Bwrdd Gwasanaethau Lleol
Torfaen
Local Service Board

On behalf of the Community Safety Partnership

Overview Report:

Domestic Homicide Review into the Death of

Mrs Sharon B

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Commissioned by Torfaen Borough Council

Date: November 2014

• Foreword by the Chair of the Review

Sharon, Chelsey and Mary are names the family have chosen to represent their loved ones. The family had stated that they wanted Sharon, Chelsey and Mary to be known by their given names and not anonymised in any form; they feel that this is disrespectful as they feel they should name their loved ones. They understand this is however a requirement stipulated within the statutory guidance provided by the Home Office when reporting upon this review.

This report outlines the findings and future learning recommendations following the Domestic Homicide Review into the death of Mrs Sharon B who died alongside her daughter Chelsey, aged seventeen years old, and her granddaughter 'baby' Mary aged 6 months on 18th September 2012.

The panel members wish to send their condolences to the family of Sharon, Chelsey and Mary and to thank them for their generosity of spirit and hugely valuable input into this report.

Sharon's mother, Mrs S, described Sharon as *"a great character, the life and soul of the party, lively and funny"*. Sharon's partner, Mr P, said that *"Sharon was a very special lady; she would talk to anyone and was always organising family get-togethers and good times with their friends"*.

Mr H, Sharon's surviving son, describes Sharon as *"a great mum"*. Mrs D Sharon's best friend, who spoke with her every day, believes *"Sharon was the best friend anyone could ever have".*

Without doubt Sharon, her daughter Chelsey, and granddaughter Mary, are sorely missed every day by those who knew and loved them.

Jan Pickles OBE

Glossary of terms

DACC- Domestic Abuse Conference Call – A daily conference call (Monday to Friday) where the Police and other attending agencies share information and plan action on domestic abuse incidents that have occurred in the preceding 24 hours .This approach was piloted in Gwent lead by Gwent Police.

DASH- Domestic Abuse, Stalking and Honour based Violence risk checklist – This is a risk identification, assessment and management model developed by UK Police Forces and partner agencies in 2009. The author of this report was a member of the expert panel who devised the model. The aim is to enable all frontline staff some with limited training, knowledge and skills to use evidence based questions to advise victims on their level of risk and then appropriately manage the risk to keep victims as safe as they can be.

DHR – Domestic Homicide Review

GP – General Practitioner

HMIC – Her Majesty‘s Inspector of Constabulary

INI- Impact Nominal Index Introduced in 2005 post the Bichard enquiry as an information sharing electronic mechanism between Police Forces as an interim approach prior to the construction of the Police National Database (The author was shown a reconstruction of the use of this database for this case and acknowledges its failings)

IPCC- The Independent Police and Crime Commission

IDVA – Independent Domestic Abuse Adviser these are trained individuals who provide services to victims of domestic abuse to reduce the risk they are facing

IMR – Independent Management Review a review prepared by agencies involved in this tragedy written and scrutinised by a member of staff not involved and a senior manager within the organisation

MARAC – Multi Agency Risk Assessment Conferences- Multi agency meetings where high risk victims (i.e. victims that score 14 or over positives to the DASH questions, or who have experienced 3 or more incidences of known domestic abuse in a certain time frame or those who an agency feels is at high risk of harm) of Domestic Abuse are discussed and actions plans to make them safer are designed and specific actions agreed

NHS- National Health Service

NICU- Neonatal Intensive Care Unit

PNC – Police National Computer a database which contains formal information known to the Police and is accessible to all Police Officers

PND – Police National Database a database which contains intelligence and other formal Police information on individuals. This database was established in June 2011(Gwent Police were an early adopter and as such information from other Forces was limited as it was uploaded as they came online) At this point the INI system became obsolete

SBAR Situation, Background Assessment an assessment tool used in the Neonatal Intensive Care Unit to assess risk and need

SERAF – Sexual Exploitation Risk Assessment Framework

SEWSCB – South East Wales Safeguarding Children's Board

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Introduction - The circumstances that led to this review

On 18th September 2012, emergency services were called to a domestic fire at the B family home in Cwmbran. The fire consumed the property and took the lives of Sharon, Chelsey and Baby Mary.

A joint investigation by Gwent Police and South Wales Fire and Rescue Service concluded that the fire was started deliberately. Subsequent investigation led to the arrest and charge of Mr M, the 27 year old boyfriend of Sharon's 17 year old daughter, Chelsey, and the father of baby Mary.

In July 2013, Mr M was found guilty of the murders of Sharon, Chelsey and baby Mary. Newport Crown Court awarded Mr M a 30 year indeterminate sentence for public protection.

This sentence was later increased to 35 years on appeal by the Solicitor General, on the grounds of undue leniency. The Appeal Court Judge Lord Thomas in his concluding remarks stated:

"The murders of three members of the family took place against a background of controlling and abusive behaviour by the offender".

The initial investigation identified that domestic violence may well have played a significant part in these deaths.

For that reason and in accordance with the statutory Guidance relating to Section 9 of the Domestic Violence, Crime and Victims Act (2004), The Torfaen Local Service Board commissioned a Domestic Homicide Review (DHR). I was appointed as Chair of the DHR and author of this independent report in July 2013. I am employed by the NSPCC as Service Head for Professional Partnerships across Wales, Scotland and Northern Ireland.

I am a qualified and registered social worker with over thirty five years' experience of working with offenders and victims of domestic abuse and sexual violence, both operationally and in a strategic capacity.

In 2004, I received an OBE for services to victims of domestic abuse for the development of both the Multi Agency Risk Assessment Conference (MARAC) model and for development of the concept of Independent Domestic Violence Advisers (IDVAs).

I was a member of the Expert panel that drafted and introduced the DASH model in 2009. In 2010, I received the First Minister of Wales' Recognition Award for the establishment of services for victims of sexual violence.

In 2012, I was part of the expert team that advised the lead Welsh Government Minister on the development of the proposed Gender-based Violence, Domestic

Abuse and Sexual Violence (Wales) Bill. I have completed the Home Office training for chairs and authors of Domestic Homicide Reviews.

I am not currently employed by any of the statutory agencies involved in the review (as identified in section 9 of the Act) and have had no previous involvement or contact with the family or any of the other parties involved in the events under review.

