Domestic Homicide Review Report:

Adult A

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1. Preface

1.1 As one of Wales' newest cities, Newport forms the gateway between Wales and England and the economic motor for the South East Wales region. The geographical area of Newport covers 217.7km2, approximately 1% of the total area of Wales at 21,225 km2.

1.2 Newport is the third largest city in Wales. The current population of Newport is 146,558 based on the most recent ONS 2013 Mid-Year Population Estimate, which is approximately 4.75% of the total population of Wales. The ONS 2011 Census household count for Newport was 63,445, approximately 5% of the total number of households in Wales. The 2014 estimated household count for Newport based on analysis of localised Council Tax and Electoral Registration records is circa 67,000.

1.3 Newport consists of 20 Wards, 14 Community Councils and 95 Lower Super Output Areas. There are two parliamentary constituencies in Newport, Newport East and Newport West, each returning one elected Member of Parliament.

1.4 Domestic abuse now has a much higher profile on the policy agenda both nationally, through the publication of the Welsh Government's Domestic Abuse Strategy, as well as locally through the development of work-based policies for domestic abuse. Strategic governance for domestic abuse and issues linked to the national agenda in Newport is held by the One Newport Local Service Board (LSB), which acts as the statutory community safety partnership for Newport. Newport City Council is leading on the Gwent wide Domestic Abuse Pathfinder Project, sponsored by the Welsh Government.

1.5 Domestic Abuse services for Newport are coordinated from the Multi Agency Unit within the Information Station within Newport City Centre. Within this unit, organisations such as Llamau, BAWSO and Victim Support have been based to deliver a coordinated, seamless service. Newport City Council's Independent Domestic Violence Advocate Service is also based there. Referrals come through Domestic Abuse Case Conference (DACC), with high risk cases being referred to the IDVA service through the Multi Agency Risk Assessment Conference (MARAC). There is also come capacity for drop-in services, links with counseling provision and training facilities.

1.6 Newport is seeing an increase in referrals each year and is expecting this trend to continue. The data shows that there has been a year on year increase in the number of recorded Domestic Abuse incidents from 2,643 in 2011/12 up to 3064 in 2012/13 (16%). There has been a recent increase in recorded Domestic Violence despite a previous year on year decrease. The number of domestic violence crimes has increased from 630 in 2011/12 up to 796 in 2012/13 (26%).

1.7 One Newport Local Service Board (LSB) is leading the Domestic Homicide Review (DHR) process in line with Home Office guidance.

1.8 The circumstances that led to the Domestic Homicide Review

1.9 At 11.13am on Monday 5 May 2014 Adult B contacted Gwent Police via the 999 system and informed the Police operator that he had murdered his girlfriend Adult A by strangling and stabbing her.

1.10 He also said that they had a pointless argument the night before, she locked herself in the bathroom and things got out of hand.

1.11 Police officers from Gwent Police went to Adult B's address and found Adult A in the bathroom; she was dead. Adult A was fully clothed with her coat on. She had her hand bag and a "*kit bag"* over her shoulders. The officers who attended the call formed the opinion that she had been about to leave the address. She had also been covered with a duvet.

1.12 A post mortem examination identified that Adult A had died from a combination of strangulation and the 27 stab wounds she had sustained, one of which had severed the femoral artery.

1.13 Adult B was arrested for the murder of Adult A and during his interview provided a prepared statement admitting his part in Adult A's death and disposing of the knife he had used. He pleaded guilty to murder and was sentenced to 20 years imprisonment with a minimum term of 16½ years before consideration of parole.

1.14 There had been limited contact with agencies prior to Adult A's death. During the review period there was only one incident that identified potential domestic violence/abuse.

1.15 On 3rd March 2015, One Newport Local Service Board (LSB) determined that Adult A's death appeared to fall within the criteria of the Multi-Agency Statutory Guidance for the conduct of domestic homicide reviews' issued under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004) in that Adult A's death was caused by: *'a person to whom she was related or with whom she was or had been in an intimate personal relationship'*

1.16 The Consideration Panel decided that a domestic homicide review should be conducted. The Chair of One Newport Local Service Board ratified the decision on 3rd March 2015. Notice was given to the Home office on 30th April 2015 of the intention to carry out a domestic homicide review.

1.17 On 1st April 2015 all agencies were asked to seal their records and undertake checks of involvement with Adult A and Adult B. They were asked to undertake a review of their records relating to any relevant contact there might have been with Adult A and Adult B.

1.18 **Scope of the Review**

1.19 It is believed that Adult A, the victim and Adult B, the perpetrator had been in a relationship for three months prior to her death. The scope of the review will include information on Adult A and Adult B between 5th May 2013 and 5th May 2014.

1.20 The purpose in going further back into the relationship history of Adult A and Adult B is to ascertain patterns of behaviour and context in which to consider the Domestic Homicide Review with relevance to their relationship. The panel felt that a one year time scale was sufficient time to ensure relevant information was recorded.

1.21 However, if any agency felt there was relevant information outside the time period under review it was agreed that the information should be included in their Internal Management Review (IMR). As well as the IMR's, each agency provided a chronology of interaction with the identified individuals including what decisions were made and what actions were taken. The IMRs considered the Terms Of Reference (TOR), whether internal procedures were followed, whether on reflection they were considered adequate, arrived at a conclusion and where necessary, made a recommendation from the agency perspective

1.22 Terms of Reference

1.23 The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims of domestic abuse

- Clearly identify 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 those lessons to service responses and include any appropriate changes to policies and procedures

- Prevent future domestic homicides through the improvement of service responses for all victims of domestic abuse, and their children, through improved intra or inter-agency working

The review will address:

- Whether the incident in which Adult A died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence

- Whether there were any barriers experienced by Adult A or family / friends / colleagues in reporting any abuse in Newport or elsewhere, including whether they knew how to report domestic abuse should she have wanted to

- Whether Adult A had experienced abuse in previous relationships in Newport

or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died

- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Adult A that were missed

- Whether Adult B had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Adult A or Adult B that were missed

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city

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

Specific to this review the following will be considered:

- In relation to vulnerable adult, the review will highlight any learning from this case which would improve safeguarding practice in relation to domestic violence experienced by the vulnerable adults or carers of vulnerable adults at risk

- In particular the review should identify whether there is any learning in relation to effective communication, information sharing, risk assessment and following of appropriate procedures for all those services involved with the vulnerable adult concerned. It should also highlight any good practice that can be built upon

1.24 The rationale for the review process was to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide and abuse.

The review identified the following general areas for consideration:

1.25 **Family engagement**

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?

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

1.26 **Legal Processes**

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

1.27 **Research**

- How should the review process take account of previous lessons learned from research and previous DHRs?

1.28 In order to reach a view on whether the death could have been predicted and/or prevented, each IMR author was asked to include information on and analysis of all the following issues specific to this case:

1.29 **Diversity**

- Are there any specific considerations around equality and diversity issues, such as ethnicity, age and disability that may require special consideration?

1.30 **Multi agency responsibility**

- Was the victim (Adult A) subject to a Multi-Agency Risk Assessment Conference?

- Was the perpetrator (Adult B) subject to Multi Agency Public Protection Arrangements?

- Was the perpetrator subject to a Domestic Violence Perpetrator Programme?

- Did the victim have any contact with a domestic violence organisation or helpline?

- Was either the victim or the perpetrator a 'vulnerable adult'?

- Were there any issues in communication, information sharing or service delivery between services?

1.31 **Individual agency responsibility**

- Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults and with wider professional standards?

- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator?

- What was the quality of any multi-agency assessments?

- Was the impact of domestic violence on the victim recognised?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

- Was there sufficient management accountability for decision-making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

1.32 **Issues which relate to ethnicity, disability or faith which may have a bearing on this review**

Adult A had a learning disability.

1.33 **Other DHRs in the region or nationally which are similar, and the availability of relevant research**

None have been identified at the time of writing.

