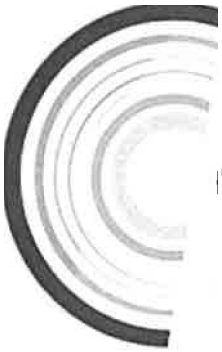

Cardiff
Caerdydd

Domestic Homicide Review
Overview Report

William

January 2016

Report produced by Martyn Jones BSc (Hons) Independent Chair and Author
August 2018

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List of Abbreviations

CAU	Community Addition Unit
CPR	Child Practice Review
CRC	Community Rehabilitation Company
CAFCASS	Children and Family Court Advisory and Support Service
DASH	Domestic Abuse Stalking Honor (Risk Assessment)
DHR	Domestic Homicide Review
DVDS	Domestic Violence Disclosure Scheme
DWP	Department of Work and Pensions
EMT	Emergency Medical Technician.
HMP	Her Majesty's Prison
IMR	Individual Management Report
IOIS	Integrated Offender Intervention Service
PPD/1	Public Protection Notice (Police)
POVA	Protection of Vulnerable Adults
SIO	Senior Investigation Officer (Police)
SSO	Suspended Sentence Order
STAR	Safety Trust and Respect (Support Program)
TSP	Training Skills Program

For the purpose of this review the victim will be known as William, a pseudonym chosen by the Domestic Homicide Review panel.

The members of the review panel offer their sincere condolences to the family of William for their sad loss in such tragic circumstances.

1. Introduction

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of William aged 59 years. His daughter, the perpetrator (known as P), was initially detained under section 136 of the Mental Health Act but later arrested and charged with his manslaughter. P appeared before the Crown Court in March 2017 and was found not guilty by reason of insanity. However, P was sentenced to a hospital order under the Mental Health Act.

1.1.2 No family member chose to participate in the review so informative detailed information on both William and P's antecedent history was not available to the review panel.

1.2. Purpose of a Domestic Homicide Review

1.2.1 The Domestic Violence, Crimes and Victims Act 2004 establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011 and reviewed in December 2016[2]. Under this section, a Domestic Homicide Review means a review "of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by -

a) a person to whom they are related or with whom they are or had been in an intimate personal relationship, or

b) a member of the same household as themselves, held with a view to identifying the lessons to be learnt from the death.

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[3], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behavior, violence or abuse between those aged 16 or over who are or have been

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[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crimel DHR-guidance*

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews - Home Office 2016

[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance

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*
- *emotional*

1.2.5 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

- establish what lessons are to be learned from the homicide regarding the way in which local professionals and organizations 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.
- apply these lessons to service responses including changes to the policies and procedures as appropriate.
- prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.
- to assist the victim's family in their meaningful healing process.
- contribute to a better understanding of the nature of domestic violence and abuse.
- highlight good practice.

1.3. Process of the Review

1.3.1 South Wales Police notified Cardiff Partnership Board of the homicide on 24th March 2016. The Cardiff Partnership Board reviewed the circumstances of this case against the criteria set out in the Government Guidance and recommended to the Chair of the Partnership that a Domestic Homicide Review should be undertaken. The Chair ratified the decision.

1.3.2. The Home Office was notified of the intention to conduct a DHR on 18th May 2016 An independent person was appointed to chair the DHR Panel and prepare and present the overview report.

1.3.3 Home Office Guidance[4] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review. There were extenuating circumstances as to why this review was not completed within this time frame. The protracted criminal justice process and the multiple parallel investigations all contributed to this delay. Furthermore, this review run parallel to a Regional Safeguarding Board, Child Practice Review.

1.4 Independent Chair and Author

1.4.1 Home Office Guidance[5] requires that.

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on evidence the review panel decides is relevant," and "... The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the Cardiff agencies involved in the review."*

1.4.2 The Cardiff Partnership Board appointed Mr. Martyn Jones from the Winston Partnership Limited to be both the chair and independent author.

1.4.3 Martyn Jones is a former Senior Detective Officer with South Wales Police having retired from the force in 2011. Mr. Jones has many years' experience in homicide investigation and at one time was the force lead in Public Protection matters across South Wales. Prior to this review process, Mr. Jones was not involved, either directly or indirectly with members of the family concerned or the delivery or management of services by any of the agencies. Mr. Jones chaired meetings and personally met with individual organizations to discuss parallel investigations.

1.4.4 Mr. Jones is a consultant to Winston Limited and works with Mr. Malcolm Ross, also a consultant with the same company. Mr. Ross attended some of the panel meetings.

[4] Home Office Guidance 2016, pages 16 and 35.

[5] Home Office Guidance 2016, page 1.

1.5 Domestic Homicide Review Panel Proceedings

1.5.1 In accordance with the statutory guidance, an independent DHR Panel was established to oversee the process of the review. Mr. Jones chaired the panel. Other members of the panel and their professional responsibilities were:

Name	Designation	Agency
Martyn Jones	Independent Chair & Author	
Malcolm Ross	Independent Chair & Author	
Natalie Southgate	Policy & Development Manager	Cardiff Council
Nicola Jones	Domestic Abuse Co-Ordinator	Cardiff Council
Nikki Harvey	Safeguarding Manager	Welsh Ambulance Service National Health Services Trust
Judy Brown	Safeguarding Nurse Advisor	Cardiff and Vale UHB
Susan Schelewa	Operational Manager Adult Services	Cardiff Council.
Natasha James	Service Manager, Safeguarding & Review Children's Services	Cardiff Council
Sue Hurley	Independent Protecting Vulnerable Person Manager	South Wales Police
Gail Weaver	Business Support Officer	Cardiff Council
Linda Hughes -Jones	Head of Safeguarding	Cardiff and Vale UHB
David Bents	Senior Officer	South Wales Fire and Rescue Service.

1.5.2 None of the Panel members had direct involvement in the case or had line management responsibility for any of those involved. The Panel met on six occasions. This was in addition to two joint management meetings with the senior leadership team from the Child Practice Review. The Chair / Author of the review also had separate meetings with agency leads involved in the parallel investigations. There was also a number of telephone conferences with senior medical professionals responsible for the care of P.

1.5.3 The Panel was supported by an Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur due to this review having been undertaken. The panel met on six occasions. The Chair, accompanied by the Policy and Development officer for Cardiff Council, met with the management team of the Child Practice Review on two occasions.

1.6 Parallel Proceedings and Investigations

1.6.1 The Panel were aware that the following parallel proceedings and investigations were being undertaken:

- Cardiff Partnership Board advised HM Coroner on 17th August 2016 that a DHR was being undertaken.

- The Review was commenced in advance of criminal proceedings having been concluded and therefore preceded with awareness of the issues of disclosure that

may arise.

- South Wales Police advised the Panel that they had self-referred an internal issue to the Independent Police Complaints Commission regarding their initial response prior to the house fire. The Police Complaints Commission advised South Wales Police to review their involvement internally.

- The Cardiff and Vale University Health Board participated in a Child Practice Review organised by Regional Cardiff and Safeguarding Board.

- 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.

1.6.2 These multiple investigations and reviews presented unique challenges to the panel in terms of sharing information and the management and coordination of individual agencies.

1.7 Time Period

1.7.1 It was decided that the Review should focus on the period from 1st January 2008 up until the time of death of William 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.

1.7.2 The Review also considered any relevant information relating to agencies' contact with William and P outside the timeframe as it impacts on the assessment in relation to this case.

1.8 Scoping the Review

1.8.1 The process began with an initial scoping exercise. This was prior to the first Panel meeting. The scoping exercise was completed by Cardiff Council to identify agencies that had been involved with William and P prior to the homicide. Where there was no involvement or insignificant involvement, agencies were advised accordingly.

1.9 Individual Management Reports

1.9.1 An Individual Management Report (IMR) and comprehensive chronology was received from the following organizations:

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

1.9.2 Guidance was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

- allow agencies to look openly and critically at individual and organizational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standard.
- identify how those changes will be brought about.
- identify examples of good practice within agencies.

1.9.3 Agencies were encouraged to make recommendations within their Individual Management Reports, these were accepted and adopted by the agencies that commissioned the reports. The recommendations are supported by the Overview Author and the Panel.

1.9.4 The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

1.10 The Area

1.10.1 Cardiff is the capital and largest city in Wales. The 2011 census identified an estimated population of 861,400 living in both the confines of the city and within the peripheral urban zone. The city is the county's chief commercial center, the base for most national, cultural and sporting institutions. The Welsh Government's debating chamber, the Senedd, is located at Cardiff Bay. This is the main building for democracy and devolution.

1.10.2 Cardiff has an ethnically diverse population due to its past trading connections, immigration, and large numbers of foreign students who attend university in the city. The ethnic make-up of Cardiff's population at the time of the 2011 census identified that almost 53,000 people from a non-white ethnic group reside in the city. This diversity, especially that of the city's long-established Muslim community, is celebrated during a series of cultural exhibitions and events.

1.10.3 Cardiff Council is the governing body for the city. Governance and accountability for community safety sits with the Safer and Cohesive Communities Board which reports to the Public Services Board, chaired by the Council's Chief Executive.

2. Summary

2.1 During the early hours of Sunday 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. William, 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.

2.2 South Wales Police commenced initial enquiries and established that P resided at the address with her father William.

2.3 After being discharged from hospital P was initially arrested under section 136 of the Mental

Health Act; however, following the discovery of her father's body, she was arrested for his murder.