Purpose of a Domestic Homicide Review

The purpose of a Domestic Homicide Review (DHR) is to:

- Ensure the voice of the family is at the centre of the review process;
- Establish the facts that led to the incident on 18 September 2012, and to identify whether there are any lessons to be learned about the way in which professionals and agencies, both locally and across borders, worked together to safeguard the family;
- Listen to family, friends and others in the community who have views on this tragedy and to ensure these views are reflected in the report;
- Establish whether the agencies or inter agency responses were appropriate leading up to at the time of the fire on 18 September 2012;
- Establish whether the agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process;
- Set out where lessons have been learnt how they will be acted upon and explain what is expected to change as a result;
- Publish the findings in accordance with the Home Office Guidance to enable the lessons learned to be shared in the wider arena.

The process followed

This section summarises how the DHR panel sought to manage the review process, including the membership and operation of the panel, keeping the family central to the process, the scope and methodology, reporting and communications.

Membership and operation of the review panel

A Domestic Homicide Review Panel (the 'Panel') was established from a core group of statutory members of the Community Safety Partnership (commissioned through the Local Service Board (LSB)) and partners that could contribute to the review. This included:

- Torfaen County Borough Council
- Heddlu Gwent Police
- Aneurin Bevan University Health Board
- South Wales Fire and Rescue Service
- Bron Afon Community Housing, and
- National Probation Service (Wales).

An Independent Domestic Violence Adviser (IDVA) was in attendance to ensure specialist domestic abuse knowledge was central to the learning process. The panel's membership is noted in Appendix 1.

The panel met on nine occasions from July 2013 to June 2014. One meeting was hosted in the community, offering an opportunity for community members to contribute.

As Chair, I met with NHS colleagues to develop and inform their single-agency Independent Management Review, helping to shape some internal recommendations.

I met with the Kaleidoscope substance abuse service to review its screening of referrals for domestic abuse risk and they agreed to review their risk assessment procedure and information sharing with the referrer to ensure if a service user is not co-operating the referrer formal knows this.

I received a one to one presentation on the Police National Database in April 2014 and observed the limitations of the system.

The signed off Police IMR was not submitted until July 2014. Torfaen Social Care and Housing provided a chronology of their involvement with the family and a draft

IMR at the beginning of this review process and a more detailed analysis in September 13.

The late submission by the Gwent Police delayed the process of review and analysis of the circumstances that lead to these tragic deaths and therefore the completion of this report.

Keeping the family central to the process

As a guiding principle, the panel sought to involve the families of the victims as early in the process as possible, taking account of who the family wished to have involved as lead members and to identify other people they thought relevant to the review process.

The next of kin for the family was identified as Mrs S, Sharon's Mother, Chelsey's grandmother and Mary's great grandmother. Mrs S gave me individual permission to view Sharon, Chelsey and Mary's medical records as part of the review.

In July 2013, immediately on being appointed, I visited Mrs S as well as Mr S (Sharon's step–father, who due to ill health did not participate in the interview) and Mr H (Sharon's son).

I have also spoken with Mr P (Sharon's partner) and Mrs D (Sharon's closest friend and confidant). I have been very impressed with their dignity and patience in the face of their grievous loss.

During these interviews, Sharon was described as a loving and much loved daughter, mother, partner and best friend who was missed by them every day. They, as family and friends, struggle with their grief but all were determined to contribute to prevent this from happening to another family.

I have kept them fully informed throughout the process and will share my final report with them prior to submission.

Home Office guidance states that whilst careful regard should be given to *sub judice* and the primacy of the coroner's inquest, a Domestic Homicide Review should not be delayed by the judicial process.

However as the trial was imminent the panel agreed I would contact the perpetrator after sentencing. In effect, Mr M refused to meet with me or to participate in the review. In September 2013, the Chair of the Serious Case Review and I met with Mr M's mother, Mrs M to ascertain relevant background information on Mr M.

The DHR panel agreed a communications strategy that sought to keep the family informed, if they so wished, throughout the review and used both the Family Liaison Officer and the Housing Association to keep in regular contact with them.

As Chair, I have tried to be sensitive to their wishes, their need for support and any existing arrangements that are in place to achieve this. For example, after my initial visit to the family we arranged for a Fire Service visit to provide reassurance on future risk of fire. This visit was welcomed by the family who found it to be of real value to them.

In reporting the views of individuals who witnessed the actions of the services involved, the Review Panel is not endorsing those views as an accurate or as a fair assessment of the services provided. They are the views and opinions of the family and friends and should be considered with respect, in that they may offer lessons for the services involved.

Scope and methodology

Whilst respecting Sharon, Chelsey, Mary and their family the review sought to do the following:

- Establish whether the events of 18 September 2012 could have been predicted or prevented;

- Consider the period of two years prior to the deaths of Sharon, Chelsey and Mary, subject to any information emerging that prompts extending the review to earlier incidents or events. (This was later amended to include any previous incidents or threats of fire committed by Mr M following information received from his mother and the Wales Probation Service);

- Consider the way in which information was exchanged across borders between agencies in response to the transitory life style of the perpetrator;

- Request Individual Management Reviews from each of the agencies defined in Section 9 of the Act and to invite responses from any other relevant agencies or individuals identified through the review process;

- Seek the involvement of the family, neighbours and friends to provide a robust analysis of the events;

- Take account of the Serious Case Review, coroner's inquest, criminal proceedings and other relevant enquiries in terms of the timing and contact of both the perpetrator agencies with the family.

- In recognising that this tragedy affected the whole family, work closely with the Serious Case Review Panel established by the Local Safeguarding Children Board, to share relevant information, avoid duplication of effort and ensure in particular that the impact on the family and other stakeholders is minimised;

- Produce a report that summarises the chronology of the events, details the actions of the agencies involved with analysis and comment, and makes

recommendations for safeguarding families and children where domestic abuse is a feature;

- To aim to produce a draft report by the end of January 2014. (This proved impossible as the Independent Police Complaints Commission report and the Gwent Police Independent Management Review were not available until late July 2014).

- The final draft will be shared with family members prior to being presented to the commissioning authority. The final draft will be sent to the Home Office for quality assurance and then published in such a way that will respect the family's privacy.

NB: It should be noted that it is **NOT** the purpose of a Domestic Homicide Review to either establish how the victims died, or to identify who is culpable for their deaths. These are matters for both the coroner's and criminal courts.

Equally, it is not the purpose of the review to apportion blame to agencies or individual practitioners. Instead, the purpose of the review is to **identify lessons** that can be learned to improve awareness and agency responses that may ultimately prevent others from becoming victims of domestic violence in the future; an outcome Sharon's family believe she would have wanted.

The methodology used to develop this overview report is outlined in Appendix 2 of this report.

Reporting of this review

It is my intention that this final draft is shared with Sharon's close family - Mrs S, Mr H and Mr P - and that they have had the right to comment on it. If they express a difference of opinion on anything contained in the report, this will be clearly noted in the final report that is circulated to the Home Office before publication.