1.34 **Methodology**

This overview report has been compiled from and analysis of the multi- agency chronology, the information supplied in the Internal Management Reviews (IMRs), the supplementary reports; interviews conducted as part of the IMR and overview report process, consideration of previous reviews and findings of research into various aspects of domestic abuse and with the help and support of family members.

1.35 In preparing the overview report the following documents were referred to:

- The home office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Call an End to Violence Against Women and Girls – HM Government (November 2010)
- Barriers to Disclosure – Walby and Allen, 2004.
- Home Office Domestic Homicide Reviews – Common themes identified and

lessons learned – November 2013.

- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007
- Agency IMR's and Chronologies

1.36 **Participating Agencies**

The following agencies were asked to give chronological accounts of their contact with Adult A and Adult B prior to Adult A's death:

- Gwent Police
- Aneurin Bevan University Health Board
- Newport City Council Adult and Community Services

1.37 Each agency was required to report the following:

- A chronology of interaction with Adult A, her family and/or Adult B
- What action was taken and analysis of those actions
- Whether internal procedures were followed and if those procedures are appropriate in light of the death of Adult A
- Conclusions and recommendations from the agency's point of view

1.38 **DHR Panel Chair/Overview Report Author**

The LSB requested tenders from suitable applicants to act as Chair and overview report author.

Following a competitive process, Johnston and Blockley Ltd was commissioned to provide the Chair and Overview Report Writer role

1.39 One of its partners, Mr. Tony Blockley, undertook the role of Chair and Overview Report Writer. He is a specialist independent consultant in the field of homicide investigation and review. He has senior management experience in all aspects of public protection. He has been involved in numerous homicide reviews throughout the UK and abroad, was chair of MAPPA and was responsible for all public protection issues when he was head of crime in a UK police force. He has been involved in numerous DHRs and serious case reviews. He is also a special advisor to a 3rd sector organisation that provides domestic abuse services (not in the area covered by the Newport Community Safety Partnership) and a Senior lecturer at the University of Derby, criminology. Within this role he is also actively researching domestic abuse and in particular barriers to reporting domestic abuse and the consequence of risk management within this context. This includes the analysis of DHR's and extensive interviewing of victims and perpetrators**.**

1.40 **The DHR Panel**

The LSB agreed the formation of the overview panel comprising of agencies that had had contact with Adult A and Adult B during the period under review, as well as those that did not, including a representative from a specialist Domestic Violence Service.

A consideration of the review was to ensure there was a suitable representation of panel members who were able to provide knowledge and experience of domestic violence and abuse. It was also considered appropriate to ensure there were panel members who understood ADHD and persons with learning disabilities to ensure the context in which the victim was abused was fully understood. The presence and participation of Aneurin Bevan University Health board, an IDVA, Newport Women's aid and the head of adult and community services together with all other members achieved this.

1.41 The DHR Review Panel consists of:

• Tony Blockley	Johnston and Blockley Ltd Chair and Report Writer
• Caroline James, LSB Coordinator	Newport City Council
• Supt Glyn Fernquest	Gwent Police
• Jonathan Griffiths, Head of Adults and Community Services	Newport City Council
• Lin Slater, Assistant Director of Nursing (Safeguarding)	Aneurin Bevan University Heath Board
• Professor Catherine Bright Consultant Psychiatrist and Clinical Director Learning Disability	Aneurin Bevan University Health Board
• Nicola Davies	National Probation Service
• Sharon Wilkins, Head of Housing Services	Newport City Homes
• Carole Parsons, Independent Domestic Violence Advisor	Newport City Council
• Tori Brown, Service Manager	Newport Women's Aid
• Angelina Rodriquez, Deputy Chief Executive	Bawso

In addition, the IMR Report authors are:

• Alys Jones	Newport City Council
• Steve Davies	Gwent Police
• Linda Brown	Aneurin Bevan University Health Board

1.42 Family members were invited to participate in the review process. Adult A's maternal grandmother (Relative 1) who Adult A lived with, Adult A's sister (Relative 2) and Adult A's birth mother (Relative 3) took part in the review.

Adult B has been written to in prison inviting him to participate in the DHR process,

but to date he has not responded.

1.43 **Parallel processes**

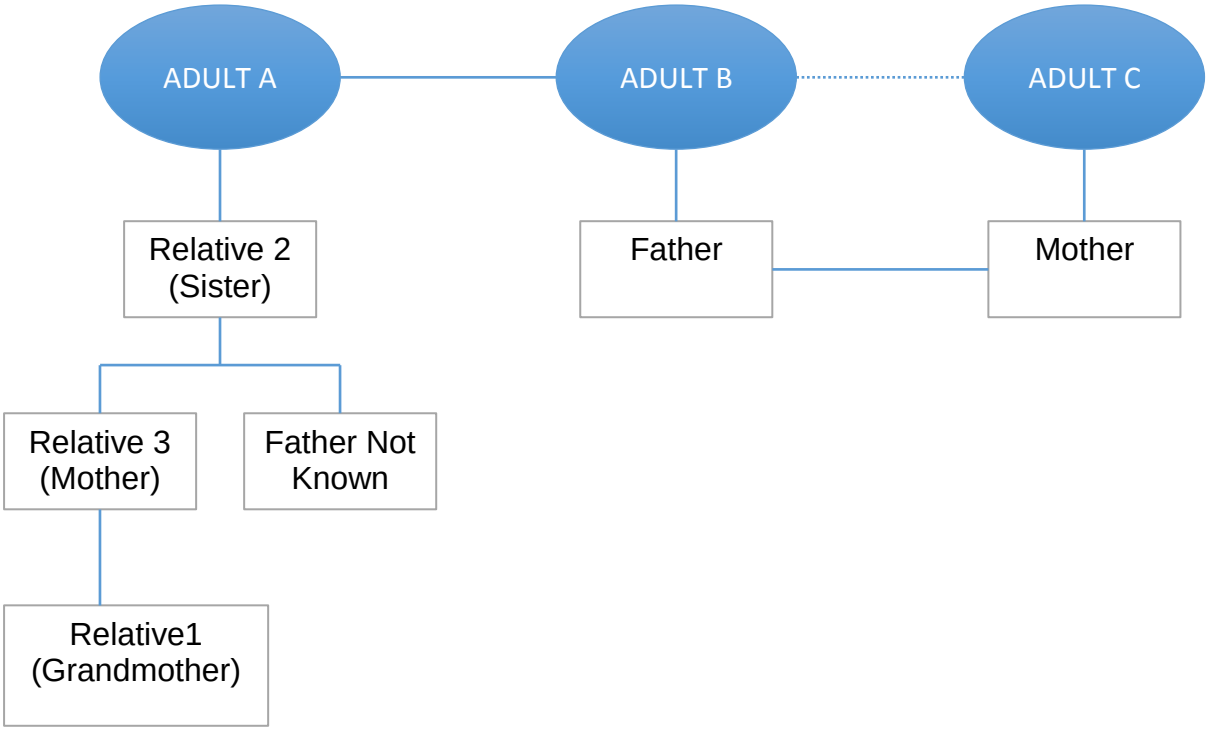
1.44 **Inquest / Criminal Investigations**

There was a thorough police investigation into the circumstances of the death of Adult A resulting in the murder trial. Adult B was found guilty of murder and was sentenced to 20 years imprisonment with a minimum term of 16½ years before he can be considered for parole.

1.45 Although the death of Adult A was referred to the Coroner, no inquest took place in line with legislation.

1.46 **The involvement of family members**

1.47 **Family composition** (Of those referred to in the review)



1.48 The panel agreed that the review would benefit from the involvement of family members; it was recognised that they may have an important role to play to provide background information, not known to services and to provide information about Adult A and Adult B.

1.49 The family members, Relative 1 and 3, sister of Adult A were contacted after the trial to inform them of the DHR process. Whilst the panel acknowledges this was not strictly within the Home Office guidelines, it was felt appropriate, after consultation with the Police Senior Investigating Officer, to delay the notification and invitation because many of the family were likely to be called as witnesses during the criminal

proceedings.