2.4 A postmortem later revealed that William had died as a result of smoke inhalation. P was found to be unfit to be formally interviewed by Police officers. P was consequently detained at a Medium Security Psychiatric unit in West Sussex.

2.5 After clinical assessment and specialist clinical support, Police officers did eventually interview P within the Psychiatric Unit. P was later charged with the murder of her father.

2.6 P appeared before the Crown Court via a video link from the Psychiatric Unit. A charge of murder was reduced to that of manslaughter. P denied manslaughter on the grounds of insanity at the time of the incident.

2.7 Insanity is defined as "a defect of reason caused by a disease of the mind".

2.8 Evidence provided by a consultant forensic psychiatrist confirmed that the defence of insanity applied in this case.

2.9 The trial judge commented "The defect of reason must be such that the defendant did not know what she was doing or, if she did know, she did not know the act was wrong”.

2.10 The jury found P not guilty of manslaughter.

2.11 The trial judge made orders under Section 37 and Section 41 of the Mental Health Act meaning P will remain at the Psychiatric Unit for treatment.

2.12 The death of William was the catalyst for a number of parallel investigations including a referral for an Extended Child Practice Review for Child A to Cardiff and the Vale Safeguarding Board. P was the mother of Child A. At the time of the death, the child had already been removed some months earlier from P under a Formal Care Order and was in a foster placement. It was agreed that the CPR would be conducted. The CPR was conducted parallel to the DHR. The focus of the DHR was primarily towards the victim and P. Whilst the focus of the CPR was on Child A. A conscious effort has been made to avoid duplication.

3. Terms of Reference for the Review

Aim

3.1 The aim of the Domestic Homicide Review is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organizations 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.
- prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- contribute to a better understanding of the nature of domestic violence and abuse,
- highlight good practice.
- consider the findings of all parallel investigations and focus on any relevance to domestic abuse.
- provide all participating agencies with a generic terms of reference document to assist in the preparation and presentation of individual management reviews.

Process

3.2 An Independent Chair/Author was commissioned to manage the process and compile the report. Membership of the Domestic Homicide Review Panel included representatives from relevant agencies. The Chair/ Author was also required to meet and liaise with other lead investigators from other agencies responsible for the parallel investigations and reviews.

Confidentiality and Dissemination

3.3 The findings of this review are restricted. Information is available only to participating officers, professionals and appropriate line managers. This will remain until the review has been approved by the Home Office Quality Assurance Panel for publication.

3.4 The panel found themselves in some difficulty in deciding upon a suitable pseudonym. As previously outlined, the family decided not to support the review. The pseudonym was chosen during a panel discussion.

3.6 The Community Safety Partnership intends publishing the review in compliance with Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews, 2016.

3.7 The review has been identified as a case study by the Welsh Government Single Unified Safeguarding Review as an example of the multiple challenges and competing priorities that are required to be negotiated when you have a number of complex parallel investigations.

Individual Needs

3.8 Home Office Guidance[6] requires consideration of individual needs, specifically stating: 'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted.'

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

- eliminate discrimination, harassment, victimization and any other conduct that is prohibited by or under this Act.
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

3.10 The Review gave due consideration to all of the Protected Characteristics under the Act.

3.11 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

3.12 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act.

Family Involvement

3.13 Home Office Guidance[7] requires that:

> "Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

3.14 The 2016 Guidance[8] illustrates the benefits of involving family members, friend and other support networks as:

a) assisting the victim's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for whatever time they need after the homicide.

b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on the victim's and perpetrator's perspectives rather than just agency views.

c) helping families satisfy the often expressed, need to contribute to the prevention of other domestic homicides.

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[6] Home Office Guidance 2016, page 36.

[7] Home Office Guidance 2016, page 18.

[8] Home Office Guidance 2016 Pages 17-18.

d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of the victim and/or perpetrator in order, to, see the homicide through the eyes of the victim and/or perpetrator. This approach can help the panel understand the decisions and choices the victim and/or perpetrator made.

e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information, as well as testimony to the emotional effect of the homicide. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

f) revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) enabling families to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

3.15 Despite written correspondence with an invitation to support the review family members decided not to participate. The review panel accepted this position. Additionally, information from the Extended Child Practice Review was explored to identify friends, neighbours, and potential work colleagues who could assist this review. This also proved unsuccessful.

3.16 In this case the Overview Report Author contacted the Senior Investigating Officer (SIO) from South Wales Police at an early stage. A meeting was held to discuss management of the criminal investigation and the review process. An agreement was made to progress both matters.

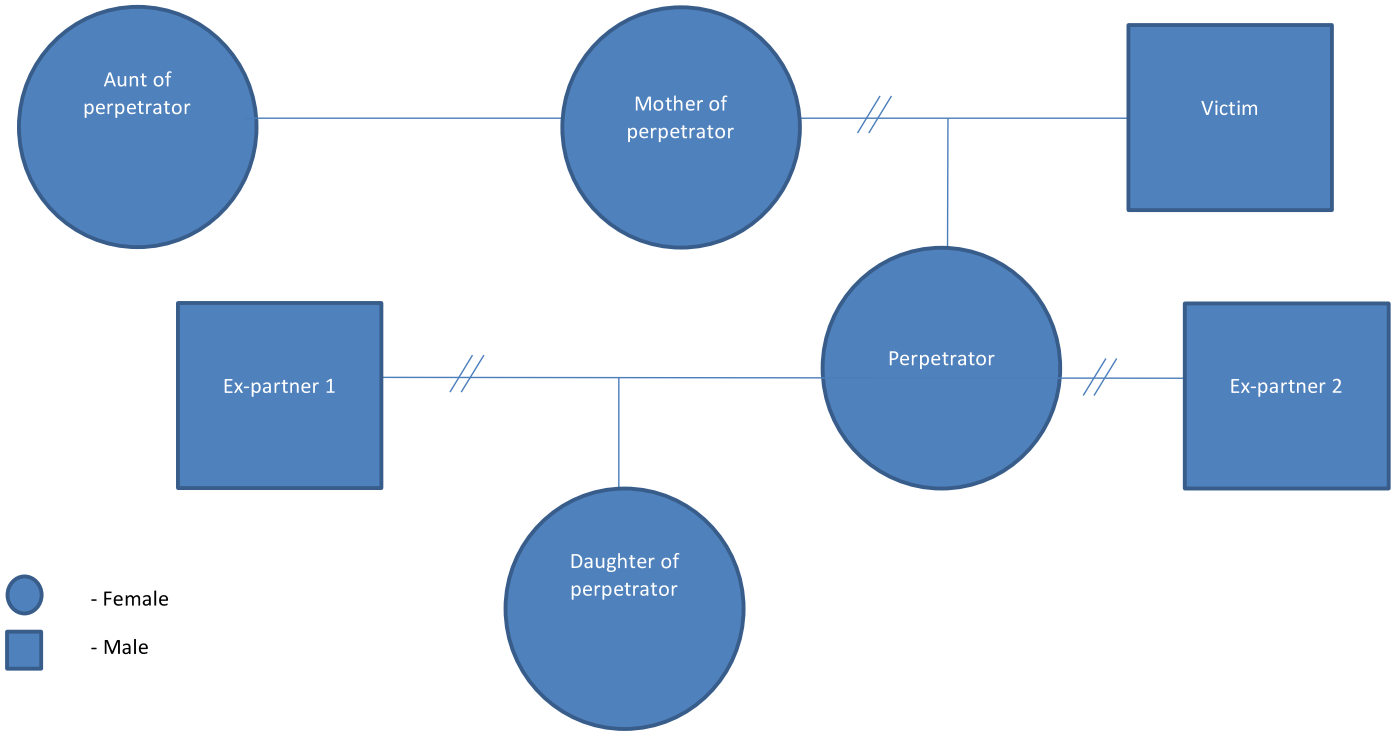
3.17 Meetings were also held with the Chair of the Child Practice Review and investigators with the other parallel investigations to agree common ground on progressing all enquiries. These meetings were also utilized in an attempt to reach out to the family. Findings from these processes are further discussed and explored in this report.

Subjects of the Review

3.18 The following genogram identifies the family members represented by the following:

Known as	**Description of relationship between individuals mentioned in this review.**
Victim William	Father of perpetrator
Perpetrator (P)	Daughter of victim
Mother	Estranged wife to victim
Aunt	Sister-in-law to victim
Daughter	Granddaughter of victim (Child A)
Ex-partner 1 (R1)	
Ex-partner 2 (R2)	

Genogram regarding William



4. Summary of Key Events

4.1 The first recorded partnership intervention with P is dated May 2009 during the birth of her daughter Child A. Maternity staff submitted a Child Protection referral as a result of concerns that P was agitated and threatened to leave the hospital with her newborn baby. A Child Protection Assessment was undertaken, and a partnership agreement was made not to progress the matter. However, the assessment identified support mechanisms that were put in place which included support from a midwife.

4.2 In June 2010 P presented herself to Cardiff Council as being homeless. P presented housing officers with information that she had left the family home due to violence from her mother towards herself and her father, William. P explained that William was disabled and that her mother was his principal carer.

4.3 Investigations by housing officers revealed that there were counter allegations from P's 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. Allegations of possible domestic abuse appear to have been dealt with internally by housing officers, and the information was not shared with other partner agencies.

4.4 During a routine visit to the family home as part of a support mechanism a Community Psychiatric Nurse raised concerns regarding the well-being of Child A. This was based on P's misuse of prescribed painkillers and a heated argument amongst family members in the presence of the baby. A referral was made to Children's Services and the Community Addiction Unit to support P.