Once the final draft is agreed by the Panel, the Chair of the Community Safety Partnership (CSP) via the LSB will submit the report to the Home Office quality assurance panel.

An executive summary will be available on the Torfaen County Borough Council website and made available to wider partners.

The public executive summary will, as in this report be anonymised to protect the family and to comply with the Data Protection Act 1998, However this is against the wishes of the family who wished them all to be identified by their real names but is a requirement of the statutory guidance.

A copy of the review will be sent to Mr M.

Media and communication

It was agreed at an early meeting of the panel that the management of all media and communication matters was to be undertaken through a joint team drawn from the statutory partners represented on the panel, and led by South Wales Fire and Rescue Service.

The aim in asking the Fire Service to lead was to highlight the link between domestic abuse and arson to the public and to professionals (whether threatened or actual).

No steps were taken to inform the public that a review was being held in order to protect the family from any unwanted media attention. However, a reactive press statement was drafted to respond to the enquiries that would inevitably come at the end of the trial of Mr M.

This press statement explained the basis for the review, why it was commissioned, by whom, and the basic methodology. It also emphasised that the panel was attempting to work closely with the family, friends, neighbours and employers where relevant throughout the process.

As previously stated, an executive summary of the completed review report will be published on the Torfaen Council website to which all agencies will be able to create a link to internal intranet websites, with an appropriate press statement available to respond to any enquires.

Panel members also commit to distributing the recommendations of the review via their own websites and the joint Domestic Abuse Forum, and to raise in learning forums with other partner agencies.

As Chair, I have agreed with the Local Safeguarding Children Board that I will participate in local learning events that follow on from this report.

The Facts: case chronology

According to the multi-agency chronology prepared for the Serious Case Review and added to for this review, Sharon had 69 contacts with agencies concerning her daughter from the summer of 2009.

Sharon telephoned agencies on 19 separate occasions, and she persistently expressed her concern about her daughter Chelsey's relationship with Mr M.

Sharon, according to her family and friends, always put her family first and clearly tried her very best - with the support of those family and friends - to keep her daughter and granddaughter safe.

Most of the information on Mr M's background was not known at the time of his relationship with Chelsey, though he was described as *"posing a significant risk to Chelsey"* by Gwent Police as early as November 2010.

Chelsey has been described by Mrs D, Sharon's best friend, as *"head over heels"* for Mr M, unwilling to hear *"bad things about him",* or to end the relationship.

Chelsey and Mr M met in 2010 through the social networking site *Face book*. Chelsey was 15 at the time, and according to family and friends was an unsophisticated naive young woman.

Mr M was a 26-year-old man described later by his mother as a *"loner"*, who often travelled the country apparently aimlessly on trains. Mrs M stated that her son had originally been in a special school but then as he got older was moved to mainstream education.

She portrayed him as inexperienced in personal relationships and younger than his years. She acknowledged that she knew little of his day-to-day life.

Mrs M the mother of Mr M said that as a teenager Mr M used fire as a threat to control her.

She recalled that Mr M had set fire following an argument to her bed when he assumed she was in it, when in fact she had already left the house as she was scared of him , she believes he mistook the dog who was on the bed for her. The Fire services were called with two fire engines attending, however as it was Mrs M property that was damaged, she chose not to press charges - a decision she now deeply regrets

Mrs M describes other occasions on which Mr M interfered with her electricity supply in order to gain access to her flat and, she believes, to frighten her.

Mrs M stated that Mr M would call her and tell her to "*watch her electrics*". She describes him as carrying knives at all times, hiding them under chair cushions

where ever he sat so that he had easy access to them, and on one occasion holding one to her throat.

On this occasion there was a witness who called the Police; her son was arrested and a ‘panic box’ installed. Mrs M did not use the panic box because she was frightened and because she did not want to get her son into trouble. The panic box was later removed despite his continued threats.

Mrs M described Mr M as developing ‘problem drinking’ when he was 16, following his grandfather’s death. She stated she told family members at the time, and repeated to myself and the author of the Serious Case Review: *“drink, knives, anger - I was on tenterhooks - I was scared - I told my family something would happen one day”.*

Mrs M chose not to press charges on the fire to her home or on Mr M’s knife assault on her. At that time, she was frightened of him as well as concerned about her son. Mrs M recalls that she rang the Police more than ten times, who took him away - but he always returned.

Mrs M stated Mr M was supervised by the local Probation Service in the Greater Manchester area and seen by a psychiatrist. The National Probation Service (Wales) has checked with their colleagues in the Greater Manchester area and there was no record of him being seen by a Psychiatrist on Probation records.

It may be that he was known to the Youth Offending Service however I have been unable to confirm this.

Mrs M stated she learned of Mr M’s relationship with Chelsey from a relative. She said that she frequently spoke to Chelsey on the phone at length, telling her to ring the Police *“if he was “kicking off”.*

She stated she told Chelsey about the fire at her home, but that Chelsey did not believe her. She described jealousy being a feature in Mr M and Chelsey’s relationship, but that Chelsey was *“head over heels for him”.*

Mrs M informed me that Chelsey’s friends would speak to her during phone calls with Chelsey and repeatedly told her that Chelsey was only fifteen years old.

This family had experienced tragedy previously when Sharon gave birth to twin sons L and H. L died shortly after birth. Some years later Sharon, D and H were subject to carbon monoxide poisoning that led to the death of D. Sharon’s mother described the effect of the loss of D as devastating for all but that it had a long term impact on his twin Chelsey’s surviving brother. Albeit the previous loss has no connection to the DHR, the loss of children through tragic circumstances meant that Sharon was close to her surviving children and lived near her mother and step father as family was very important to her.

Chelsey was a pupil at Fairwater High School before she met Mr M, where her attendance was 95% (2009).

As the relationship with Mr M developed, from 2010 onwards, her school attendance suffered. Sharon liaised closely with the school and with the education welfare service.

Sharon accompanied her daughter to school but Chelsey would then leave the site without permission. At that time the family had concerns that Chelsey was with a group of friends who were felt to be more sophisticated than her.

Before Chelsey was 16 years old, there were concerns by Education that Chelsey may be having a relationship with an older man. It transpired that the man in question lived in Newport.

Concerns were also expressed about Chelsey being in a relationship with Mr M. A strategy discussion took place in November 2010. Police information shared during the 16th November 2010 strategy discussion was incomplete. The outcome of the discussion was that single agency enquiries under S47 of Children Act 1989 would be carried out by Social Services.