The final report would not be shared with the family until after submission to the Home Office. This decision was based on the possibility that the report could have been redrafted a number of times and so this course of action would reduce the impact and stress of revisiting the family on multiple occasions.

1.50 **Family Involvement**

The DHR Panel would like not only to extend its sincere condolences to Adult A's family, but also to express its gratitude to them for their support and for the courage and dignity they have displayed throughout the process.

1.51 The Chair met with Adult A's maternal grandmother (Relative 1), Adult A's younger sister (Relative 2). During the latter part of the meeting Adult A's mother (Relative 3) arrived.

1.52 Relative 2 did not contribute information that was different from Relative 1, however she was present and reinforced the matters she was aware of. Relative 3 arrived in the latter part of the meeting and reinforced some of the information.

1.53 Adult A was on the child protection register and moved to live with her grandmother (relative 1) in July 2001. Relative 1 was given parental responsibility in July 2002.

Adult A's mother, Relative 3 was in a relationship with [redacted]

1.54 Relative 1 described Adult A's childhood as *"very difficult"*, [redacted]. Relative 1 stated that Adult A would constantly scream, shout and bite people. However, Relative 1 insisted that Adult A should have as normal a childhood as possible and supported her through mainstream schooling where she achieved success and led a normal life engaging with school and activities.

1.56 According to the family, when Adult A was about 17 years old, she began meeting boys on the internet and they would come and pick her up in cars and go off for the evening. This was a regular occurrence and Adult A would always say she would be okay. Relative 1 explained that she would be terrified and wouldn't sleep until Adult A returned home. However, whilst she was worried she also wanted to allow Adult A the freedom to enjoy her childhood and teenage years.

1.57 When Adult A was 18 years old, she wanted to start college and Relative 1 supported her in this and ensured she was able to take part in college life.

1.58 It became apparent to Relative 1 that Adult A was being financially abused, spending money on others although Adult A did not recognise it as abuse. Relative 1 believed this showed how vulnerable Adult A could be. Relative 1 gave an example of this where Adult A had a contract for a phone for £42 per month and got a free

watch; Adult A said she had sold the watch. Sometime into the phone contract, the phone stopped working and when Relative 1 enquired at the shop where it was purchased they informed her that the direct debit hadn't been paid. Relative 1 paid the bill and when asked Adult A explained she had spent her money on cigarettes. Relative 1 specifically mentioned this, as Adult A did not smoke heavily and she would not have used that many cigarettes herself, again this was a demonstration of Adult A's vulnerability. Relative 1 discussed this particular incident with the Community Learning Disability Nurse.

1.59 Relative 1 stated that Adult A was receiving benefits of £200 per fortnight and yet she took out a number of loans. One was a payday loan for £100 and she was required to pay back £600. Adult A took out quite a few other loans, but there was no evidence that she was spending it on herself.

1.60 Despite having the £200 per fortnight she brought nothing home, Relative 1 believes that Adult A's friends were taking the money, either in cash or goods such as cigarettes, alcohol and anything else they could have. Adult A allegedly sold her TV and her tablet, although Relative 1 believes she in effect *'gave it away.'*

1.61 Relative 1 stated that before her relationship with Adult B, Adult A had had two other boyfriends; each had been for about 12 months. The first relationship had broken up because Adult A described him as too demanding. The second broke up because she got fed up with his mother. There was no suggestion of violence or abuse in either relationship.

1.62 During the relationship with Adult B, he had insisted that she see her GP and go on medication, her friends also pressured her to do this. Relative 1 thought this was due to the fact they were controlled drugs and was unsure of the friends motives.

1.63 Relative 1 has no doubt that a number of Adult A's friends were a bad influence. She specifically named two; the first had been a bad influence for some time and recently the second who had been bullying Adult A (their names have not been included in this report).

1.64 There were a number of incidents that caused Relative 1 some concern regarding the relationship with Adult B. On one occasion Adult A didn't want to go home from the pub because she said *"he'll hit me."* On another occasion Adult A returned home with a bruise on her leg and when asked by Relative 1 what had happened she said she had *"slipped down the stairs".* These incidents were not mentioned to Adult A's community nurse

1.65 Relative 1 also mentioned an incident that took place around 8th April, 2014 when Adult B had strangled Adult A. (This incident will be discussed later in this report.) She said that during that incident Adult B hid Adult A's phone to stop her ringing anybody.

(N.B this is particularly relevant as during Incident 1, referred to later, she made a call on her mobile phone to her friend and so this appears to have been a separate incident (possibly incident 2) and Adult B has prevented her calling anybody).

1.66 Relative 1 was asked some specific questions regarding access to domestic abuse services. She answered that she was not aware of the services available for Adult A or for herself.

1.67 Relative 1 finally said that Adult A had told her that she *"loved him"* (Adult B) and in her view (Relative 1) *"Nobody could have done anything"* to prevent Adult A's death. Relative 2 and Relative 3 agreed with Relative 1, that '*nobody could have done anything.'*

2 The Facts

2.1 Adult A and Adult B had been in a relationship for three months prior to Adult A's death. There is no information about how they met, although the family believes it was through mutual friends. Adult B lived at his mother's address and Adult A stayed with him on occasions. Adult A lived with her grandmother who had parental responsibility for her as a child.

2.2 Throughout the three month period there were no calls to Gwent Police regarding domestic violence or abuse made by Adult A, Adult B or any other party.

2.3 Adult A and Adult B had been out at a local pub on the evening of Sunday 4th May 2014 before leaving to return to Adult B's address (as at 2.20). Whilst they returned to the address there was an argument and this continued once they returned to the address.

2.4 Adult A was upset and ran upstairs locking herself in the bathroom. Adult B persuaded her to open the door and once she did he started to strangle her. During the course of the strangulation she fell backwards into the bath. Adult B then fetched a knife from the kitchen or hall and stabbed her 27 times.

2.5 During Adult B's trial it was noted by Judge Cox that Adult B had not sought assistance for Adult A from the emergency services and had left her. During the summing up Judge Cox noted as significant the fact that Adult A had no defence injuries.

2.6 When Adult A was found she was fully dressed with her coat on. She had her handbag with her and a 'kitbag' over her shoulder. The assumption by Gwent police was that she was about to leave the address. Adult A had been covered with a duvet.

2.7 Adult B told two people of the incident before ringing the police. He told Witness 1 that he and Adult A had an argument that had gone "too far." Witness 1 told Adult B to go home and sort things out. The following day, Monday 5th May 2014, he told Witness 2 that he "had done something stupid."

2.8 Witness 2 went with Adult B to his address where he saw Adult A in the bath. Witness 2 fled the house and called Gwent Police. In the meantime Adult B had called the police and informed them he had "murdered his girlfriend by strangling and stabbing her."

2.9 During the trial the judge said that Adult B

> "*had a little and pointless argument at about 10.30pm the previous evening, you had strangled her in the bathroom, she fell into the bath and then you stabbed her with a silver knife which you had obtained from the kitchen."*

Judge Cox remarked that this was "*a sustained and brutal assault upon your defenceless 21 year old girlfriend."*

2.10 Adult B was sentenced to 20 years imprisonment with a minimum term of 16½ years.

2.11 **Background of Adult A (Victim) and Adult B (Perpetrator)**

2.12 **<u>Victim information</u>**

Adult A was a young woman who had a Mild Learning Disability. She had lived with her maternal grandmother (Relative 1) since the age of 9 years old when her mother (Relative 3) had left her in care due to a relationship with a [redacted].

[redacted]

2.13 People with a Mild Learning Disability struggle with learning (often unable to read or write) and can have difficulties with numeracy, managing money and self-care. They can be vulnerable to exploitation and this was evidenced through her exploitation by her friends and associates. This is not a reflection on Adult A but a reflection of the friends and associates abusive behaviours.