4.5 A Child in Assessment was undertaken, and closure was agreed with no further action. This was primarily based on the identification that Child A was well presented, happy and healthy. There is no information available to suggest that possible domestic abuse was being considered.

4.6 During this assessment process it was noted that P appeared to have a close relationship with William. Whenever there was a domestic disagreement that resulted in William leaving the family home, he would take P and Child A with him.

4.7 In November 2010 P again applied to Cardiff housing seeking alternative accommodation citing a continuation of violent abuse from her mother towards William. Temporary accommodation was found for one night; however, P returned to the family home the following day.

4.8 In November 2010, days after this incident, the Police were called to the family home, where it had been reported a Domestic Incident had taken place. Police Officers attended the address and met with P and both her parents. Also present was Child A, now aged 1 year. Officers record that P's mother was agitated and shouting at them. The circumstances leading up to the disturbance involved tension between family members. This had escalated although there was no suggestion of physical violence or care issues regarding Child A. Officers established that P and William had moved back to the family home having been dissatisfied with the alternative sheltered housing previously offered to them.

4.9 The Police dealt with the situation as a "verbal argument" between family members. The initial review and assessment of risk was graded as standard. A Public Protection document PPD/1 was submitted. This information was not shared with other partner agencies.

4.10 In January 2012 Housing Officers made contact with P to discuss her housing needs. It is recorded that P had stated she had returned to the family home. P was considered not to be homeless, the case was then closed.

4.11 In November 2012 an enquiry was carried out by a Community Addiction Unit psychologist to support Children's Services support to Child A. This involved an assessment of P. It was recorded that there were no current concerns and there was no reference to domestic abuse. The psychologist recorded that P was difficult to engage.

4.12 In July 2013, South Wales Police received a complaint from a General Practitioner concerning the living conditions of P's family home. This was in relation to support the doctor was providing to P's mother. The Police attended and found the accommodation to be very un-kempt with no electricity. It was established that only P's mother was home. Officers provided advice and support which included the offer of alternative accommodation at a relative's address. This was declined.

4.13 The Police Officers established that P continued to reside at the address but had informed her mother she no longer wished to remain living there.

4.14 The Officers submitted a PPD/1. The initial review and assessment of risk was graded as standard and shared with Adult Social Services for POVA (Protection of Vulnerable Adult) consideration. This was in accordance with Police policy and procedure.

4.15 The Adult Social Services team received the referral in addition to a referral from the General Practitioner citing additional financial and material abuse.

4.16 Information recorded suggests that P's mother had disclosed she had been abandoned by P and her father. It was alleged that P had been spending money and using bank cards in her mother's name. This lack of financial control had contributed to her inability to pay utility bills which resulted in her electricity being cut off.

4.17 Additionally, it was established that P had left Child A with her mother.

4.18 Prompt action was taken by Social workers who visited the family home. The child had been reportedly removed from the home by P and her father William. Social workers report that there were concerns that P was abusing opiate pain killers and was receiving support from a Community Addictions Unit.

4.19 Support was put in place for P's mother which included the provision of financial support and a food parcel. Social Workers identified potential domestic abuse regarding the financial issue; however, it is recorded that P's mother did not wish to make a complaint to the Police. This was against the advice of social workers. There is no information available to suggest a DASH risk assessment was considered.

4.20 Adult Social Services referred concerns regarding welfare and Safety of Child A to Children's Services. This was assessed and closed as no further action due to the child being left in the care of the grandmother. There were no concerns regarding the child's welfare.

4.21 During ongoing support for P's mother Adult Social workers discovered that P was claiming carers allowance for her mother. This information was shared with the Department of Work and Pensions.

4.22 Adult Social Services workers also established that P and her father were staying in accommodation being paid for by an insurance company. This was in relation to work being carried out at the family home. The insurance company informed social workers that they had paid out significant sums directly to P. These payments were then stopped. The insurance company advised that their position would be to consider its position regarding seeking Police action as they were unsure if P's mother had consented to P to act on her behalf. There is no information available to suggest what the outcome was in relation to this issue.

4.23 In August 2013 South Wales Police responded to an abandoned telephone call from a distressed female. The call was traced to the family home of P and her parents. On arrival Police Officers found that P had left the property prior to their arrival. Officers determined that this was a domestic argument between mother and daughter. A PPD/1 form was submitted which recorded that P mother did not want details of the incident to be shared with other agencies.

4.24 The incident was graded as standard, and a Domestic Abuse log was commenced. A safety plan was put in place for P's mother, which included ongoing support from Social Services and a Police marker being placed on the address. This response was in accordance with policy and procedure.

4.25 Adult Social Services also provided support after this incident which included visits to the address where it was established that P had visited the home, became abusive and removed a portable television which P claimed she owned. Social Workers confirmed that P and William were now living in a flat nearby but had completed a general housing application for another property.

4.26 Social Workers established that contact between P and her mother was being maintained in that P's mother had disclosed she had admitted to lending P a sum of money which she believed would not be repaid.

4.27 This was also confirmed in October 2013 when South Wales Police responded to a domestic dispute between P and her mother the complainant over an unpaid taxi fare. This also involved William who it was alleged had been abusive during a telephone conversation. Her mother did not wish to make a formal complaint against P and the incident was recorded as a domestic dispute. A PPD/1 was submitted, and the Domestic Abuse Log was updated.

4.28 In October 2013, Safer Wales, on receipt of the Police PPD/1, attempted to provide support to P's mother on the basis that she was the victim of domestic violence and that P was the perpetrator. A joint visit between Safer Wales and the designated social worker was arranged but did not take place due to non- client engagement. Safer Wales record that P had allegedly threatened to stop her mother having access to her granddaughter if she proceeded to complain about the domestic situation. Although this was evidence of controlling behavior the situation of disengagement was disclosed to Social Services and Safer Wales.

4.29 In November 2013, Adult Social Services within Cardiff Council record that they were in possession of information that suggested P’s mother was under pressure to provide P with financial assistance. Adult Social Services’ records indicate that P’s mother had informed the Police. There is no follow up information available from Adult Services to establish the outcome of this complaint.

4.30 The following day a Police incident was recorded in that P was arrested whilst in the company of her daughter, Child A, for shoplifting. The circumstances are that the incident occurred in a local grocery store where various food items and a newspaper were stolen. P was arrested by the Police and formally cautioned for theft.

4.31 That same month Police responded to a complaint which was classified and recorded as a civil dispute in which the owner of the property rented by P had complained that P was in rent arrears and that there was evidence of drug use and drug paraphernalia at the address. Attending Officers record no evidence of drug misuse and appropriate advice was provided regarding the rent arrears. At this time Cardiff council housing received a housing application from P for alternative housing.

4.32 In December 2013, P was again arrested for shoplifting from a local grocery store. P was again accompanied by Child A. Items stolen included food and confectionary. A Police caution was administered. During the course of the Police investigation of this incident it was established that P was struggling to pay her bills, was facing eviction from her home, and had disclosed an addiction to prescribed painkillers. The Police established that the child was not on the Child Protection Register. A PPD/1 referral was made and shared with the Intake and Assessment Social Services team of Children's Services and Health Professionals.

4.33 The information regarding potential eviction was corroborated by Cardiff Housing, who at the time were in dialogue with the owner of the property regarding the validity of the eviction notice that had been served on P. In the meantime, the Housing department were actively seeking to re-house P and her daughter.

4.34 In January 2014, a Child Protection Strategy meeting was held to discuss support for Child A. During this meeting, it was identified that P was not engaging with a Drug Rehabilitation program to address her addiction to prescribed painkillers. Adult Services would seek to actively support P by an on-going assessment during home visits.

4.35 On 2nd February 2014 the Police attended a report of a Domestic Incident at the home of P's mother. It was disclosed that both P's mother and her father William had the previous evening visited a local public house. They returned to the home to discuss a reconciliation however this led to a disagreement where William returned home. The Police response to the incident was prompt and positive action was taken regarding advice and guidance and the necessary submission of a PPD/1 referral document was made.

4.36 On 5th February 2014, P contacted the Police to complain that her landlord had forced entry into her home and made unnecessary threats regarding potential non-compliance with an eviction notice. This notice effectively terminated P's residence at the address on 23rd March 2014. When Police attended, they discovered that P had left the property prior to their arrival. They spoke with William who explained details of the proposed eviction and his desire to look for alternative accommodation. No offences were disclosed, and Officers offered appropriate advice. The incident was finalised in accordance with force policy and procedure.

4.37 Between 6th February 2014 and 28th February 2014 there are documented activities within Cardiff Housing and Safer Wales to support P in looking for alternative accommodation in lieu of her impending eviction from her home. Safer Wales records indicated that P did not attend one appointment and cancelled another. On the basis of non-engagement Safer Wales closed the case and informed Social Services. This was in accordance with their own policy and procedure.

4.38 On 25th March 2014, Police officers attended the home of P, her daughter Child A and father William at the time a forced eviction was taking place. Officers found that the landlord was in attendance with a lock smith and that the relevant date on the eviction notice was 27th March 2014. Officers arbitrated between both parties and the eviction was deferred until the relevant date. Officers identified that the eviction could potentially put the Child A at risk. A PPD/1 was submitted to notify Children's Services.