Three days after the strategy discussion in November 2010 Sharon assured the Police that to her knowledge the relationship between her daughter and Mr M was not sexual.

The Police checked Chelsey's phone and found no evidence that the contact was sexual. On the basis of this, Sharon's view of Chelsey's behaviour was accepted.

On the 21st November allegations about sexual assault were made by Chelsey's friend alleging Mr M sexually "touching" both her and Chelsey. According to the chronology, this was recorded by the Police but was not shared with Social Services.

According to Police and Social Services records, the police informed Sharon and Chelsey about Mr M posing *"a significant risk"* and discussed the concept of grooming.

In line with the All Wales Child Protection Procedures, a section 47 enquiry was initiated on the 8th December 2010. The section 47 enquiry was completed and closed the same day. It recommended that Chelsey receive some *"further work"*.

The nature of *"further work"* cannot be identified and does not appear to have been delivered by services. The Serious Case Review will highlight the compliance with Child Protection Procedures.

Child sexual exploitation is the coercion or manipulation of children and young people into taking part in sexual activities. It is a form of sexual abuse involving an exchange of some form of payment which can include money, mobile phones and other items, drugs, alcohol, a place to stay, 'protection' or affection.

The vulnerability of the young person and grooming process employed by perpetrators renders them powerless to recognise the exploitative nature of relationships and unable to give informed consent. There is no record of sexual exploitation risk assessment framework (SERAF) assessment being completed.

A sexual exploitation risk assessment framework (SERAF) which includes four categories of risk had been developed for inclusion in the All Wales Protocol. The SERAF enables safeguarding actions to be linked to evidence of risk, thereby facilitating both preventive action and appropriate interventions and is intended to inform appropriate responses in relation to children and young people's safeguarding needs.

Over the next five weeks (from 09.12.10 – 18.01.11), Sharon contacted the Police and Social Services four times, expressing significant concerns. These concerns were that Mr M- a man she had been told by Police was dangerous - was threatening her sixteen-year-old daughter via unwanted texts.

Mr M was also sending death threats to her son Mr H, for example *'threatening to slaughter him".* Sharon was advised to keep the texts and talk to the Police, and that a social worker would talk to Chelsey.

This approach again placed responsibility on Sharon and Chelsey to manage a man who posed a significant risk. It was at this point that Chelsey was sharing some information with her mother.

The relationship between Chelsey and Mr M continued in 2011. He was seen sleeping rough in the area and (separately) arrested on the 29th January 2011 for non-payment of fines.

At this point, information was requested from Greater Manchester Police on Mr M. Sharon was also visited by the Police but did not disclose a criminal offence, despite on the 18th January 2011 reporting him for threatening to slaughter Mr H in a text.

During this period, Mr M returned to Bolton: in April his mother rang the Police following another domestic assault by him on her.

In August 2011, Gwent Police received a third party report of Mr M physically assaulting Chelsey in a local park. Chelsey did not make any disclosure and denied any assault by Mr M.

The family state that Sharon tried hard to discourage her daughter's relationship with Mr M during this time, but that proved impossible as Chelsey was prepared to sleep rough with him.

Sharon and Mr P, her partner, tried another approach - that of involving Mr M in family meals and family life generally. However they were unable to sustain this approach because of Mr M's difficult and abusive behaviour.

Chelsey had bought a tent and they slept in this together near the house and then in the garden. Chelsey would come into the house to shower and eat. Mrs S, Mr P and Mrs D describe Sharon as exhausted by her attempts to keep her daughter 'safe ' from Mr M.

They feel she received limited help from services. They describe Sharon as keen to engage with any agency that she thought could help her.

Chelsey learned she was pregnant in October 2011. During the course of eleven subsequent health appointments (five with the General Practitioner) Chelsey could have been screened under the All Wales Care Pathway, which may have led to a DASH checklist being completed.

Family and friends describe Sharon as very supportive to her daughter throughout her pregnancy. In December 2011, it was confirmed she was pregnant with twins.

On 1st March 2012, Chelsey presented with week-old injuries at her GP surgery from *"falling down the stairs".* This is a common explanation for domestic abuse injuries and delayed presentation when seeking medical advice is a known risk factor identified in Royal College of General Practice guidance.

According to Mrs D, Sharon attended nearly all of Chelsey's ante-natal appointments and was concerned for her daughter's wellbeing.

Within five days of the birth of the twins on 10th March 2012, with Baby A stillborn and Mary a poorly baby, nursing staff identified Mr M as a problem.

Nursing staff requested information on Mr M from the health visitor; this information could have been accessed from the Social Services S 47 enquiry records, and at this point the Safeguarding Lead should have been alerted (Safeguarding Children: Working Together Under the Children Act 2004).

A member of staff from the Neonatal Intensive Care Unit (NICU) contacted Social Services on 2nd April 2012 and was then briefed about Mr M and concerns of grooming.

According to family and friends, Sharon supported Chelsey to express breast milk and continued to do so until May 2012, with Chelsey showing considerable commitment to her daughter.

Each evening after visiting the hospital, Sharon would speak with Mrs D and expressed her determination to support Chelsey and Mary - acknowledging that it may in the long run be her who would care for the baby.

The chronology refers to the health visitor checking with Sharon if events surrounding the twins A and M's birth had brought back memories of the birth of Sharon's twin sons, one of whom died at birth.

This was good practice and demonstrated either good local knowledge or thorough record checking. This conversation was followed up five days later by the health visitor, who visited Sharon at home. Sharon appears to have had a good relationship with Chelsey's health visitor.

On 17th March 2012, staff at the NICU observed inappropriate sexualised touching between Mr M and Chelsey (seven days after the twins' birth). The touching was perceived as being reciprocal, Chelsey was not considered to be vulnerable but immature.

At this time, NICU staff were not aware of the grooming concerns; they were made aware by Social Services on the 2nd April.

Later recording (3rd April) by the Special Care Baby Unit reinforces this view of Chelsey by describing her behaviour as *"not behaving appropriately with Mary".*

Sharon appears also concerned in that she asks specifically for any concerns about Chelsey to be reported to Social Services by health professionals. Mrs D states that Sharon was of the view that Chelsey away from the influence of Mr M was a good mother.

On 20th March 2012 the chronology states that the health visitor had a *"long chat"* with Sharon. The Health Visitor does not recollect any concerns being disclosed by Sharon.

In the summary report to the GP from the neonatal Unit on 28th March 2012, Chelsey is seen as complicit in the couple's presenting difficult behaviour in the NICU despite Mr M being told not to attend the Unit if drunk. At this stage domestic abuse in the form of coercion or controlling behaviour by Mr M is not considered as a possibility by health professionals.