2.14 At the age of 10, Adult A was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). From an early age Adult A was identified as an individual who would require support from services and she had a Community Learning Disability Nurse who visited the home regularly. [redacted]. This also includes PTSD and other disorders carried into adulthood. Some research supports the assertion that individuals with ADHD are more vulnerable and susceptible to abuse. It is important that professionals are aware of this link.

2.15 Adult A was identified as a vulnerable adult by Aneurin Bevan University Health Board but there was not the same level of clarity by Newport City Council Adult and Community Service. This will be commented on later in the report.

2.16 Adult A was assessed as having mental capacity to make certain decisions and take control of her life and specifically referenced within the Newport City Council IMR is that within the Mental Capacity Act 2005 it was recorded that,

> **"***The main and presenting principle is that "A person must be assumed to*

have capacity unless it is established that they lack capacity." All professionals referred to in the chronologies who had involvement with her all agreed that the assumption was fully met. This would, therefore, allow her to make potential unwise decisions regarding all key aspects of her life."

In 2012 at the age of 20, Adult A was diagnosed with autistic spectrum disorder. During that diagnosis the Consultant stated that *"[Adult A] presents as more able than she is."* It is clear from discussions with Relative 1 that Adult A had a challenging childhood due to her condition, but due to the wishes of Adult A and in order that she was able to lead as normal a life as possible and take part in teenage activities they had nurtured her and kept her in mainstream education.

2.17 It is recorded in Newport City Council's Adult and Community Services notes that Adult A *'presents as very able.'* She was able to use public transport independently and had stayed at home with her boyfriend (not Adult B) when Relative 1 went on holiday. It also states that "*However, on- going observations over subsequent years had shown her to be far more intellectually able and independent than was originally assumed."* There are no medical records that support this information.

2.18 During 2013, there was concern for Adult A, articulated by Relative 1 and the Community Learning Disability Nurse regarding her medication and that she (Adult A) was putting herself at risk, staying out and drinking excessively. There was a belief by Relative 1 and health professionals that she was being financially exploited by friends. Adult A had taken out pay day loans and also sold a number of personal items, Relative 1 was concerned why she was doing this as she had no financial commitments and had adequate financial support. This matter was never reported to police or investigated further by anyone. This should be seen as a missed opportunity to identify potential abuse.

2.19 According to Relative 1 and 2, Adult A had three boyfriends, including Adult B. Neither Relative 1 nor Relative 2 had been aware of any problems with the previous two.

2.20 **Perpetrator Information**

Adult B was a single man living with his mother, at her address. He was unemployed and had been for some time.

2.21 Adult B had little involvement with agencies, apart from one recorded incident when the police were involved on 20th November 2010.

2.22 This incident occurred with a previous partner (Adult C) when Adult B had an argument with his father and his father's partner (Adult C's mother) which led to him assaulting both his father and his partner (His father had left Adult B's mother and commenced a relationship with Adult C's mother) .

2.23 Following the assault he had returned to Adult C's flat and began to *'act very strange towards her'*, so much so that she left the flat fearing for her safety.

2.24 After Adult C had left the flat Adult B, took possession of a knife and was seen in the

locality stating he had 'stabbed and cut up his girlfriend.' Adult B was overpowered by members of the public and later arrested by police. Adult C was subsequently found safe and well although Adult B had 'trashed her flat.'

2.25 Adult B received a suspended sentence for the assaults and the criminal damage to the flat.

2.26 Adult B had no further involvement with any agencies until Adult A's death.

3 Chronology

3.1 There is only one recorded previous incident of domestic violence/abuse involving Adult B which has been referred to previously. This occurred in November 2010.

3.2 He was made subject to a 12 Month Suspended Sentence Order on 13th December 2010 that terminated one year later, 12th December 2013.

3.3 In 2011, Adult A was reported as a missing person, but was found safe and well a short time after being reported.

3.4 During February 2013, Newport City Council Adult and Community services conducted a routine unified assessment visit with Adult A and Relative 1. The assessment was completed and it was evaluated that Adult A did not have any eligible assessed needs for them to meet.

3.5 In March 2013, Gwent police had returned Adult A home, when she had got lost in Cwmbran. Relative 1 explained that she had not been lost, but had missed the last bus home, so Adult A flagged down a police car who returned her home.

3.6 In February 2014, during a home visit by the Community Learning Disability Nurse Adult A talked about her new boyfriend, Adult B. The Community Learning Disability Nurse discussed safe sex and Adult A agreed to take appropriate precautions.

3.7 On 7th March 2014, Adult A told the Community Learning Disability Nurse that she had been staying out with friends and that her friend only wants her for her money. She described an incident where she kissed a boy and told her boyfriend [Adult B] when she was drunk. Adult A was given advice regarding her alcohol consumption.

3.8 On 8th April 2014, during a home visit, the Community Learning Disability Nurse gave Adult A further advice regarding behaviour, alcohol consumption, staying out all night, finances, cleanliness of room, taking illicit substances. During this visit Relative 1 reported that Adult A disclosed to have *"been almost strangled by [Adult B] last week".* The Community Learning Disability Nurse discussed a Vulnerable Adult referral (this is also known as a POVA referral). A vulnerable Adult/POVA referral provides details of the specific abuse. It is not a risk assessment (this will be referred to in the learning from the review section.) Adult A did not want any police involvement and did not give consent to disclosure. The Community Learning Disability Nurse completed a POVA referral; this should be seen as good practice.

3.9 On 9th April 2014, Relative 2 reported the same incident to the Community Learning Disability Nurse. On 10th April 2014 there was a telephone discussion between the Vulnerable Adult Safeguarding manager and the Community Learning Disability Nurse who made the referral. At this time the vulnerable adult safeguarding manager took the view that no significant harm had occurred and that the POVA threshold has not been met and subsequently closed the referral.

The following is taken from the *'Protection of Vulnerable Adults Guidance for designated lead managers on thresholds for the application of the wales adult protection inter-agency policy and procedures' (final draft February 2011):*

Abuse is defined In Safe Hands and clarified within Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse as

> *"a violation of an individual's human and civil rights by any other person or persons"*

It may take any of the following forms and sometimes combinations of these categories:

- *physical abuse*
- *sexual abuse*
- *psychological/ emotional abuse*
- *financial/ material abuse*
- *neglect and / or omissions*

The purpose of the initial evaluation is to determine if the referral is likely to meet the threshold for action to be taken under the Wales Adult Protection Policy and Procedures.

This done by determining three factors:

1. *Whether the alleged victim is a vulnerable adult*
2. *Whether there may have been, or is an immediate risk of, abuse resulting in significant harm*
3. *Whether there has been an abuse of trust, including a failure to meet a duty of care.*

It concludes that:

A referral meets the threshold for adult protection if the initial evaluation concludes that it is likely that the alleged victim is a vulnerable adult and it is likely that they have been, or are at immediate risk of being, abused and that this is likely to result in significant harm.

3.10 On 23rd April 2014, during a home visit by the Community Learning Disability Nurse information was given by Relative 1 that Adult A had taken out two pay day loans, was selling personal items, smoking and taking drugs (non-prescribed).

3.11 On 5th May 2014, Adult A was murdered.

3.12 **Other information**

This section outlines information that was known by friends of Adult A but not by the agencies involved. The information has come to light following Adult A's death and during the police investigation into her murder.

The information gathered from these individuals is the best recollections they have. Their memories were vague and without specific detail to ensure factual correctness, particularly relating to time periods and dates.

3.13 **Incident 1**

At about 1am on a Sunday morning (date unknown) Adult A rang a friend (Witness 3) and was upset and crying. Adult A said *"we were arguing and [Adult B] has just tried to strangle me."* The call lasted for between ten to 20 minutes during which Witness 3 heard the sound of knocking on a door. She then heard adult B saying in what she describes as a harsh voice *"come on [Adult A], come out, stop having your tantrum."*

3.14 Witness 3 asked what had happened but Adult A didn't tell her what the argument was about or why Adult B had tried to strangle her.