4.39 On 28th March 2014, P was involved in an incident of shoplifting at a local store. Police officers attended and reported P by way of summons for theft. There is no information available to suggest that P was accompanied at the time. The matter was subsequently referred to the Crown Prosecution Service who decided not to prosecute.

4.40 On 28th March 2014, Cardiff Housing Options are notified that the landlord now seeks a court possession order to repossess a house that is P current home address.

4.41 On 12th May 2014, P vacates the property and on 14th May is found temporary accommodation by Cardiff Housing.

4.42 At this time there was considerable Safeguarding activity by partners with regards to supporting Child A. There is no information available to suggest that domestic abuse was a contributory factor to this situation.

4.43 This support was coordinated by an agreed Safeguarding plan.

4.44 On 15th September 2014, Adult Social Services receive a referral from an Occupational Therapist concerning both P and her mother. The referral contains information that P is desperate for assistance. Adult Services respond promptly and ascertain that the concern relates to P's concern that her mother was not being properly supported by social workers. Social workers report that during a meeting, the mother of P apologised for this approach and stated P was agitated over Children's Services involvement with her daughter. A support plan was put in place for P's mother.

4.45 In October 2014, P's mother contacted the Police to raise concerns over the safety of P and Child A. The mother explained that she was intending to babysit for P to go out for the evening. When both P and her child did not turn up, she made telephone contact with P who informed her that two males were at the house and that they had smashed a door. Police Officers attended and found no damage. They spoke with P and her boyfriend, identified as R2. Officers submitted a PPD/1 form having established that the child was on the "At Risk Register". The information was subsequently shared with the Social Services "Intake and Assessment" team and considered by professionals managing Safeguarding matters with Child A.

4.46 In November 2014, P contacted South Wales Police and made an application for disclosure of information under the provisions of "Claire's Law" in respect of her then partner R1. "Claire's Law" can be identified as the Domestic Violence Disclosure Scheme (DVDS) which gives any member of the public the right to ask the Police if their partner may pose a risk to them.

4.47 This request was delegated to a Detective Officer from a local Public Protection Unit. Police records indicated that after repeated unsuccessful visits to the family home, the Officer finally spoke with P to discuss the application. The Police Officer recorded that during a discussion with P she had informed him that she no longer wished to have any disclosure. The reason provided was "It's all sorted now".

4.48 South Wales Police had information that confirmed R1 was known to the Police having been involved in incidents of Domestic Abuse with a previous partner. These records confirmed that R1 was subject to a protection from harassment order with a previous partner. This information was shared with partner agencies managing the Child Safeguarding process.

4.49 Again, at this time there was significant multi-agency activity with regards to Child Protection; however, there is no recorded information that Domestic Abuse was identified.

4.50 In January 2015, P was arrested for shoplifting from a local grocery store. P was charged with theft and bailed to appear before the Magistrates Court. Whilst in custody, P was tested for drugs. The test indicated that there was a positive re-action for Opiates. P denied taking controlled drugs. Consequently, a referral was made to the Integrated Offender Intervention Service (IOIS) for a follow up assessment.

4.51 In February 2015, P appeared before the Magistrates Court in relation to the charge of theft. A guilty plea was accepted, and P was given a conditional discharge for 12 months and to pay a victim surcharge of £15.00.

4.52 Despite two appointments being offered, P failed to attend the Integrated Offender Intervention Service. P was arrested and appeared before the Magistrates Court. The court gave P an absolute discharge.

4.53 In February 2015, Police Officers attended the home of P's mother. It had been reported that P's mother and William had been involved in a domestic incident. It was reported that both had been drinking alcohol whilst watching a rugby match on the television. They had an argument which resulted in William leaving the address before the arrival of the Police. Police Officers submitted a PPD/1 form although it is recorded that P's mother refused to allow information from this incident to be shared with other agencies.

4.54 In February 2015, P takes up another residency in rented accommodation in the Cardiff area, provided by Cardiff Housing.

4.55 In March 2015, P again contacts South Wales Police to make an application for disclosure of information under the provisions of "Claire's Law". This is in relation to a new partner identified as R2.

4.56 This application for disclosure was delegated to a local Public Protection Department. When Detective officers met with P, they record that P no longer wished to pursue the disclosure request. P confirmed that she was still in a relationship with R2. It is recorded that P stated to Police Officers "He has been up front about his record and had confessed to beating up his last two girlfriends, but he would not do it to her." P did not disclose that she was the victim of Domestic Abuse.

4.57 South Wales Police held information that R2 was known to them as a perpetrator of Domestic Abuse. R2 was at the time subject to both a Restraining Order and a Protection of Harassment Order. The Police created an occurrence although was tasked in error to an obsolete Police inbox that was no longer being monitored. When the mistake was identified P was contacted by the Police, however P declined the information being offered regarding R2.

4.58 In April 2015, P was arrested for shoplifting from a local grocery store. At the time, she was accompanied by R2. P was charged with theft and appeared before the Magistrates Court the same month. A guilty plea was accepted and P was fined, ordered to pay court costs, and given a Community Order.

4.59 Whilst in Police Custody P was again tested for drug use. There was a positive reaction for Opiate use. A referral was made to the Integrated Offender Intervention Service and an appointment made. P did not attend the appointment. She was arrested and appeared before the Magistrates Court. The court gave P another Community Order to report to The Women's Pathfinder managed by Community Rehabilitation Company (CRC). The Order was in place for a twelve-month period, with a Rehabilitative Requirement.

4.60 The Pathfinder project 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 further offending.

4.61 P did not attend the first appointment with CRC. This missed appointment was accepted by the relevant offender manager due to P explaining that she had caring responsibilities for her parents.

4.62 During the month of April 2015, P received support from the Women's Pathfinder program. However, during one support session with CRC staff it is recorded that staff felt P was under the influence of drugs. The session did not take place and P was provided with a taxi to return home. CRC made an immediate referral to Children's Services in respect of potential safeguarding issues regarding Child A. Additionally, the Police were contacted regarding P's involvement in unlawful drug use.

4.63 There was a prompt response from both Children's Services and the Police. Social Workers contacted P's parents to ensure Child A was safe and being cared for. Police Officers advised CRC that P was not committing a crime by attending the session whilst under the influence of drugs. This information was shared with partnership agencies managing safeguarding issues surrounding Child A.

4.64 In May 2015, P was arrested for shoplifting from a perfume store. When initially detained by a store detective, P was found in possession of items of food and children's clothes from other stores. P was charged with theft and bailed to the Magistrates Court.

4.65 Whilst in Police custody, P again tested positive for Opiates use. Another referral was made for an appointment with the Integrated Offender Intervention Service.

4.66 P appeared before the Magistrates Court, pleaded guilty to theft and received a three- month prison sentence suspended for twelve months.

4.67 CRC risk assessed their own process in supporting P and it is recorded that they had decided not to allow any supervised or unsupervised access to their facilities. At this time, CRC were supporting P in her court appearance. This sentence included further engagement with the Integrated Offender Intervention Service and Pathfinder Program.

4.68 There were two failed appointments where P did not attend CRC in accordance with the conditions as set by the Magistrates Court. Telephone contact was made with P and a final written warning letter was posted to P. Unfortunately, the final written warning did not have the appropriate effect and a Breach letter was posted on 10th June 2016.

4.69 At the time, the Cardiff Housing Anti-Social Behavior Unit received complaints from residents that P's home address was the subject of significant anti-social behavior involving possible drug misuse, visits by gangs of youths, minor disturbances and an identification that there were young children residing at the address. The Unit also identified that P was in arrears with her rent. An investigation case was opened.

4.70 CRC withdrew the Breach letter having identified there was confusion in relation to the internal recording of information. A separate appointment was therefore offered to P for July 2015. It is recorded that P did not attend this additional appointment. Another Breach letter was therefore posted.

4.71 In June 2015, steps are taken by Cardiff housing to begin proceedings to terminate P tenancy on the basis of rent arrears. The following month, P requested a review of this decision based on issues surrounding the payment of benefits.

4.72 In July 2015, P's mother and William contacted Cardiff Fostering services seeking consideration as potential alternative carers for P daughter. An initial enquiry form was completed, and a viability assessment was completed. The request received a negative outcome in that:

- William resided with his daughter and was reliant on his wife for finances. It was recorded that William had been unable to stand up to his wife during domestic related incidents.
- William did not consider P to be a problem, rather the male company she was keeping.
- William did not wish to be assessed as a kinship carer and he stated he intended to apply for a Special Guardianship Order (SGO). This special-order shares parental responsibility of the child with the parent. Kinship carers do not have parental responsibility.

4.73 In this month, P again failed to keep an appointment with CRC Pathfinder. A breach letter was sent to her for failing to attend this appointment and another failed appointment arranged for the previous month of June.

4.74 Also in July 2015, a Children's Services Multi-Agency Review meeting took place to review the circumstances of Child A. It is clear that this review was carried out with some vigor. A number of protective factors were identified and preventative measures were put in place. During this review, incidents of Domestic Abuse were not identified.

4.75 On 30th July 2015 P was arrested and later sentenced to sixteen weeks imprisonment. This was in relation to persistent breaches of a failure to comply with the Offender Rehabilitation Program with CRC. In fact, P failed to attend the Magistrates Court hearing and an arrest warrant was issued by the court. At this time P also received a "Street Warning" having been found in possession of a small amount of cannabis.

4.76 A "Street Warning" is a proportionate Policing method to deal with offenders found in possession of a small amount of cannabis, consistent with personal use. The offender admits the offence and consents to the warning.