Mrs D, Sharon's best friend to whom she confided in most days said that Mr M slept in the hospital chapel while Mary was in hospital and that this was known to the Chaplain as they had spoken with him. This was not known by health professionals caring for the family and so not recorded in the chronology.

It may be considered that in future the Chaplaincy share concerns with health professionals.

In the 2nd April 2012 NICU report known as SBAR (Situation, Background Assessment recommendations), staff report thinking that Chelsey may have *"learning difficulties".*

In the context of all the other risk and vulnerability factors previously mentioned, this additional concern amounted to sufficient evidence to make a child protection referral.

When on the 3rd April 2012 a referral is made by the NICU to Social Services, the concern appears to be for Mary and not Chelsey.

Chelsey is still a child and NICU are informed by the local authority that she was thought to have been groomed by a man who "posed significant concerns" he had also been observed by a midwife on the midwifery unit to have arrived and as a result had not been allowed to visit the Neonatal Unit.

The strategy discussion involving the Police and Social Services the next day agreed to undertake a single agency Section 47 assessment under the 1989 Children Act (Social Services records), despite being aware of Mr M ' previous convictions including 'threats to kill'. The Section 47 assessment commenced a week later on 11th April 2012. Chelsey a recently bereaved new mum appears to have been told

"To play a role in being proactive at Dad (MR M) being appropriate whilst on the Unit"

On 14th May 2012, a social worker contacted the Special Care Baby Unit and stated they would reopen the case owing to Mr M past convictions; the social worker requested NICU documentation and that NICU reports concerns regarding the parents' visits and parenting skills.

An initial assessment was commenced on the 16th May. At this point Social Services records describe Mr M as abusive to Chelsey and Sharon. The nature of the threats was extreme, for example *"to dig up baby A and to kill Chelsey so that Mary does not have her milk*". (Soon afterwards Chelsey gives up breastfeeding).

Social services referred Mr M to the Kaleidoscope project to address his alcohol abuse. He was also advised about his homelessness situation but records do not indicate whether his coercive and threatening behaviour was addressed.

A decision was taken to convene a child protection case conference. This decision was later revised and a decision to refer the family for intensive daily support to Chelsey to help her parent independently. According to Mrs D, these actions reassured Sharon.

By July 2012, Mr M was again homeless and not cooperating with Kaleidoscope, but from the chronologies, Social Services were unaware of his lack of engagement with the service.

Mrs D described Sharon's understanding of family focus intervention to me as confusing for Sharon, as when Sharon, Chelsey and Mr M were seen together on the 12th July 2012 they were asked to describe a perfect day and his perfect day did not involve being with his family but drinking alcohol.

The chronology indicates that his controlling and threatening behaviour was identified by Sharon as this was the reason he could not stay in her home; she described him to Social Services as *"controlling and paranoid".*

It was recorded that a safety plan was considered for baby Mary, who was still in hospital, but that this was not considered for Sharon or Chelsey despite Chelsey being described as *"not vocal"* and unaware of the risk posed by Mr M. According to family and friends, over the next few weeks Sharon's concerns mounted culminating on 13th August 2012 when Mr H, Chelsey's brother, believed Mr M was trying to procure Chelsey to a Polish lorry driver to gain money for alcohol, and Mr H alerted his mother and the Police.

This led to a family argument. It was at this point, Mrs D believes, that Sharon felt she would have to care for Mary as she believed Chelsey was choosing Mr M over her baby. Mrs D described Sharon as relieved that Chelsey had finally made a decision but sad that it was to put Mr M first for now.

On 15th August 2012, Sharon became aware that Mr M's behaviour had become more extreme and reported to Social Services that he told his mother (Mrs M) that baby Mary was dead and that Chelsey had told her mother that Mr M had been physically abusive to her.

This did not trigger any assessment of domestic abuse risk, or any attempt to seek specialist advice or a multi-agency approach to this complex situation. At this point Sharon decided she would not allow Mr M into their home and would no longer supervise contact between Mr M and Mary.

On 22nd August 2012 a discharge meeting took place at which Mary's need for oxygen was discussed, at the same time, discussed at the meeting was the inherent risks of having oxygen in a home. Although the Social Worker had earlier noted Mr M would not be present, according to NHS records, he appears to have been present. The meeting identified the need for careful management of the oxygen and its flammable nature.

On 28th August, the night before Mary was supposed to be discharged; Mr M used the oxygen as a threat.

Following an argument on the phone with Chelsey and Sharon, who were both at the hospital; he threatened to *"put on the oxygen"*.

Instead he caused damage to the home which had been prepared for Mary's discharge from Hospital.

The dogs defecated in the house and then escaped from the house. Mrs D describes the dogs as well behaved and not allowed upstairs; she believes they must have been frightened to soil inside the house.

On the 29th August 2012, Sharon B attended Cwmbran Police Station to report that Mr M had cut all the electrical leads in her home, snapped the key to the electric meter and taken her door keys.

The officer responded to this by obtaining a statement and reporting an offence of criminal damage, submitting a crime complaint and believing a proportionate safety plan was put in place, which included new locks being fitted to the address the same day.

The officer then briefed her acting Sergeant but the case was not prioritised and remained in the hands of the officer who took the complaint.

Bron Afon Community Housing were contacted by the Police on 29th August 2012 and arranged for the locks to be changed that day.

Bron Afon Community Housing understood the referral was due to domestic abuse by Chelsey's ex-partner but did not refer Chelsey or Sharon to Social Services or as a case to the daily Domestic Abuse Conference Call (DACC) which was operational in Gwent as they assumed it has already been referred.

Bron Afon Community Housing has since amended their procedure and now has a single point of contact for domestic abuse cases that works with all of the DACC cases to ensure this cannot happen again.

Training is being provided to all front line staff to ensure they understand why this process is to be followed

Analysis –the missed opportunities to intervene

The Home Office guidance for Domestic Homicide Reviews warns authors to be aware of hindsight bias and therefore it is critical that this report reflects the policy and procedural framework in place at the time.

Since September 2012, the changes that have occurred to policies are:

- Extending the definition of domestic violence and abuse to include young people aged 16 and 17
- Extending wording to capture coercive control

The new definition was implemented from 31st March 2013. Both of these changes may have afforded some protection to the B family. (Full definitions please see Appendix 3)

The Serious Case Review will highlight missed opportunities where Chelsey and Mary are concerned but as Sharon, Chelsey and Mary's needs were entwined I will acknowledge some of them.

