided to officers suggested that P's father also resided at this address. There is no information available to suggest the outcome of this investigation or if the resident's concerns were shared with others.

CRC officers made an unplanned visit to P home address on the 9th October 2015. Officers record that they found both P and her father present. Both were in good spirits and a positive and supportive relationship was observed. P was provided with another CRC appointment.

During the months of October and November 2015 P generally attended CRC appointments where she received support from the Offender Intervention Service. Failed attendances were mitigated by way of P concerns that she was afraid of losing her child after the conclusion of

Child Care Proceedings. For example, non-attendance at a Pathfinder appointment was mitigated by way of P attending a Family Court hearing.

In December 2015 continued non-attendance at CRC and various supportive programs resulted in a breach process being instigated.

On 31st December 2015 Police attended the home of P's mother where P was found to be intoxicated and banging on the door of her mother's home. Officers escorted P away from the scene and conveyed her home into the care of her father. This information was shared with CRC.

CRC records indicate that subsequent to this incident a breach letter was posted to P with a requirement for P to attend the Magistrates Court on the 20th January 2016, and in the interim period arrangements were put in place to carry out another un-planned visit to P.

CRC records also indicate that they had indicated support to Children's Services in final care proceedings for Child A.

At this time there is no information of partnership intervention or support to any other incident involving P's mother or father.

During the afternoon of the 9th January 2016 Police officers attended to an incident where it had been reported that P was in a confused state, she had been banging on the door of her mother's home and had been standing in the roadway holding up vehicular traffic. Police officers escorted P home and left her in the care of her father. Police officers also contacted ambulance control and arranged for the attendance of paramedics.

Due to demand pressures, there was a considerable time delay in the attendance of paramedics. Paramedics did attend during the early hours of the 10th January 2016.

On arrival by ambulance staff report that P refused any treatment. P was left in the care of her father.

Later that morning emergency services responded to the house fire where they found P's father. A subsequent post-mortem examination identified his cause of death as smoke inhalation.

P was later held in Police custody.

**<u>Analysis and Recommendations</u>**

The Review Panel has identified P experienced complex mental health issues prior to this incident. On the basis that P declined to give consent to disclosure of medical history the panel have not had access to medical records to further explore these complexities.

The panel relied on the report prepared by an Independent Consultant Psychiatrist for Crown Court purposes to understand some antecedent history and the nature of the mental health diagnosis.

The panel respects the family decision not to engage with the review.

There is a paucity of information available in relation to the victim. There is no precise information available to suggest the victim was either a victim or perpetrator of domestic abuse. In fact, the victim is seen throughout the review as a person who accepted parental responsibility for P. This is evidenced when Police Officers when called upon to support P escorted her home into his care.

P received significant multi-agency support both in terms of the care of Child A and to confront alcohol and drug mis-use.

The STAR and Pathfinder programs are two examples of bespoke support that was put in place.

Local policies and procedures appear to have been complied with in the risk assessment of P as a vulnerable person. Whilst this appears acceptable in terms of statutory responsibility, the issue remains as to why P chose not to cooperate more fully and support agencies. This may well have been discussed during appearances at the Magistrates Court for non-compliance.

The Extended Child Practice Review (CPR) which was managed parallel to this review found no information to suggest domestic abuse was a significant factor within the family group. Furthermore, the CPR concluded that although P mental state was a crucial factor in the homicide court case, during the period of this review there was no formal reference to an actual diagnosed mental illness, all input refers to her drug misuse behaviour.

The CPR made a number of Child Safeguarding recommendations that are found within their final written report

South Wales Police, WAST and CRC have all conducted internal reviews. They form part of an internal learning process.

The review panel has not had access to these individual internal reports. South Wales Police incorporated their internal review into their contribution to this DHR. Both WAST and CRC declined disclosure. The DHR action plan captures relevant areas for improvement across all agencies.

**List of Recommendations**

The following recommendations are made:

**Recommendation 1**

**That the outcomes of both the Child Practice Review and Domestic Homicide Review are shared and considered by the Cardiff Public Services Board and any consistent themes are acted upon in a coordinated way.**

Recommendation No 1 is designed to capture all relevant information of both reviews and to ensure there is corporate responsibility within the Public Services Board to ensure cross fertilisation of outcomes relating to recommendations and action plans.

**Recommendation 2**

**The Home Office Quality Assurance Panel provides additional information clarity with regards to the Home Office Guidance for the conduct of domestic Homicide Reviews dated December 2016. Particular clarification is required of paragraphs 99 and 100 that relates specifically to Health Service support to such reviews.**

This recommendation relates to the perpetrator declining consent to agree to disclosure of medical records. The panel was made aware that this information exists however a corporate decision was made within the health authority not to disclose on the basis of no individual consent.

**Recommendation 3**

**Cardiff Housing reviews policy, practice and relevant training to ensure all staff are aware of their responsibilities in tackling Domestic Abuse especially in taking a partnership approach to problem solve.**

The panel identified that there was an awareness and training need for housing officers to identify domestic abuse and be conditioned to take a partnership approach to problem solve. Housing officers especially those engaged in duties to tackle anti-social behaviour are, in an operational context, often in direct contact with members of the public. This has been identified within the Housing Directorate.

**Recommendation 4**

**The Cardiff Public Services Board reviews both its strategic and tactical management and support to victims of mental health especially those victims currently being supported for substance and alcohol addiction.**

At the criminal trial the issue of mental health was a significant contributory factor to the conduct of P. Independent clinical diagnosis was a crucial factor in determining insanity as a defence. On the basis of information provided to the panel this acute mental health illness was not identified or shared with any statutory agency prior to the homicide.

The panel believes that if information of this nature is identified and shared with statutory partners then relevant risk assessments conducted at the relevant time may well address appropriate support mechanisms commensurate with the identified condition.

**Conclusion**

Although the victim died as a result of a domestic homicide there is no precise information available to suggest he was either a victim or perpetrator of abuse. As previously outlined in this report the victim can be described as a loving father who took his parental responsibilities seriously.

P was diagnosed with complex mental health issues fuelled by drug and alcohol addiction.

The clinical report prepared by a consultant states;

> "With the benefit of hindsight and taking into account her (P) slow progress in hospital I conclude that this was not a drug-induced psychotic illness but rather the onset of a mental illness which can be classified as either schizophrenia or schizoaffective psychosis in which symptoms of schizophrenia and a prominent mood disorder co-exist"

This report suggests comorbidity in that there was, in respect of P's condition, the presence of more than one mental health condition.

This condition appears not to have been identified by any partnership agency prior to the homicide.

The review panel did not wish to express a conclusion on the predictability or preventability of this tragic incident.

After the criminal trial the crown court judge commented:

> "I have no doubt you loved your father and the two of you were very close, you will have to live with the responsibility for starting the fire and its consequences, but I am satisfied that your blameworthiness was very low."

Martyn Jones

Independent Chair and Author