4.77 At this time, Children's Services were moving towards civil childcare proceedings.

4.78 Additionally, South Wales Police were investigating disclosures made by Child A. These disclosures were sensitive in nature and involved consultation with the Crown Prosecution Service.

4.79 Both P and William were witnesses in this investigation and both co-operated with the Police Investigation. At the time, the Police responded to a request from P's mother that they accompany William to P's house to collect personal belongings. William feared for his own safety if P or her boyfriend was home at the time. There is no information available to suggest why this request was made or what was the background to this concern. The Police assisted William without any incident.

4.80 A male suspect was identified and interviewed by the Police. Although an initial decision was taken to charge this person with criminal offences, the Crown Prosecution later decided to discontinue all charges against him.

4.81 In August 2015, Children's Services identified a suitable foster placement for Child A. The following month, September 2015, after a Review Child Protection Conference, Child A was removed from the Child Protection Register on the basis that she was now under the care of Looked After Children with foster parents.

4.82 On the 24th September 2015 P is released from custody and attends her first appointment with CRC. P was released on license and subject to a Post Sentence Supervision Order. The license expired in November 2015.

4.83 CRC record that induction to their support was explained to P, including support to address her drug addiction. It is recorded that P felt she was being set up to fail in that the location of the drug rehabilitation sessions was difficult to access. CRC records indicate that this was addressed by the provision of information that identified good bus links to the venue.

4.84 On the 30th September 2015, P attends a CRC appointment. During a supportive session P discloses that she has ended her relationship with R2 but acknowledged that this may resume. P further discloses that R2 was abusive towards her and states this was a contributory factor as to why Child A had been removed from her care. The CRC support worker identifies this as potential Domestic Abuse and arranges for P to attend a supportive program called STAR (Safety Trust and Respect).

4.85 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 or, if they are in an abusive relationship, the knowledge on how to leave that relationship safely.

4.86 P did not attend the first appointment for the STAR program arranged for the 2nd October 2015. The CRC support worked issued P with a written formal warning.

4.87 On 1st October 2015, Cardiff Council Anti- Social Behavior Unit received new information from a local complainant regarding anti-social behavior at P's home address. The nature of the complaint related to alleged drug dealing and excessive noise. The information provided suggested that William also resided at the address. There is no information to suggest this information was shared with others or what the outcome was of any subsequent investigation.

4.88 On 9th October 2015, CRC officers, in response to P's failed appointment, made an unplanned visit to her home address. They found both P and William present. The officers report that both P and William were in good spirits and a positive and supportive relationship is observed. P was reminded of the importance of compliance where she responded that her history of substance misuse impacted upon her memory. P was provided with another CRC appointment.

4.89 CRC records indicate that P kept appointments on the 16th October and 23rd October but failed to attend an appointment on 30th October 2015. A decision was taken to send P a final warning letter. In response, P advises the CRC case worker that she was unwell and unable to make the failed appointments. P was unable to provide any medical evidence in support of her illness.

4.90 On the 4th November 2015, P attends an appointment with CRC. During this meeting P is

challenged about her non-compliance for failing to attend previous meetings. A three-way meeting with an Integrated Offender Intervention Service support worker is discussed. This was seen as a positive intervention of support but was not followed up.

4.91 On the 12th November 2015, P attends an appointment with CRC. During this session it is recorded that P discussed the Police investigation regarding Child A and the likelihood of her losing full time custody. P storms out from the CRC office. There is no follow up action from CRC. P was clearly distressed at this time.

4.92 On the 18th November 2015, P attends further appointment with CRC. CRC staff continue the discussion from the previous meeting. It is recorded that P was very upset as no one had told her about the potential outcome of the childcare proceedings. P became quite aggressive and left the office. CRC support worker notes that this was the only time she had witnessed P behave in such a way. No formal warnings about this behavior were issued to P, it was felt that under the circumstances further support was needed.

4.93 On that day, CRC records indicate that CRC staff attempted to contact Children's Services and CAFCASS (Children and Family Court Advisory and Support Service) to obtain further information regarding Child A.

4.94 On the 19th November 2015, the license period for P ends. Support to P is continued with an appointment with a Women's Pathfinder Support Worker.

4.95 On the 20th November 2015, P attended an appointment with a Pathfinder support worker. Issues such as benefit payments were discussed.

4.96 On the 27th November 2015, P did not attend a Pathfinder appointment. Although enquires reveal that P had in fact attended a Family Court hearing that day. The breach was deemed acceptable in the circumstances.

4.97 On the 4th December 2015, P did not attend an appointment with a Pathfinder support worker. Enforcement action was undertaken however there is no record of a breach letter being posted to P.

4.98 On the 8th December 2015, CRC records indicate that staff were pro-active in liaising with Cardiff Housing to confirm P's rent arears and offer of a payment plan. Furthermore, contact was made with Children's Services and the CAFCASS team to seek support in reinforcing the importance of communicating to P the importance of attending CRC appointments.

4.99 On the 15th December 2015, P did not attend a CRC appointment. A final warning is issued.

4.100 On the 21st December, P attends an appointment. CRC records indicate that P offered no explanation as to why previous appointments were not undertaken. P was reminded of the importance of compliance, especially with regards to the future relationship and contact with Child A. Discussions were had regarding re-commencing support from the STAR program and possible TSP program (Thinking Skills Program) to commence after Christmas.

4.101 CRC records indicate that the final warning process for failed appointments still stand.

4.102 On the 30th December 2015, P did not attend a CRC appointment. A CRC support worker attempts to contact P by telephone, but this is unsuccessful. A breach process is instigated, and a letter posted to P.

4.103 At 1725hrs 31st December 2015, Police record an incident where it had been reported that P

had been sitting on her mother's doorstep and had been banging on the door. Officers attended and found P intoxicated. P mother was not at home, so P was conveyed to the home of William and left in his care.

4.104 This information was shared by the Police with CRC as a “reportable incident”.

4.105 The reportable incident was recorded by CRC on the 5th January 2016. The CRC support worker records an intention to discuss this incident with P during an unplanned home visit later in the week. It was noted that P was already in Breach. Furthermore, CRC record that on the 6th January they had received information from IOIS confirming that P had fallen out of treatment by failing to keep appointments and has been reluctant to engage in testing. IOIS intended to write to P to advise unless there was engagement the service would be withdrawn.

4.106 CRC responded to this information by suggesting this non-engagement would be discussed with P during an unplanned home visit the following week.

4.107 On the 7th January 2016, CRC records indicate that a Breach letter was sent to P with a requirement to attend Magistrates Court on the 20th January 2016.

4.108 On the 8th January 2016, CRC records also indicate that CRC would support Children’s Services in final care proceedings for Child A. The CRC support worker would attend court if required.

4.109 At 1321hrs 9th January 2016, Police record an incident where again it had been reported that P was banging on the door of her mother's home address and was standing in the middle of the road holding up vehicular traffic. Officers attended and found P in a confused state. The officers formed an opinion that P was under the influence of drugs. The officers spoke with William who informed them since the previous Christmas P had come off a methadone program and ever since had been acting strangely. The Police officers further record that William had informed them that he believed P was not using any drugs and was not seeking any medical advice regarding her mental health.

4.110 The Police Officers arranged for the attendance of an ambulance and left P in the care of William. The ambulance did not arrive at the address until 0059hrs the following day, some eleven hours after the Police request. On arrival ambulance staff report that P refused any treatment. P was left in the care of William.

4.111 At 0435hrs that same morning, emergency services responded to information of a house fire at the home of P and William. William was recovered from the address and provided with first aid. At 0536hrs, paramedics report that William had died a subsequent postmortem identified cause of death as smoke inhalation.

4.112 P was found outside the property. P was arrested by Police Officers on suspicion of the murder of William and conveyed to a local Police station. Although P was initially deemed fit to be detained and interviewed a further medical examination identified that P was deemed unfit. P was subsequently taken to a mental health Psychiatric Unit.

5. Learning and Recommendations

Police Involvement

5.1 South Wales Police involvement with P and her family is well documented in that incidents of reported domestic abuse were attended to promptly and positively. This was in accordance

with policy and procedure. These incidents involved verbal arguments between P and her mother and on some occasions William.

5.2 Incidents were properly graded in terms of first response. Although PPD/1 forms were completed some incident information was not shared with other agencies. This has now changed in that significant organizational policy changes have been made by South Wales Police in the way they respond and deal with domestic abuse incidents. A PPD/1 form is now required to be completed in respect of all domestic abuse incidents irrespective of whether incidents involve verbal or physical abuse and information is shared with partner agencies. South Wales Police also utilise a Domestic Abuse log to capture all relevant information.

5.3 Police Officers also responded to incidents of shoplifting at local grocery stores involving P, who on some occasions was accompanied by her daughter. The Police caution option was often used, and a PPD/1 was completed and shared with Children's Services and other relevant support agencies.

5.4 On the occasions that P was arrested and detained for shoplifting Police custody staff carried out drug testing. These tests indicated positive outcomes for the use of Class A substances. This information was made available to agency partners including the Integrated Offender Intervention Service for on-going assessment.

5.5 Police Officers also attended the home address of P at the time she was served with an eviction notice by a private landlord. Officers provided advice on a civil process and also submitted a PPD/1, sent as a high priority to Children's Services due to concerns regarding P's young daughter.

5.6 Police data systems also highlight information that they were aware that P's daughter was on the 'At Risk' register. Public Protection Police Officers played a key role in both strategic and tactical support to Child A during the child protection process. This support is discussed in more detail in the Child Practice Review.