In this report Gwent Police are referred to the Police and Torfaen Borough Council Social Care & Housing Service are referred as Social Services and Aneurin Bevan University Health Board services are referred to as Health

Identifying Mr M's early pattern of behaviour

Although outside of the scope of this review I will note that there appears missed opportunities around how Greater Manchester Police (GMP) managed Mr M ' abusive and threatening behaviour to his mother when he was both a child and a young person.

Agencies records in the Bolton area were not available to the review. According to Mrs M, he had threatened her violently with a weapon and damaged her property by fire with impunity as she as the victim was too fearful to press charges.

Clearly, by her behaviour and by her own admission, Mrs M was scared enough to ring the Police and seek help on at least ten separate occasions.

Access to the information held on Mr M in the Bolton area by agencies would have changed the actions according to the agencies on the review panel.

Referring Chelsey for possible sexual exploitation

Although this issue will be fully addressed by the Serous Case Review I will refer to it in some detail as it was an opportunity to intervene early in the events which lead to the death of three people.

In 2010 Sharon, Torfaen Social Services and Education Services all appear to have had concerns about grooming and possible child sexual exploitation not only related to Chelsey but also to a school friend.

These concerns did not trigger an appropriate risk assessment as laid out in the All Wales Child Protection Procedure which directs staff to complete a Sexual Exploitation Risk Assessment Framework (SERAF).

Later opportunities to complete a SERAF were also missed by the Police in November 2010 and by health professionals during her antenatal care and whilst at the Special Care Baby Unit.

It cannot be known what impact the completion of this assessment would have on practice. I acknowledge professionals' understanding of Child Sexual Exploitation was limited in 2010 but procedure relating to assessing and managing Child Sexual Exploitation was in place through the All Wales Child Protection *Procedures 2008.* The definition of Child Sexual Exploitation is:

The sexual exploitation of children and young people is a hidden form of

abuse though the concepts of exploitation and exchange are central.

Child sexual exploitation includes:

• *abuse through prostitution;*

• *abuse through using children to produce child sexual abuse images*

and material;

• *abuse through grooming whether via direct contact or the use of*

technologies such as mobile phones and the internet;

• *abuse through trafficking for sexual purpose*

Although Chelsey was 16, she was still a child and met that definition as had already provided a man ten years older than her a sexualised photograph of herself digitally. The Procedure goes on to advise:

"LSCBs [Local Safeguarding Children Boards] should ensure clear guidance and working protocols are in place describing arrangements to respond to concerns that children (including 16/17 year olds) are or may be being abused through sexual exploitation

The Safeguarding Children and Young People from Sexual Exploitation Supplementary guidance to Safeguarding Children*:* Working Together Under The Children Act 2004 Supplementary guidance to Safeguarding Children*:* January 2011

A sexual exploitation risk assessment framework (SERAF) which includes four categories of risk has been developed for inclusion in this All Wales Protocol. The SERAF enables safeguarding actions to be linked to evidence of risk, thereby facilitating both preventive action and appropriate interventions and is intended to inform appropriate responses in relation to children and young people's safeguarding needs.

A sexual exploitation risk assessment should be undertaken to establish if a child is in need and requires protection. This should be completed by Social Services, within 7 working days of the referral. The risk assessment will consider all the vulnerabilities and risks and place the child in one of four categories of risk: not at risk, mild risk, moderate risk or significant risk."

I understand that this approach to Child Sexual Exploitation was systematically applied by all Torfaen services from early 2011 but prior to that the social services had referred to Barnardos SERAF Service for individual services from 2008.

Gwent Police launched Operation Artemis (now ceased) in March 2011 to tackle the sexual exploitation of children, following concerns raised by children's services

department over a pattern of behaviour that had appeared in Newport and Torfaen, concerning adolescent teenage girls displaying risk taking behaviours.

By 2014 three quarters of their staff had been trained in indicators and procedures around Child Sexual Exploitation but in 2011 this knowledge and skills was limited to some staff.

As early as 8th December 2010, professionals had used the term *"grooming"* when relating to Chelsey's relationship with Mr M. I understand the SERAF risk assessment tool did not become standard practice for Social Service Managers until August 2011 but Social Services did have other tools in place to manage risk.

Sexual Exploitation had been considered in late 2010 by agencies involved and had a SERAF been completed on Chelsey, the age difference between her and Mr M would have been sufficient to place her in the mild to moderate risk category as that age difference is identified as a significant risk factor.

This coupled with the risk factor of her leaving school premises would have meant Chelsey met the threshold.

The Social Services Department disagree with this position stating that the known information relating to Chelsey would have placed her at low risk as she had a protective and proactive parent.

However In my opinion though this is disputed by Social Services and Gwent Police neither was Chelsey spoken to about keeping safe or work undertaken to build her self esteem /resilience to the pressures from Mr M or others.

SERAF identifies actions to be undertaken at the different levels of risk. For no current risk to mild risk they suggest:-

- Educate to stay safe;

- Consider multi-agency meeting to share information and agree a plan to address risk and/or need;

- Work on risk awareness and staying safe should be undertaken with this child/young person;

- Review risk following any significant change in circumstances.

On 19th and 20th November 2010, Sharon contacted the Police on three occasions to report her concerns about her fifteen-year-old daughter seeing a man who was ten years her senior when she should have been in school; and who then sent her threatening texts.

On the 20th November 2010, Sharon reported that Chelsey's friend alleged Mr M had assaulted her and *"touched" Chelsey* sexually; Chelsey admitted sending a *"special photo"* to him of her in a partially undressed state (now known as sexting). A Police National Computer (PNC) check on Mr M revealed flags for weapons and violence.

In my view (though others members of the panel disagreed) all of these factors indicate child sexual exploitation and at this point a SERAF should have been completed or at very least Chelsey offered advice and guidance to deal with the complexities of 'grooming'. Social Services dispute this stating this was undertaken during the Section 47 enquiries.

The panel wish to note that these factors were also indicators of domestic abuse and should have led professionals involved with Sharon and Chelsey to consider domestic abuse.

The links between Child Sexual Exploitation and domestic abuse can be part of the same continuum and professionals can get diverted by the need to categorise these vulnerabilities. However in this case neither concerns resulted in a specific risk assessment being completed or a risk management plan being followed.

Early awareness of healthy and unhealthy relationships

Chelsey received limited information at school about healthy relationships; a play about domestic abuse had been delivered at Fairwater High school previously but it has not been possible to trace if Chelsey attended.

The review panel and Sharon's family and friends are unanimous in the view that all children and young people should have consistent education on healthy and unhealthy relationships from a young age with a view to increasing their understanding and awareness of healthy relationships so building resilience to controlling and abusive relationships in the future.