3.15 After the call ended Witness 3 called Adult A back and was told by Adult A *'that everything was now OK and she was fine'.*

3.16 Witness 4, who is the boyfriend of Witness 3, knows Adult A and Adult B and has often been in their company socialising. He has seen them arguing and as he describes *'screaming and shouting at each other.'*

3.16 **Incident 2**

About six weeks prior to the death of Adult A, Witness 3 and Witness 4 met Adult A, who was upset. When asked what was wrong Adult A said that Adult B had tried to strangle her, *"he had locked his arms around her neck and pulled them tight together."* Following this incident Adult B had made out he was joking to Adult A.

3.18 Witness 3 advised Adult A to end the relationship which she did, however after a few days she recommenced the relationship.

3.19 **Incident 3**

Sometime before her death, Adult A went and stayed at Witness 5's address as she had fallen out with Relative 1. During that stay Adult A told her that Adult B was a drinker; that he drank every day and took drugs and he had tried to strangle her.

3.20 On 22nd April 2014, Adult A called Gwent Police to assist in recovering property which was at Witness 5's address. The police were told that Adult A had stayed over for two nights, on the 18th and 19th April 2014.

3.21 **Incident 4**

Witness 6, is a friend of Adult A and although he has not seen her for some time they keep in regular contact through Facebook. In a message Adult A told Witness 6 that she had dumped her boyfriend [Adult B], describing him as a "*complete and utter twat."* When he asked why, Adult A replied that Adult B had tried to strangle her. This was dated 7th April 2014. On 14th April Adult A messaged Witness 6 and told him that she was back in a relationship with Adult B.

3.22 This would seem to coincide with incident 2 and therefore place that date as around 7th April, just less than a month before Adult B killed Adult A.

3.23 **Incident 5**

Witness 7 knows Adult A, but not Adult B and they keep in touch via Facebook. Witness 7 received a message from Adult A asking what she would do if her boyfriend tried to strangle her. Witness 7 replied that she would be annoyed and angry. Adult A responded telling her that her ex-boyfriend (Adult B) had tried to strangle her. This would again seem to coincide with incident 2.

3.24 Incident 2 would also coincide with the report made to the Community Learning Disability Nurse on the 8th April 2014. If incident 2,3,4,5 and 6 are all the same, incident 1 would appear to be separate and another episode of strangulation.

3.25 **Previous incidents between Adult B and Adult C**

Adult C was in a relationship with Adult B for 10 months from February 2010 until November 2010. During the relationship Adult B's father left Adult B's mother and started a relationship with Adult C's mother.

3.27 Adult C was living with her young baby from a previous relationship and after a few months of the relationship starting with Adult B he moved in with her.

3.28 She stated that Adult B drank alcohol every day and recalled one incident when he had been writing rap lyrics about an ex-girlfriend. Adult C did not like being compared to the ex-girlfriend and got up to leave the room. Adult B threw a *'pint glass'* at her, narrowly missing. He then came to her and placed his hands around her throat, holding her for between 30-60 seconds. Adult B was screaming at her and Adult C was screaming to be released. Adult C's baby woke up and Adult B released her to go and get the baby.

3.29 Adult C also described the incident on 20th November 2010, when Adult B had met his father and Adult C's mother, she had not witnessed what had happened, but was aware something had happened. When Adult B returned to Adult C's address they had argued and when she went to bed he had said something similar to 'sweet dreams.' The manner in which he spoke to her and his demeanor made her feel uneasy and she feared for her safety, so she went to stay with her father. It later transpired that Adult B had 'trashed' her flat and had been arrested saying he had killed her and 'cut her up.' The relationship ended after this incident.

4 Analysis of involvement

In this section practice is analysed and evaluated against policy and procedure via the IMRs. Further analysis takes place in the next section directly answering the TOR questions.

4.1 Gwent Police

Gwent police had little involvement with the Adult A (the victim) or Adult B (the perpetrator).

4.3 In 2004, Adult B witnessed a fatal road traffic collision and provided assistance to the victim. According to his mother this had an emotional effect on him, but no more detail was obtained. During his interview for Adult A's murder he repeatedly referred to this incident as giving him *"dark thoughts".* This was not considered relevant during his trial or by the psychiatrist that saw him during the trial process. During his summing up Judge Cox said "*Beyond the explanation that you lost it, no good reason has been given for this horrific attack."*

4.4 In November 2010, an incident occurred with a previous partner (Adult C) when Adult B had an argument with his father and his father's partner (Adult C's mother) which led to him assaulting both his father and his partner (his father had left Adult B's mother and commenced a relationship with Adult C's mother).

4.5 Following the assault he had returned to Adult C's flat and began to 'act very strange towards her', so much so that she left the flat fearing for her safety.

4.6 After Adult C had left the flat Adult B, took possession of a knife and was seen in the locality stating he had 'stabbed and cut up his girlfriend.' Adult B was overpowered by members of the public and later arrested by police. Adult C was subsequently found safe and well although Adult B had 'trashed her flat.'

4.7 This incident was dealt with appropriately by Gwent Police. Adult B was arrested and was sentenced at court for his actions. The incident was 3½ years before the death of Adult A and could not have been recognised as a significant precursor event towards her death.

4.8 In January 2011, Adult A was reported as a missing person, but returned a few hours later safe and well. This incident was dealt with appropriately and is not relevant to domestic violence/abuse or the death of Adult A.

4.9 In March 2013, Adult A flagged down a police car for a lift home when she had become lost in Cwmbran. According to relative 1 Adult A had missed the last bus and was attempting to get home when the police car found her and gave her a lift. This is not within the police IMR and it may be that the incident was not recorded within the police systems, however it should be seen as good practice in the circumstances to assist a lone young woman.

4.10 Gwent Police were called to assist Adult A to collect her belongings from a friend's

house (Witness 5). This is not within the IMR of Gwent Police, but is not considered relevant in the death of Adult A or any of the attendant circumstances.

4.11 There is no other incident in which Gwent Police were involved. They had no information to share and had other agencies shared information with them, their lack of involvement meant that it would have had little bearing on any outcome or their actions.

4.12 **Aneurin Bevan University Health Board (ABUHB)**

ABUHB were involved with Adult A and her family form an early age. In 2010, a Community Learning Disability Nurse supported Adult A and her family due to Adult A's diagnosis of Learning Disability, ADHD and Autism. The same Community Learning Disability Nurse has supported her from that date through to the date of her death. This should be seen as best practice to provide continuity of knowledge and family reassurance.

4.13 During a home visit on 20th March 2013, it was reported that Adult A had been brought home by Gwent Police after becoming lost in Cwmbran. The Community Learning Disability Nurse had a discussion with Adult A regarding her personal safety. There was no indication of any abuse or of domestic violence and it appeared to be an isolated incident.

On speaking to the family Relative 1 explained that Adult A had missed the last bus and had started to walk home when police officers stopped her and gave her a lift. This has been commented on in the Gwent Police section of this report.

4.14 During April 2013, there were several home visits by the Community Learning Disability Nurse who discussed strategies to manage behavior and aggression and compliance with taking medication, which Adult A was sometimes non compliant with her medication. Adult A recognised her behavior improved when taking medication and agreed to take it more frequently.

4.15 On 22nd May 2013, during a home visit it was identified that Adult A was putting herself at risk by staying out at night, drinking alcohol which effected the effectiveness of her medication, spending excessive amounts of money, which appeared to be financial exploitation by friends. There was a long discussion about her personal safety and strategies to use to cope with situations and where to get help. At this time there were still concerns about Adult A's compliance with taking her medication. There was no disclosure of actual or potential domestic abuse at this time. The panel considered whether the nurse had missed information but it was felt by the panel that she had not. The panel recognises the challenges for professionals and the application of hindsight in the knowledge that Adult A was murdered. However the learning from the reviews should inform practice and it is important that every avenue is considered and this includes questions pertaining to domestic abuse.