5.7 It has been identified that the Police were called upon to support P, her mother and William in various domestic disputes, however there is no information available to suggest that identified conduct justified a criminal investigation or consideration of powers and tools such as Domestic Violence Protection Orders. The Police responded positively to requests from P for access to the Domestic Violence Disclosure Scheme (Claire's Law). Police Officers on two separate occasions met with P to discuss this when concerns were raised regarding two ex-partners.

5.8 There was good attention to detail in that these requests were recorded, however, this review and the CPR identified that these requests were not shared with multiagency partners. There were no PPN's created or intelligence reports generated.

5.9 Although outside the scope of this review, it is significant to identify that the Police did investigate serious criminal allegations regarding Child A. The protracted nature of this investigation necessitated close liaison with the family group and the Crown Prosecution Service. During the course of this investigation, Domestic Abuse was not identified.

5.10 The day before William's death, Police Officers conveyed P's home having been found in a confused state. Officers left her in the care of William and arranged for an ambulance to attend the address for a medical assessment. Officers determined that ambulance staff were ideally suited to carry out the assessment and that William was the right person to care for P.

5.11 After the death of William, South Wales Police decided that on the basis of the close proximity between Police contact with P and the death of William, the matter was voluntarily referred to

the Independent Police Complaints Commission (IPCC). This organisation is now known as the Independent Office for Police Conduct (IOPC)

5.12 The IOPC referred the matter back to the Professional Standards Department of South Wales Police for an 'in-house' review. This review concluded that the Officer's actions were acceptable.

5.13 This review took into consideration that on being initially arrested for murder P was initially deemed fit for detention and interview. It was only later whilst in Police custody and after medical assessment that P was deemed unfit and taken to a Psychiatric Unit.

Wales Ambulance Services NHS Trust (WAST)

5.14 For the purpose of this review, WAST involvement with the family can be identified within an 18-hour time frame period leading up to the death of William. There are no records prior to this period that relate to WAST involvement within the family group.

5.15 WAST command and control confirm that they received information from South Wales Police requesting attendance at the family home. The Police had suggested that P was displaying psychiatric and or, abnormal behavior.

5.16 An Emergency Medical Technician (EMT) crew were dispatched. Their arrival was timed at some eleven hours after the initial call. The crew found P in bed and uncooperative. The crew were asked to leave by P. It is documented that the crew spoke with William who stated that it was unknown if P was being supported by any mental team, but that P had recently come off methadone. The medical crew left the address with no further action.

5.17 This is the last known contact between professionals and P before William’s death.

5.18 WAST conducted an in-depth internal review of this response.

5.19 It was identified that the eleven-hour time delay was due to the high demand of WAST resources at that time. The review identified that ambulance control room staff continued to liaise with the Police command and control regarding this particular incident.

5.20 At the time, it is recorded that ambulance control staff attempted to make telephone contact with William, but these attempts were unsuccessful.

5.21 In accordance with a WAST response, matrix EMT crews were deployed to other calls on the basis of priority.

5,22 At the time, WAST were in possession of information that P was uninjured and in the care of William.

5.23 In response to the actual attendance by WAST staff, the review identified that there were no records from the EMT crew who attended the call to understand their rationale to support their decision to leave P in the care of William immediately prior to his death.

5.24 There are no records available to support any assessment of P’s clinical condition or mental health status when considering her behavior as described by the Police. Furthermore, there was no assessment of her mental capacity to consider if P was competent to make an informed decision regarding her continuing care.

5.25 There was no description of P’s physical condition.

5.26 Although this incident was at the time of high demand, the review identified concerns that implementation of WAST policy and procedures in relation to first response at the address was not carried out. This non-compliance has been dealt with internally.

5.27 A number of other learning outcomes have been identified and will be addressed within a WAST action plan.

Children's Services

5.28 Children's Services had substantial and significant involvement with the family in their support for Child A.

5.29 This involvement was subject to an extended Child Practice Review (CPR) commissioned by the Cardiff and Vale of Glamorgan Regional Safeguarding Children Board. Welsh Government guidelines state that:

- the criteria for the review are met in accordance with guidance set by the Social services and Well-Being Act 2014.
- a Safeguarding Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has
    - died; or
    - sustained potentially life-threatening injury**;** or
    - sustained serious and permanent impairment of health or development and
    - the child was on the child protection register and/or was a looked after child on any date during the 6 months preceding.
- the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

5.30 This review was led by experienced professionals with no direct involvement with the child or family and with no immediate line management responsibilities for practitioners involved.

5.31 The process undertaken by the review to some extent replicates that of the DHR process in that a panel of professionals from Health, Education, Social Services, Probation, Welsh Ambulance, Family Support Teams and Safeguarding Professionals all contributed to the review. Some of these professionals also supported the DHR process.

5.32 This review identified that Child A may well have been present at incidents of reported domestic abuse. The Extended Child Practice Review identified concerns about domestic abuse involving the grandparents and occurring in the presence of P and Child A. These incidents were considered as part of wider safeguarding issues subject to the Extended Child Practice Review.

5.33 It is not the intention of this DHR to review the CPR or to summarize its findings. The CPR can be found in a separate report document.

5.34 The CPR identified a number of recommendations that fall within the umbrella of Practice and Organizational Learning and Improving Systems and Practice. It must be noted that these recommendations are very much based on interagency support for Child A prior to the

homicide.

5.35 These recommendations can be found under the following headings.

- The Child Practice Review Process
- The Voice of the Child
- Public Protection Notices (PPN) Process
- Interface with Adult Services
- Consent to information Sharing
- Practitioners' response to mother and her disruption of the Child Protection Process.
- Working with hostile and uncooperative parents.
- Decision-making within a child's timeframe
- Poly-victimization and disclosure
- Record Keeping and multiagency communication.

5.36 These recommendations were presented to the Cardiff and Vale of Glamorgan Regional Safeguarding Children's Board.

Therefore, the DHR panel recommends:

Recommendation One

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

5.37 It will be noted that the CPR concluded that P's mental state was a crucial factor in the homicide court case although during the period of that review there was no formal reference to an actual diagnosed mental illness for P, all input with P refers to her drug misuse behavior and intervention with CAU. The DHR did not find any information to contradict this conclusion.

Community Rehabilitation Company

5.38 The National Probation Service were not involved with P. This support was provided by the Wales Community Rehabilitation Company.

5.39 This Company provides rehabilitation and offender management to help reduce reoffending and protect the public.

5.40 Support is provided to low and medium-risk offenders with the provision of knowledge, skills and support to enable them to stop offending. This support is available to offenders who are released from prison on license as well as offenders who are sentenced to less than 12 months' imprisonment.

5.41 CRC co-ordinates and facilitates various support options and mechanisms such as the Women's Pathfinder program, Thinking Skills Program (TSP), Safety, Trust and Respect Program (STAR) and the Integrated Offender Intervention Service (IOIS). All of these support services were at one time offered to P.

5.42 The CRC supported P after Magistrates Court appearances for shoplifting and subsequently after a breach of Suspended Sentence Orders (SSO).

5.43 Generic assessments were carried out and P was offered varied support. This was in accordance with CRC practice and procedure.

5.44 In September 2015, during an appointment with CRC it is recorded that P discloses that she was once in an abusive relationship that resulted in her daughter being removed from her care. Safety advice was offered by the CRC case officer along with an appointment for P to attend a STAR supportive program. It is recorded that P accepts this support. There is no information available from any other source to suggest that Child A had been removed from parental care as a result of domestic abuse.

5.45 There is no information available to suggest this disclosure was risk assessed or shared with other partner agencies. Although, of course, it is noted that P was previously in this abusive relationship which suggests she had moved on.

5.46 In October 2015, P failed to attend an appointment to commence the STAR program, so a formal warning was issued by the CRC case officer. A further alternative appointment within a 7-day time frame was also missed by P.

5.47 Consequently the CRC support officer followed up these failed appointments with an unplanned home visit. The support officer records that P was present with her father, William. A positive and supportive relationship is observed they were both jovial with each other. When advised of the importance of compliance, P explained that her history of substance misuse had impacted upon her memory. This was accepted by the CRC support officer.

5.48 P attended her next appointment with CRC; however, there is no information available to illustrate what happened during this meeting or if the STAR program was recommenced. There is no information available to establish if domestic abuse was discussed.

5.49 In the same month of October 2015, P again failed to keep an appointment with CRC. The case officer noted that P had made contact with the office to explain she was unwell but was unable to provide medical evidence to support this. Due to this failed appointment and previous non-compliance P was issued with a written final warning.

5.50 In November 2015, P kept three appointments with CRC. During one such meeting, P disclosed to the case worker that she was upset that there was an investigation into safeguarding concerns regarding her daughter. P was clearly agitated and upset and had stormed out of the office. The CRC IMR identified that there was no immediate follow up recorded by the support officer which in the circumstances would have been appropriate.

5.51 Seven days after the office incident, CRC records indicate that the support worker had repeatedly attempted to contact Children's Services but with no success, so contact was made with CAFCASS. The support worker was in possession of limited information, so was unable to properly assess P's situation. This matter was not escalated to a team manager.

5.52 During the period between 20th November 2015 and the 10th January 2016, the date of William's death, there is sporadic compliance by P to attend various appointments organised by CRC. There are four recorded failed appointments and two meetings where P had attended.