A more supportive approach from education services

From the chronology supplied, the content of the education welfare contact with Sharon and Chelsey appears punitive. A more supportive and reflective approach may have engaged Chelsey at an early point.

The focus on attendance may well meet targets but did not appear to encourage exploration with Chelsey of *why* she was absent; concerns around grooming should also have triggered a more compassionate response.

The School appears to have accepted Chelsey's truanting was "less urgent as she neared 16 " as opposed to concerns about what she was doing when she should have been in their care.

Frequency and patterns of service contact should feed into risk assessment

In December 2010 and January 2011 Sharon made four calls to the Police and Social Services raising significant concerns about her daughter's safety.

This number of calls in a short period appears not to have impacted on these agencies' assessment of risk. A pattern of frequent calls where there is low risk often goes unnoticed - but these calls was from a family who had already been warned about how the alleged perpetrator *"posed a significant risk".*

The nature of the threats was to cause *"death"* or *"slaughter"* and therefore should have been considered from the perspective of child abuse. Some of the panel expressed the view that the prevalence of domestic abuse can lead to professionals seeing the behaviours as less risky than they are. Therefore the systematic use of appropriate assessment tools should be central to practice.

Missed opportunities to undertake DASH assessment

The Completion of any risk assessment is not an end in its own right it does not equal making someone safer, it helps to inform action which is still decided upon and carried out by professionals who mainly help someone to make themselves safer.

It does however ensure that victims views are systematically taken into account and leads to multiagency processes and robust safety planning.

In late December 2010 and early 2011 Sharon and Mr H were Chelsey's main protection against Mr M despite Chelsey's determination to be with him.

This highlights the concern that third party or family members can be at risk and that this risk can escalate as they attempt to protect their loved one.

Mr M's threats to Sharon and Mr H is identified in the Police IMR it was investigated and no offences were disclosed.

Although Chelsey was under 18 years of age, the principle of a domestic abuse investigation should have been considered, leading to the completion of the DASH risk checklist.

Undertaking DASH may have led to checks into Mr M's history and could have led to a MARAC referral (if informed by full disclosure from Greater Manchester Police of the three previous threats to set fire to homes and the actual fire he started in his mother's bedroom).

I acknowledge that at this time it was unlikely that Chelsey who was described as being *"head over heels"* for Mr M would have disclosed sufficient concerns herself;

professional judgement, informed by knowledge of Mr M's previous behaviour and the family's known concerns risk management, should have weighed in favour of a plan/safety plan.

Between 09.12.10 – 18.01.11, Sharon contacted the Police and Social Services four times, expressing significant concerns. These concerns were that Mr M- a man she had been told by Police was dangerous - was threatening her sixteen-year-old daughter via unwanted texts.

Mr M was also sending death threats to her son Mr H, for example 'threatening to slaughter him". Sharon was advised to keep the texts and talk to the Police, and that a social worker would talk to Chelsey.

This approach again placed responsibility on Sharon and Chelsey to manage a man who posed a significant risk. It was at this point that Chelsey was sharing some information with her mother In January 2011.

Gwent Police requested information from Greater Manchester Police following a report of Mr M sleeping rough. Had this been shared appropriately when it was received, it should have raised concern about Mr M's behaviour and to a decision to put in place, or at least consider a Child Protection referral and a risk management plan.

The Gwent Police IMR refers to the information being in a format which was not user friendly, the Impact Nominal Index system indicated that four Forces had information on Mr M and this was not followed up.

I am aware that Gwent Police has introduced the Niche system in February 2014 and is sure this situation where they would hold such vital information and not share it internally or with partner agencies would not now arise.

They plan to hold briefing events in April 2014 on what both the Police National Database and NICHE can provide partner agencies to manage the expectations that they can access in real time all the background information and intelligence on an offender.

In August 2011 Gwent Police received a call from Chelsey's friend to say a male was hitting her friend. The Police attend and accepted the explanation of "*play fighting"* despite the significant age difference.

As Chelsey did not engage or disclose domestic abuse the incident was accepted at face value and no checks were made. Although DASH was not considered as Chelsey was under 18 years old, a referral should have been made to Social Services as Mr M was an adult nearly ten years her senior.

On 15th August 2012, Sharon became aware that Mr M's behaviour had become more extreme and reported to Social Services that he told his mother (Mrs M) that

baby Mary was dead and that Chelsey had told her mother that Mr M had been physically abusive to her.

This again did not trigger any assessment of domestic abuse risk, or any attempt to seek specialist advice or a multi-agency approach to this complex situation. At this point Sharon decided she would not allow Mr M into their home and would no longer supervise contact between Mr M and Mary.

Sharing information with NHS professionals

From the chronology it would appear health professionals saw Chelsey and Mr M as a conventional couple despite the significant age gap and her youth.

It would appear that Neonatal Intensive Care Unit (NICU) staff were not initially privy to the grooming concerns, or to the fact that Mr M was a man who *"posed a significant risk".*

The NHS Independent Management Review (IMR) has recommended that the Lead Safeguarding Professional should be informed if any future child known to Social Services is known to NICU so that they can be fully informed; this is particularly important as when a baby is admitted to NICU it is of course a crisis time in the health of the infant, a stressful time for the parents and a busy time for staff.

Assessment by NHS professionals

The chronology describes health professionals as not recognising a 16/17 year old pregnant young woman with twins as a child or as potentially vulnerable, and this was perhaps influenced by the presence of her mother who appeared to be very supportive.

The IMR does not indicate that health professionals asked Sharon, Chelsey's mother, if she had any concerns about her young pregnant daughter and her older boyfriend.

Later Sharon expressly asks if health staff will report any concerns they have about the couple to Social Services. Mrs D believes Sharon felt she was sometimes seen as *"too involved"* and that her *"taking over"* was preventing Mr M from taking more responsibility. There is no evidence in the chronology or the Health IMR to suggest this was the case.

In March 2012 when the Health Visitor who knew the family well had a 'long chat ' with Sharon the recording does not identify any risks or action taken. Even if Sharon had not disclosed any concerns all were aware that here was a risky situation with a vulnerable baby, a new young and recently bereaved mother, and a man who had been described as "posing a significant risk" with an alcohol problem as a father.

The chronology does not record any attempt to see Chelsey alone to discuss these concerns in line with the procedure identified in the All Wales Ante Natal Care Pathway. However the Health Visitor would have planned to visit the family on discharge from the hospital

The All Wales Domestic Abuse Care Pathway places responsibility on Health professionals to ask pregnant women and those in the ante natal period about domestic abuse.