4.16 On 5th May 2013, Adult A took part in a family consultation session, which she found beneficial. [redacted].

4.17 On 19th July 2013, a Wales Applied Risk Research Assessment (WARRN) was completed and an action plan put into place.

WARRN assessment:

The strategy for Adult Mental Health Services in Wales recommends " Every user in contact with mental health services should have a structured assessment of risk written in their case records "

This is a formal written assessment of the individuals and families needs, this assessment is carried out yearly.

4.18 Following the assessment the Summary of Risk Formulation for Adult A was:

"[Adult A] *is at risk of exploitation due to her vulnerability. She is able to understand the risks and actions needed to keep herself safe.* [Adult A] *has a good relationship with her [Relative 1] and open dialogue She is also able to communicate her concerns to the Community Learning Disability Nurse.*

The action plan:

1. *Community learning disability nurse to provide [Adult A] with information on personal safety*

2. *Community learning disability nurse to provide [Adult A] with information on self -soothing strategies*

3. *Community learning disability nurse to provide [Adult A] with information on anger management including advice on what could happen if she physically assaulted someone*

4. *[Adult A] and her family to continue attending family therapy sessions*

5. *[Adult A] to be encouraged to take her medication as prescribed*

4.19 During a family consultation visit on 9th August 2013, Adult A disclosed she got stressed [redacted]

4.20 On 15th October 2013, during a visit to the consultant at the Civic Centre, Newport alternative medication to assist Adult A was discussed as she had stopped taking her prescribed medication and Adult A had reported that *"she didn't seem to be doing too bad."* The plan was for the Community Learning Disability Nurse to monitor Adult A.

4.21 On 27th January 2014, during a home visit there were still safety concerns for Adult A regarding her staying out at night, fighting and drinking. There was a discussion about a referral to Social Services, although Adult A was unwilling. Recorded in the Newport City Council IMR is that Adult A *"does not appear to want to address the issues Community Learning Disability Nurse trying to work with [Adult A] to reduce*

harm and maintain personal safety." The panel considered the same point (4.15) regarding reflection on practice and recognise this was an opportunity to ascertain any information that would have identified domestic abuse.

4.22 On 18th February 2014, Adult A disclosed to the Community Learning Disability Nurse that she has a new boyfriend (Adult B) and the Community Learning Disability Nurse re-enforced the importance of personal safety.

There is nothing in the notes that provides details of Adult B. Adult A's personal safety and ability to make good decisions has been questioned over preceding months and there is no record of the identity of the 'new boyfriend'. This lack of knowledge meant that Adult B's identity was not known and so a full assessment of risk was unavailable. If his identity had been known then further action could have taken place including the notification to Gwent police and/or specialist services to support Adult A. This could also have included a notification to Adult A of adult B's relationship history and behaviour under 'Claire's Law'. However it was recognised and documented that the Community Learning Disability Nurse had assessed Adult A as having capacity in these areas and Adult A therefore had autonomy albeit that she was also a vulnerable young woman.

It is also recognised by the review that there may have been an opportunity to engage Adult A to discuss potential domestic abuse. The community Learning Disability nurse had undertaken work to help Adult A keep herself safe and at this point Adult A had not shared information about domestic abuse..

4.23 During a home visit on 7th March 2014 a number of issues were discussed, including her increased alcohol consumption and giving away money. The 'capacity' of Adult A was assessed and there was advice given about managing her personal safety.
There is nothing recorded that would indicate there was any discussion regarding the new boyfriend.

4.24 On 8th April 2014, during a home visit concerns were raised by Relative 1 that Adult A had been strangled by Adult B. Within the ABUHB clinical record it is recorded that Adult A was "*presenting today as loud and aggressive said did not want to go to police that she had hit him first denied any other physical incidents*."

At this time the concerns were assessed by the Community Learning Disability Nurse as requiring a POVA referral even though Adult A did not consent which should be seen as positive action and good practice.

The Community Learning Disability Nurse did recognise the abusive behaviours during this visit and completed the POVA referral.

There is nothing to indicate that the identity of the 'new boyfriend' was questioned and so any risk assessment was based on the answers provide by Adult A. It is also recognised that some victims may omit certain details or leave out entire incidents. This has been shown to increase when discussing incidents with friends and families and the minimisation is increased further when discussing with professionals.

It is known that victims disclose incrementally – giving fuller disclosures as they build

trust and confidence, sometimes depending on who they are talking to therefore it is important that professionals are aware of the impact of minimisation and utilise professional curiosity within the process of risk assessment rather than over reliance on the questionnaire based approach that create barriers to disclosure.

Following the POVA completion the Community Learning Disability nurse reviewed Adult A's WARRN risk assessment.

The Community Learning Disability Nurse would have viewed the POVA referral as the pathway to highlight concerns in respect of a vulnerable adult in the context of an episode of domestic violence. This is seen as the process for all forms of abuse including domestic abuse to be considered. Social services are the lead agency to investigate the concerns raised in a community POVA referral.

It is not clear what the relationship between a POVA referral and a DASH risk assessment is.

DASH (Domestic Abuse, Stalking and Honour based violence) risk assessment is the nationally recognised risk assessment model. It is a common checklist for all agencies and is specifically designed for domestic violence and abuse.

The purpose of a domestic violence risk assessment is to

- *Help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.*
- *Decide which cases should be referred to MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.*
- *Offer a common tool to agencies that are part of the MARAC process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence*

4.25 During the final home visit before Adult A's death, the Community Learning Disability Nurse again attempted to address Adult A's *'over activity'* symptoms, Adult A denied any drug misuse and a further family therapy session planned.

There is nothing recorded during this visit that would suggest any questions were asked concerning the previous visit and the behaviours exhibited by Adult B towards Adult A, this could, with hindsight, be seen as a missed opportunity.

4.26 **Newport City Council, Adult Services**

Newport City Council Adult Services have had limited involvement with Adult A and they have only been in direct contact with her on one occasion.

4.27 Prior to the dates of the review they have two records, the first dated 24th October 2012 and refers to emails from the Community Learning Disability Nurse from ABUHB to a social worker from the community social work service.

The email specifically refers to Adult A's eligibility. It states that Adult A "*presents as very able. She is able to use public transport independently and stayed home with her boyfriend (Not Adult B) whilst her grandparents went on holiday*. *During Transitional Summer Scheme Adult A was the most able person in the group..."*

The Community Learning Disability Nurse also informed the social worker that Adult A's consultant diagnosed Adult A with Autistic Spectrum Disorder and that Adult A presents as more able than she is.

The email also refers to an educational psychology report dated 2002 that provides information concerning Adult A's functioning ability with an explanatory note from the Community Learning Disability Nurse saying that *"possibly if it was repeated it may go up a little but she thinks her (Adult A's) presentation masks her functioning at times."*

4.28 The second recorded contact with Adult A was when a unified assessment visit was conducted on 6th February 2013 with the social worker and Community Learning Disability Nurse at Adult A's address, Relative 1 was present throughout this visit.

It is recorded within the IMR (Social Services) notes that Adult A was fully engaged and that Adult A "*does not have a Learning Disability and does not meet the criteria for Community Adult Learning Disability Team."*

The unified assessment was completed and it concluded that Adult A "*does not have any eligible assessed needs for Adult Social Services, Newport City Council to meet."*

This assessment referred to whether or not Adult A required assistance/support to live independently in the community. It was assessed and concluded that she did not need assistance or support at that time.

4.29 On 9th April 2014, a POVA referral was received by the Protection of Vulnerable Adults Team, submitted by the Community Learning Disability Nurse. The referral referred to Adult A's mother (Relative 3) reporting to the Community Learning Disability Nurse that Adult A's boyfriend (Adult B).