5.53 CRC were in possession of information from IOIS that P had fallen out of a treatment program for drug addiction and had failed to attend appointments and had been reluctant to engage in

drug testing. P had received written advice from this service that if non-engagement continued there was a likelihood the service would be withdrawn.

5.54 CRC were also in possession of information from South Wales Police that on the 31st December 2015, P was found by officers outside her mother's house intoxicated and generally being anti-social.

5.55 On the 7th January 2016, CRC decide to instigate breach proceedings. A letter was sent to P which included a requirement to attend Magistrates Court on the 20th January 2016. There is no information available to suggest this decision was shared with other partner agencies

5.56 The CRC support officer also records an intention to conduct an unplanned home visit to P preceding the Magistrates Court appearance.

5.57 CRC's last personal contact with P was on the 21st December 2015 during a planned appointment. Failed attendance was discussed along with continued offer of support after the Christmas holidays. There is no documented information regarding P state of health or behavior. P appears compliant to advice and receptive of further support.

5.58 A review of CRC record logs post-incident indicate that a telephone discussion took place with an unidentified social worker and an office manager from CRC that stated social services had during a parenting assessment with William identified that William was vulnerable as P had been taking money from him and a Protection of Vulnerable Adult (POVA) assessment had been considered. William had declined this assessment but stated sometimes P could be evil.

5.59 The CRC support worker for P was unaware of this information. CRC advise that if the information had been made available to CRC this would have significantly impacted upon the risk assessment undertaken by the support worker.

5.60 Post-incident, CRC commissioned a Serious Further Offences (SFO) review into the organisation's involvement with P. The findings of this review have not been shared with the DHR.

5.61 The CRC IMR identifies a number of supervisory issues in relation to quality assurance of record keeping and dip sampling. These matters are contained within the CRC action plan.

5.62 In June 2018, the UK Government announced that supervision of all offenders in Wales would be brought together into the National Probation Service (NPS). Therefore, in future CRC and the NPS would be aligned.

Cardiff and Vale University Health Board

5.63 Cardiff and Vale University Health Board provide both Primary and Secondary health care to the Cardiff region.

5.64 The Health Board confirmed that they had significant involvement with P.

5.65 On the basis that P had not consented to her records being disclosed for the purpose of a DHR, health panel members sought advice on disclosure.

5.66 Legal advice obtained by the lead Executive Medical Director of the Health Board was not to disclose the P medical records.

5.67 A letter from the Medical Director dated March 2017 confirmed this position. This

Correspondence is attached as an Appendix.

5.68 The DHR chair and author also contacted the Medical Director and Consultant Forensic Psychiatrist responsible for P treatment whilst she remained in a secure unit.

5.69 Correspondence received from the Medical Director within the secure unit dated November 2017 confirmed that P did not consent to participate in the review. The Medical Director confirmed that P had the capacity to refuse consent to participate in the DHR process.

5.70 A copy of this correspondence is also attached to an Appendix.

5.71 In view of this position the DHR panel have not had the opportunity to review the Health Boards support and involvement with P.

Therefore, the panel recommends:

Recommendation Two

The Home Office Quality Assurance Panel provides additional information and 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 is critical to those perpetrators who have been subject to judicial proceedings and are serving substantial custodial sentences.

5.72 The panel relied on information contained within a confidential psychiatric report that was prepared at the request of the Crown Prosecution Service for the Crown Court proceedings.

5.73 This report is discussed in more detail in the 'Perpetrator Management' section of this report.

5.74 In relation to William there is no health information that could be considered relevant as part of this review.

Cardiff Council Housing

5.75 Cardiff Council managed their own bespoke housing services within a recognised Housing Services Department. There is also an Anti-Social Behavior Unit within the department.

5.76 Housing Services first recorded contact with P in June 2010 where they received an application from P for accommodation on the basis that P was homeless, and that P had informed them she was subject to domestic abuse from her mother, who was also abusing her father, William. There is no information to explain if the alleged domestic abuse was subject to a multi-agency risk assessment or if the disclosure was acted upon.

5.77 Investigations by housing officers revealed there were conflicting allegations within the family group that contradicted P's allegations. The department found alternative temporary accommodation for P who it later transpires later returned to the family home.

5.78 P soon after made another application to the Housing Department citing allegations of domestic abuse as the reason she wanted to move out from the family home. Investigations by housing officers found conflicting allegations within the family group. There is no

information available to suggest a multi-agency approach was taken to address this allegation.

5.79 Temporary accommodation was found; however, within a short period of time, P returned to the family home.

5.80 In January 2014, the department received information from P that she was due to be evicted from her private rented accommodation and that she would become homeless. Investigators from the department ascertained that the private landlord had decided to pursue eviction based on damage to the property and perceived drug taking. The department processed a potential homelessness case and looked for alternative accommodation.

5.81 There is evidence that suggests the department actively negotiates on P's behalf with the private landlord to obtain time to find alternative accommodation. Although, in May 2014, due to the existence of a court order P vacates the privately rented home and is immediately placed in temporary accommodation with Cardiff Housing.

5.82 In October 2014, P, whilst in temporary accommodation is placed on a priority list for a permanent home address.

5.83 In January 2015, P, is allocated a permanent home by Cardiff Council. P vacates her temporary accommodation and takes up residence. It is worthy of note that prior to taking up residence, Cardiff Council carried out refurbishment works on the property before the tenancy commenced.

5.84 In June 2015, the Housing department commence proceedings to terminate the tenancy of this property on the basis of rent arears. P challenges this process citing delays in benefit payments as the reason that rent payments are not being met.

5.85 In July 2015, P settles her rent arrears, and the termination proceedings are cancelled.

5.86 In August 2015, P informs the department by way of written correspondence that she is currently in prison and unable to meet rent payments. This is noted by the department who retain the property for P pending her release from custody.

5.87 In November 2015, a housing officer visited P after her release from Prison and found minor defects and damage in the home. Arrangements were made to support P and repair and replace damaged items.

5.88 Cardiff Housing received two separate complaints of anti-social behavior that relate specifically to P whilst a tenant. There is a paucity of information available to suggest how these complaints were dealt with. What is evident is that no formal action was taken in respect of a possible breach of tenancy for such behavior.

5.89 The Cardiff Housing IMR identifies problematic relationships within the family group. On occasion, this evidence points to an abusive relationship between family members. The department accepts that further investigation of alleged domestic abuse could have been made. The department accepts that there is a training and development need for all staff especially those who manage anti-social behaviour.

The panel recommends that:

Recommendation Three

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.

Specialist Support and Intervention.

5.90 Safer Wales is an independent charity whose mission is to support, protect and empower people often caught up in domestic abuse.

5.91 Safer Wales did not provide direct support to either P or William as victims of domestic abuse. However, they provided support to P's mother as a victim of domestic abuse and identified both P and William as alleged perpetrators towards her.

5.92 The first recorded incident is in October 2013 where a referral was received from a support worker from STEPS. This is in relation to an incident of alleged verbal abuse by P and William. Safer Wales record that appropriate safety advice was provided to P's mother and a series of welfare checks were made. There were no further incidents reported at that time.

5.93 Safer Wales liaised with a dedicated social worker for P's mother. They established that there were concerns of long-term financial exploitation by both P and William. Attempts to implement a POVA process to protect her were refused on the basis that P's mother felt this would further strain relationships within the family group. There is no information available to suggest consideration was given to escalate to a Multi- Agency Risk Assessment Conference (MARAC).

5.94 In November 2013, due to client disengagement and in accordance with policy and procedure Safer Wales closed their case. This was deemed an acceptable and appropriate course of action.

5.95 In February 2014, Safer Wales were again consulted by a health professional about potential support to P's mother. This was in relation to tenancy issues. It is recorded that there were no concerns regarding domestic abuse. Attempts by Safer Wales staff to further engage were unsuccessful. In March 2013 the case was again closed in accordance with policy and procedure.

5.96 Safer Wales records also indicate that in August 2014, Adult Services had informed them that they had ended their support for P's mother on the basis that various disability needs had been met and that P and Child A would often visit her. There was no mention of domestic abuse.

6 Perpetrator Management

6.1 Within the defined time frame of this review P was managed and supported by a number of public agencies. This is documented in both the summary and sequence of events section of the report.

6.1 Due to the panel not having access to information from family sources or the perpetrator herself the panel relied on a Confidential Psychiatric Report to understand the complexities of

P antecedent history and understanding of her mental state.

6.2 The Crown Court relied heavily on the content of this report before determining sentence.

6.3 The report was prepared by an Independent Consultant Forensic Psychiatrist who had access to P's medical notes, police investigation reports, the deceased's medical notes, defense statements and a previous psychiatric report. The Consultant also had the opportunity to interview P and relevant nursing and medical staff involved in her care.

6.4 The report states that P had a normal life until her father William lost his butchers business when she was 15 years old. P described herself as an A star student, she had friends and had a stable home life with both parents. At this time, P denied any mental health problems.

6.5 During her teenage years P admitted smoking cannabis and had dabbled in taking cocaine amphetamines and diazepam. P also admitted using oxycontin an opiate pain killer that had been prescribed to her mother. P had become addicted to this drug when she herself was prescribed this medication by her General Practitioner. This continued until she attended the community addiction unit and was then prescribed a synthetic opiate for the next seven years.

6.6 During her time of minor offending, P decided she needed a new strategy in her life, so she stopped using the opiate substitute. P was then prescribed methadone as an alternative. P stopped using methadone one week prior to the homicide. P denied a history of alcohol abuse.

6.7 At the time of this drug addiction, P was clear in her mind that she had never suffered previously from psychiatric symptoms. P had never been out of touch of reality and apart from occasional feelings of depression she never saw herself as having a mental health problem.

6.8 P described her relationship with her father William as great, she was a daddy's girl. William would often take her to watch football, he never treated her badly and was never aggressive or violent.

6.9 After her parents separated, William came to live with P and her daughter, Child A. At the time, an ex-boyfriend was also living with them. P described this partner as violent and later discovered that Child A was subject to a sensitive Police investigation where she was a victim. Even at this time, P continued to have a good relationship with William.

6.10 P explained that she was imprisoned which resulted in Child A being taken into care. After Child A was taken into care and following release from prison, P lived alone with William for approximately four months prior to the homicide. They continued to have a good relationship. P would look after the house and see Child A regularly at a contact center. P also had a good relationship with her mother. At this time P explained she had no friends or boyfriends.

6.11 P disclosed that she was experiencing difficulties in her relationship with Social Services. This was based on an insistence that P had to come off methadone before any consideration could be given to Child A being returned home. P accepted that at this time she was receiving her methadone prescription daily from a drug clinic, she was smoking cannabis and she drank alcohol occasionally. P was also taking prescribed anti-depressants fluoxetine and amitriptyline, painkillers pregabalin and acupan and propranolol for anxiety.

6.12 P tended not to socialize, she preferred to stay in her room and occasionally watch television with William. P's main issue in her life was to get her daughter back from foster care.

6.13 Prior to the homicide, P explained that she last saw Child A four days before Christmas.

6.14 P can recall visiting her mother on New Year's Day 2016 and telling her mother that William had been killed in an explosion. P cannot remember why she said that, but she recalls upsetting her mother.

6.15 In the week prior to the homicide, P disclosed feeling unwell. P felt mentally rather than physically unwell. William had looked after her. P stopped taking all her medication.

6.16 P disclosed that her psychiatric symptoms consisted of hallucinations and hearing voices. P could not provide any explanation as to why she started to experience these symptoms but said it was not caused by drug abuse. P accepted that she was feeling under stress regarding issues surrounding Child A and childcare proceedings scheduled to commence on 10th January 2016.

6.17 P admitted to setting the house on fire providing, an explanation which was compatible with her hallucinations and a desire to kill herself.

6.18 P also admitted only smoking cannabis in the days prior to the incident. However toxicological evidence presented to the court indicated use of not only cannabis but cocaine, opiates and methadone.

6.19 The medical report recommended that P was fit to plead and stand trial.

6.20 The report outlined that at the time of the incident, P was suffering from a psychotic mental illness in which she was out of touch of reality.

6.21 The report went on to state.

> "With the benefit of hindsight and taking into account her 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 a schizoaffective psychosis in which symptoms of schizophrenia and a prominent mood disorder co-exist."
>
> "Whatever the precise diagnosis I conclude that the defendant (P) was suffering from a recognized medical condition at the time of killing her father (William)."

6.22 The report then concluded to recommend that P is made subject to a Hospital Order under section 37 of the amended Mental Health Act. This was accepted by the court.

6.23 This acute mental health clinical diagnosis which was a crucial factor in the court proceedings was never previously identified or commented upon by the relevant partnership agencies involved in this review.

6.24 The Child Practice Review also identified that throughout the timeline of that review, there was no formal reference to an actual diagnosed mental illness, all input refers to drug misuse behavior.

6.25 At the time that CRC managed P, there was no identification that mental health issues contributed to P's behavior and non-compliance with various supervision orders. CRC identified that the misuse of alcohol and controlled substances may well have contributed towards this non-compliance but the link towards mental health issues was not made.

6.26 It was only when South Wales Police responded to a call hours before the homicide to support P, who was found to be in a confused state, was any link made to a potential mental health situation.

6.27 Unfortunately WAST support to this incident lacked vigor in terms of the initial identification of P's condition and subsequent care and treatment.

6.28 There is widespread research and evidence that suggests drug / alcohol addiction is intrinsically linked to mental health issues. A Welsh Government Substance Mis-Use Delivery Plan 2019-2022 seeks to address this. During this review it was noted that the Crown Court report suggests comorbidity in that there was, in respect of P's condition, the presence of more than one mental health condition.

6.29 This undoubtedly contributed to a complex situation in which partner agencies found themselves confronted with. Challenging mental health complexities that were difficult to identify and manage.

The panel recommends:

Recommendation Four

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

7. Parallel Investigations

7.1 As outlined previously in this report there were a number of parallel investigations undertaken by relevant partner agencies involved in this review. Significant coordination and negotiation were undertaken to support the domestic homicide review.

7.2 South Wales Police voluntarily referred their involvement to the Independent Office Police Conduct. The IOPC considered the situation and decided to refer the matter back to South Wales Police for an "in house" review.

7.3 The full circumstances of Police Officers actions immediately before William's were reviewed by the force Professional Standards Department. This review determined that the officer's response was reasonable, and actions were in accordance with force practice and procedure.

7.4 The Child Practice Review held a training event in September 2017 which focused primarily on the findings of the review and the safeguarding issues surrounding Child A. The scope and outcome of the review has been explained previously in this report.

7.5 Although the CPR did not identify domestic abuse within its program of work, Children's Services which supported the CPR identified that social workers involved with Child A had a lack of awareness and understanding of the various forms that domestic abuse can take. For example, there was a lack of knowledge and understanding of risk assessment tools. To address this, an action plan has been developed that includes an intention to arrange joint training events with other relevant professionals.

7.6 WAST NHS Trust carried out an internal review of their support to William and P immediately prior to the homicide. As previously outlined, it was identified that Trust practice and procedure was not carried out by first responders. This has been dealt with as an internal matter. This internal review report was not made available to the DHR Panel.

7.7 CRC also carried out a Serious Further Offence review into their support to P.

7.8 This review identified information that suggested during a parenting session a social worker had recorded a disclosure from William that sometimes P could be 'evil". This information was shared post SFO commission.

7.9 This information has not been corroborated from any other source.

7.10 In March 2018, CRC advised the Chair / Author of this review that the SFO report would not be disclosed to the DHR panel. Therefore, this information could not be explored further and the findings of this SFO review are unknown. The SFO review was conducted post submission of their Individual Management Review.

7.11 Multiple parallel investigations by their very nature create difficulties especially with regards to competing priorities. This was certainly a significant contributory factor in the delay in completing this review process.

7.12 The Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews provides guidance on parallel investigations. Paragraph 40 (c) outlines the benefits of running parallel investigations. Within this review, professionals sat on both panels therefore ensuring good cross communication. This has been highlighted as good practice and essential for cross fertilization of information.

8 Family Views

8.1 As previously outlined in the report, despite written invitations to do so the family chose not to participate in the review. Written approaches were made to family members of both William and P.

8.2 In addition to a written invitation to P, extensive consultation took place by way of telephone conferencing with senior clinical directors at the secure unit to arrange the support and participation of P in this review. This proved unsuccessful.

8.3 Information was shared with other parallel investigations to explore all avenues to support family participation.

9 Conclusions

9.1 This review has not had the benefit of medical history of P. The review relied solely on the psychiatric report prepared for the Crown Court hearing.

9.2 The review had very little information with regards to William's antecedent history.

9.3 Generally, organisations shared information effectively amongst themselves by the use of integrated structures that exist between partnership agencies. At the time of providing support to the family for a variety of issues, including incidents of domestic abuse, agencies were confronted with a complex child protection situation that required careful management. Local policy and procedure was complied with and there is no evidence to suggest that any process was unsound or not fit for purpose. All agencies have given a commitment to accept the learning from this review with focus on the agreed recommendations.

9.4 Although there were incidents of domestic abuse within the family group there is no evidence to suggest this was a significant contributory factor to William's death.

9.5 At the time of the criminal justice process, it was accepted by the Crown Court that P was suffering from a psychotic mental illness. It was concluded that this was not a drug-induced psychotic illness but rather the onset of a more complex mix of psychosis.

9.6 This condition was not identified by any partner agency during the time any agency had contact with P.

9.7 No parallel investigation found evidence to support this medical diagnosis.

9.8 After the criminal trial the crown court judge commented, “I have no doubt that 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.”

List of Recommendations

Recommendation One

That the outcomes of both the Child Practice Review and the 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 Two

The Home Office Quality Assurance Panel provides additional information and 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 is critical to those perpetrators who have been subject to judicial proceedings and are serving substantial custodial sentences.

Recommendation Three

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.

Recommendation Four

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.

Bibliography

Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews - Home Office 2011 www.homeoffice.gov.uk/publications/crrine/DHR-guidance

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews - Revised August 2013 Home Office

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews - December 2016 Home Office

Child Practice Review Report for the Cardiff and Vale Regional Safeguarding Children Board – Extended Child Practice Review

Confidential Psychiatric Report on Perpetrator by Dry L A Joseph, Consultant Forensic Psychiatrist St Charles Hospital London.

Welsh Government Substance Misuse Delivery plan 2019-2022.

Appendix

Items of Correspondence

Letter dated March 2017 from Dr Graham Shortland, Medical Director from Cardiff and Vale University Health Board – Non-disclosure of medical information.

Letter dated November 2017 from Dr N Rasquinha, Medical Director and Consultant Forensic Psychiatrist from The Dene Clinic Sussex – Information regarding the Perpetrator.