> "*Attempted to strangle her and she had been afraid. Date unknown. Victim denied this was a serious incident and when asked why she was frightened she would not say."*

4.30 On 10th April 2014, following the receipt of the referral the Protection of Vulnerable Adults Team contacted the Community Learning Disability Nurse to discuss the contents of the referral.

The IMR states:

> *"Discussed salient points. Agreed that no significant harm had occurred therefore POVA threshold not met. Given this and lack of consent POVA was closed. [Adult A] had capacity according to Community Learning Disability Nurse remained involved."*

As an explanatory note the IMR also states that:

> *"Wales Interim Policy & Procedures for the protection of Vulnerable Adults from Abuse applied. Initial Evaluation undertaken. The purpose of this is to determine if the referral is likely to meet the threshold for significant harm under the Wales Protection Policy. POVA risk rating completed as per All Wales Policy. According to referral the victim did not wish to make complaint, stated that action had been playful. No injuries sustained, no medical attention required, no lasting distress. POVA threshold not met, noted need for care management support."*

4.31 The 'All Wales Interim Policy & Procedures' for the Protection of Vulnerable Adults from Abuse does not appear to have been fully implemented as the policy is clear that:

Page 23: "*If the vulnerable adult seems able to make an informed decision and does not want action or intervention, their wishes should be respected,* ***unless****:*

- *there is a statutory duty to intervene (e.g. a crime may have been committed or may well be);*
  (attempted strangulation is a crime and 'only' the police may decide otherwise)

- it *is suspected the vulnerable adult may be under the undue influence of someone else.*
  (This was not known at this time, although it appears from the review that she was)

Page 23 6.3.1 the policy also states: "*consent should not simply be accepted at face value, since some vulnerable adults need protection from emotional manipulation and exploitation."*

Page 26. 6.4.1 If abuse has not occurred but there is a likelihood of abuse occurring, or the victim has been abused but there has not been significant harm, adult protection procedures may nonetheless be used. Each situation must be judged on its merits and this judgement **must** include consideration of alternative approaches, such as:

Action by Police or Probation e.g. inclusion of information on database and/or referral to Multi-Agency Public Protection Arrangements (MAPPA) or Multi-Agency Risk Assessment Conference (MARAC)."
This process also appears to be in direct contradiction to the Newport City Council procedures which state on their website:

http://www.newport.gov.uk/en/Care-Support/Protection-of-vulnerable-adults.aspx

> *The protection of vulnerable adults (POVA) is concerned with the protection of someone aged 18 years or over who needs help with everyday living tasks, perhaps a person with disabilities, experiencing mental illness or a frail older*

person.

And includes

> ***Domestic abuse*** *– abuse in domestic relationships only, whereas adult protection includes abuse in professional relationships and specifically concerns vulnerable adults.*

It also states within the process that

> *Allegations of abuse are treated very seriously and in the strictest confidence within the limits of the law, which requires that the police are informed where there is risk to life, or information about a crime is discovered.*

The comments made in the explanatory notes do not support this statement.

4.32 The explanatory documents within the website provide details of what is a vulnerable adult and what constitutes abuse which is *"hitting, pushing, pinching, shaking, using too much medication or not allowing a person to take their medication."*

http://www.newport.gov.uk/stellent/groups/public/documents/leaflets_and_brochures/cont726035.pdf

> *The definition of a vulnerable adult is: "A person who is 18 years of age or over, and who may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or serious exploitation."*

4.33 Adult A matched the definition of a vulnerable adult as identified above and the actions of Adult B constituted physical abuse therefore Adult A should have been considered in accordance with the guidance.

4.34 The information contained within the explanatory note of the IMR contradicts the guidance issued by Newport City Council.

4.35 There was information that Adult A had been strangled and this is information about a crime. It is a matter for the police to investigate whether there was actually a crime or not.

4.36 If this investigation had taken place they would have identified that Adult B had strangled his previous partner (Adult C) and any appropriate action could have been taken by both the police and the vulnerable adult's team. This should be seen as a missed opportunity although it cannot be ascertained if this would have prevented Adult A's death.

5 Addressing the terms of reference

5.1 Whether the incident in which Adult A died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence.

- The incident in which Adult A died was not a one off. There had been one previous incident they were aware of, which had occurred very recently. Friends knew this information and the panel considered at length how they could facilitate disclosure by such friends. There were other incidents that Adult B had been involved in approximately four years before that was the same in regard to strangulation and the claim that Adult B had stabbed Adult C.

- The use of the POVA process does not appear to be clear-cut and there would appear to be opportunities for agencies to interpret the circumstances.

5.2 Whether there were any barriers experienced by Adult A or family / friends / colleagues in reporting any abuse in Newport or elsewhere, including whether they knew how to report domestic abuse should she have wanted to.

- There does not appear to have been any actual barriers to report abuse for Adult A. On the one occasion she did report it health professionals made a POVA referral against her wishes, this should be seen as good practice.

- The panel recognised the challenges and difficulties reporting domestic abuse and that they were amplified due to Adult A's disabilities. The panel also considered how the challenges and subsequent barriers of reporting could be reduced to ensure information was articulated in a manner that could be clearly understood by everybody. Also it was important that staff were also aware of these challenges and acted accordingly wherever necessary by considering everyone's personal position and their abilities to appreciate and understand the dangers they may have been in. The panel discussed the need to recognise that vulnerable people may be abused.

- Incidents of domestic violence and abuse were raised with friends of Adult A these were not reported. It is unclear why this was the case and it could be they chose not to, or did not want to be involved. Strangulation is a significant harm factor within an abusive relationship and this and the other factors should be made clear to the public and professionals alike.

- It was apparent to the panel that friends and colleagues are often a source of information and support but there is a balance between friendship and reporting abuse. It is important that learning identifies these sources of information as a crucial opportunity to report abuse in a confidential manner.

5.3 Whether Adult A had experienced abuse in previous relationships in Newport or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died.

- There is no evidence from the review or speaking to the family that Adult A had experienced abuse in previous relationships.

5.4 Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Adult A that were missed.

- There were no missed opportunities for professionals as on the one occasion Adult A disclosed the disclosure was reported by the health professional.

5.5 Whether Adult B had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

- Adult B has a history relating to abusive behavior with Adult C some four years previously. The identity of Adult B was not known despite Adult A disclosing she had a new boyfriend.

- Gwent Police were aware of the history of Adult B, however they were not aware of his current relationship or that he had strangled Adult A in the preceding months before her death.

5.6 Whether there were opportunities for agency intervention in relation to domestic abuse regarding Adult A or Adult B that were missed.

- None were identified within the review as the POVA referral wasn't actioned (see comment at 3.9)

5.7 The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city.

- The significant harm factors raising the risk of domestic violence and abuse for victims should be made clear to professionals; Strangulation, use of knives and guns, pregnancy, separation and threats to kill.

- There should be clarity regarding the assessment of domestic abuse for all individuals, particularly those at greater risk, vulnerable adults.

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

- The issue pertaining to vulnerable adults will be discussed later.

5.9 **Family engagement**

How should friends, family members and other support networks and where appropriate, the perpetrator contribute to the review, and who should be responsible for facilitating their involvement?

- Letters have been sent to all known family members of Adult A and to Adult B and his mother.

- Three of Adult A's family has participated in the review, Relative 1, Relative 2 and Relative 3.

- Adult B and his mother have been written to but neither has responded.

5.10 How matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for this?

- The panel decided that Newport City Council would manage all media and communication matters.

- An executive summary of the review will be published on the One Newport LSB website, with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed through the partnership website, the partnerships operational and strategic domestic abuse groups and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

5.11 **Legal Processes**

How will the review take account of a Coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise the judicial process?

- There will not be an inquest into Adult A's death in line with legislation.

5.12 Does the Review Panel need to obtain independent legal advice about any aspect of the proposed review?

- No conflicts or issues have been identified that would suggest this will be necessary.

5.13 **Research**

How should the review process take account of previous lessons learned from research and previous DHRs?

- Previous DHR's have been scrutinised during this review to elicit best practice. Research has extended to include academic sources including: Kemshall (2013), Walby and Allen (2004); Bain (2008); Munro (2007); Nash (2010); Brandon et al (2009); Barry (2009).

Specific documents have also been considered

- The home office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Call an End to Violence Against Women and Girls – HM Government (November 2010)
- Barriers to Disclosure – Walby and Allen, 2004.
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007.

5.14 **Diversity**

Are there any specific considerations around equality and diversity issues, such as ethnicity, age and disability that may require special consideration?

- Adult A had a learning disability, no others were identified within the review

5.15 **Multi agency responsibility**

Was Adult A or Adult B subject to a MARAC/ MAPPA?

- Neither Adult A nor Adult B was subject to MARAC or MAPPA. There was nothing in the review that would indicate either would be suitable for MAPPA.

- The review has highlighted the opportunity to conduct a domestic abuse risk assessment. It is unclear whether this would have been categorized as high, medium or low, however as discussed previously this was a missed opportunity and with the benefit of knowledge may have triggered a referral to MARAC.

5.16 Did Adult A have any contact with a domestic violence organisation or helpline?

- Adult A did not have any contact with a domestic violence agency. Domestic violence was recognised by the Community Learning Disability Nurse and referred using the POVA process.

- There is a wider issue identified by the review of services for vulnerable adults in the context of domestic abuse. A recommendation is to examine the current POVA provision and its relationship with domestic abuse risk assessment to ensure services are available and those are identifiable for the victims needing them.

5.17 Consideration should also be given as to whether either the victim or the perpetrator was a 'vulnerable adult'

- There is some confusion in the review whether Adult A was considered a vulnerable adult by all agencies. Aneurin Bevan University Health Board considered her a vulnerable adult. Newport City Council, Adult Services referred to Adult A as vulnerable but within the context of the Mental Capacity Act 2005, that *"A person must be assumed to have capacity unless it is established that they lack capacity"* was deemed to have capacity.

- The lack of clarity does not assist the understanding of services and there needs to be some common unambiguous language to ascertain an individual's status regarding their vulnerability.

- The definition of vulnerable adult taken form the Newport City Council website mirrors that issued by the Lord Chancellor's Department from the 1997 Consultation "Who Decides?"

  "A person who is 18 years of age or over, and who may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or serious exploitation."

5.18 Were there any issues, in communication, information sharing or service delivery, between services?

- There was no issue in communication, information sharing or service delivery as the only two agencies directly involved, Aneurin Bevan University Health Board and Newport City Council, had shared the information concerning Adult A. No information was shared regarding Adult B, as his identity was not known. At the point of his identity being known Gwent police were not contacted however this may have been due to the POVA process being discontinued.

5.19 **Individual agency responsibility**

Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults, and with wider professional standards?

- Newport City Council appear to have failed to follow their own policy and this has been highlighted within the main body of the review

- There are recommendations for organisations to examine their internal policies to ensure they take the learning from this review and apply it appropriately

5.20 Was the impact of domestic violence on the victim recognised?

- The vulnerability of Adult A was recognised, what is not clear if this was due to her being a vulnerable adult or due to the domestic abuse.

- There were a number of incidents reported to the Chair by Relative 1 that demonstrate domestic abuse. There was clear evidence of financial abuse and coercive and controlling behaviour by Adult B and 'friends' of Adult A. This review has been unable to ascertain why professionals were not aware of these incidents. Relative 1 identified these behaviours and shared them with the author and said she told the Community Learning Disability Nurse.

5.21 Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

- The review comments on this throughout. There are occasions when further enquiries could and should have been made to provide a wider view and shared appreciation of all the issues within the relationship.

5.22 Was there sufficient management accountability for decision-making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

- On the basis of the information available for the review there was sufficient accountability. However, as has been articulated, there were on occasions a lack of knowledge, incorrect judgments and a failure to act appropriately.

6 Lessons to be learned from the review

6.1 Throughout the review the question regarding Adult A's vulnerability has been examined. Despite scrutiny from this review it is still unclear what her status is and therefore what services should have been made available.

6.2 The question of her vulnerability and the use of a POVA referral seem to have hindered the assessment of Adult A's risk relating to domestic abuse. Due to the POVA referral process there is no consideration of the impact of Adult B's behaviour

on her.

6.3 There is no doubt that Adult A was a vulnerable adult, whether she had capacity is a separate issue. She was also the victim of domestic violence and whilst this was recognised within the context of being a vulnerable adult it was not considered as a specific issue, hence no specialised risk assessment process took place.

The lack of clarity seems to have determined a course of action and blinkered professionals. There appears to have been a concentration on Adult A's vulnerability from a disability perspective and a confusion with the referral pathway which recognised within the ABUHB IMR that highlights

> *"This highlights potential confusion in respect of the referral pathway for domestic abuse as had the young woman i.e. [Adult A] not been deemed a "vulnerable adult" it is likely that a DASH would have been considered and a possible MARAC referral made."*

It may be that if a domestic violence and abuse risk assessment had been utilised this information would have been identified and/or the POVA referral was specific in this area.

6.5 The use of a Vulnerable Adult/POVA referral could be confusing in cases of domestic violence and abuse. However had the POVA been pursued the information about the risks Adult B posed would have been discovered. The POVA referral is not specifically designed for domestic violence and does not assess the risk to the victim as a DASH assessment does. However the WARRN risk assessment undertaken by ABUHB does screen for risk of domestic violence

6.6 There should be a greater understanding of the impact of domestic violence and abuse, the behaviour of the perpetrator and the effect on the victim amongst professionals.

7 Conclusions

7.1 There is nothing in the review that indicates the homicide could have been predicted or prevented.

7.2 Adult A was a vulnerable adult and whilst she had capacity to consent to relationships she may have had difficulties recognising the impact of Adult B's behaviour. She was fully supported by her family who tried to do everything they could to ensure she had a safe and fulfilled life.

7.3 There was confusion within the referral pathway but whether this would have had any impact on the outcome is uncertain. Adult B attacked Adult A in a *"sustained and brutal assault."* There was no evidence that this level of violence had been used before by him as in the only previous incident Adult C had left the flat, before anything happened.

7.4 There needs to be some clarity in process and procedures regarding domestic abuse and violence in the context of vulnerable people. Agencies should have

sufficient flexibility to utilise appropriate assessments to determine risks to individuals

8 Recommendations

The following recommendations are made:

National (Wales)

- To review the current Vulnerable Adult/POVA referral pathway and ensure there is clarity relating to domestic violence and abuse

One Newport Local Service Board

- To ensure referral pathways are clear and that agencies are fully aware of their role and responsibilities

- To review and revise any training and awareness to ensure the lessons regarding identification of risk is made clear and that workers are clear of their roles and responsibilities.

Individual agency

Gwent Police

- To engage with partners and agencies to ensure information sharing arrangements are clear and appropriate to the relevant issue, specifically domestic violence and abuse

Aneurin Bevan University Health Board

To review and revise training and awareness to all staff involved with vulnerable adults, raising awareness of domestic violence and abuse and what action to take.

- ABUHB will have a clear process in place for staff to escalate safeguarding concerns if they feel another agency has not taken the appropriate action

- **Newport City Council Adult Services**

  Newport City Council POVA Team to consider the introduction of a Policy to ensure that in all cases where domestic violence is identified the information is shared or notified directly with the police for consideration.

- Improved clarity across adult services that in all cases, whether capacity is assumed or otherwise, the level of engagement, intervention and possible outcomes the adult expects from the process is made explicit. Such detail should then be clearly noted within case notes and revisited at each stage of future intervention. Compliance and co-operation should not be seen as the only measure.

- Ensure that Newport City Council Case Note Recording Policy and staff training clarify the need to ensure correct wording and terminology when determining service eligibility.

- Examining the role and communication with third sector specialists in domestic violence, especially in relation to adults with any learning disability and developing service provision in support of persons with learning disabilities.