The chronology could not identify that Chelsey was directly asked about domestic abuse and the responsibility defaulted to Chelsey to disclose.

The Care Pathway rationale is very clear that victims of domestic abuse are unlikely to disclose if not asked. Although Chelsey was seen on only two occasions, the All Wales Care Pathway makes it explicit that every contact must count as it may be the only contact a victim has with services.

In the summary report to the GP from the neonatal Unit on 28th March 2012, Chelsey is seen as complicit in the couple's presenting, difficult behaviour in the NICU despite Mr M being told not to attend the Unit if drunk.

At this stage domestic abuse in the form of coercion or controlling behaviour by Mr M is not considered as a possibility by health professionals

Midwifery assessment

During Chelsey's antenatal care, I believe the midwifery service – who Chelsey saw on two occasions - might have acted differently had they known about the previous concerns around grooming.

Owing to Chelsey's age and to the significant age gap between her and Mr M, Child Sexual Exploitation should have been considered.

There is however no evidence that her age and level of maturity, the age gap, her situation and the nature of the relationship with Mr M either appeared problematic to staff or raised professional curiosity.

I do note that as the pregnancy continued the complications it presented were inevitably the main concern for clinical professionals.

GP assessment

Sharon received general healthcare from her GP during this period. There is no evidence that she disclosed her concerns to her GP, who she had known for many years.

Chelsey went to see the GP on 1st March 2012 with late presentation of injuries from *"falling down the stairs";* although this may be the case it should have aroused professional curiosity.

Chelsey was a vulnerable young woman, pregnant with twins and presented with what is a common excuse for domestic violence injuries.

The Royal College of General Practitioners guidance on domestic abuse identifies late presentation, pregnancy and vulnerability as indicators that should lead to consideration of domestic abuse and identifies appropriate actions.

For the GP these are to:

- Consider the possibility
- Emphasize confidentially
- Ask the question
- Document
- Photograph
- Assess present situation
- Provide information
- Devise a safety plan

It would appear this guidance was not followed and Chelsey was not asked directly by her GP.

NICU assessment

Sharon voiced her concerns to NICU staff on the ward stating she wanted them to report to Social Services if they had any concerns.

Health professionals did not acknowledge the possibility of domestic abuse and focussed on Mary's health needs - which were significant.

After the trauma of the birth of Mary and the stillbirth of A records do not indicate any acknowledgement of Chelsey's vulnerability. The relevant NHS Lead Safeguarding Professional was not alerted.

The chronology indicates that the staff in the NICU after Mary's birth perceived Chelsey's behaviour as colluding with Mr M in *"inappropriate behaviour"* and that she was *"immature".*

Health professionals failed to consider that this immature behaviour could be as a result of grooming or control by her older partner who although they had not observed any aggression from him had been described by other professionals as *"aggressive both physically and verbally"*.

In my view this narrow perspective prevented health professionals who were ideally placed (in that they could have one-to-one conversations with Chelsey due to the long term nature of the admission) from identifying these behaviours as indicators of risk to Chelsey.

The staff in NICU appeared to not perceive Chelsey as a child though made a child protection referral for Mary. This could also have been an opportunity to consider the risks Mr M posed to Chelsey and Sharon and to trigger a DASH process.

The NICU supports many families under pressure and the rational for the All Wales Domestic Abuse Care pathway is that risk of domestic abuse increases in both pregnancy and in the post-natal period.

Therefore staff at such a key pressure point with significant exposure to parents' behaviour should be familiar with domestic abuse risk.

Social Services action

The involvement of Social Services will be reported in more detail within the Serious Case Review.

However it would appear opportunities were missed which should have triggered Child Protection processes such as to proceed to child protection conference were not followed and that decisions were made without an understanding of Mr M's coercive and controlling behaviours.

Sharon's willingness to cooperate with services was demonstrated by her calling Social Services repeatedly throughout the period under review.

After Mary's birth Sharon called asking if she could allow Mr M back into the house to wash so that he could visit Mary and told that as no child was in the house the decision was theirs, however Chelsey, a child was living at the property.

Sharon and Mr P agreed to give him another chance to stay at the house. Sharon's reassurance appears short-lived however. By the 12th June 2012, she was again raising concerns to the social worker about Mr M's behaviour, drinking and the impact he was having on Chelsey's confidence.

These concerns did not change the Social Services approach and the plan to continue with the Family Focus Team intervention remained in place.

Social Services knew that Mr M had been threatening and on one occasion physically abusive to Chelsey and that he had been described as *"controlling and paranoid"* by Sharon Chelsey's mother.

The procedure for dealing with domestic abuse is laid out in Safeguarding Children and Young People Affected by Domestic Abuse 2011, part of The All Wales Child Protection Procedure 2008.

It provides practice guidance on safeguarding children who, through being in households / relationships, are aware of or are targeted as part of domestic abuse. It aims to: protect the children, support the non-abusive partner; hold the abusive partner accountable; and improve the children's resilience.

The document identifies in 6.14:

"Like all service users, individuals who experience domestic abuse are entitled to a confidential service. The importance of confidentiality is enhanced by the fact that adults and children may be at risk of further abuse if the abusive person becomes aware that the victim has spoken about the abuse to an outside agency".

The record acknowledges Chelsey does not define Mr M's behaviour as abusive but Sharon does. However the chronology indicates that Sharon, Chelsey and Mr M were seen together and the next day Chelsey and Mr M were requested as a couple to attend the Social Services office, where again they were seen together.

According to the chronology, at no point was an attempt to see Mr M made or to hold him to account for his abusive behaviour. Social Services were aware of a 'physical altercation' between Mr M and Chelsey on the 15th August 2012. This behaviour was not explored or recognised as domestic abuse.

A significant missed opportunity by Social Services was on the 28th August 2012 when Sharon reported the damage to the property and the threat Mr M had made to turn on the oxygen". Sharon was advised to report this to the Police who were unaware of the oxygen at the property.

Mr M demonstrates controlling behaviour with agencies; for example, he contacted Kaleidoscope to say he did not need their services as he was doing well.

The contact between Kaleidoscope and Social Services appears to lack clarity with the social worker believing Mr M had met with the alcohol support worker on three occasions, and Kaleidoscope recordings indicating that Mr M stayed for five minutes on the last two occasions.

This information was not passed on to Social Services.

Police recognition of domestic abuse

On 28th August 2012 following the discovery of the damage Sharon believed Mr M had caused at her home and the distress she reported to family members that had been caused to the family pets; Sharon phoned Social Services.

She then followed their advice by reporting the next day to Gwent Police the damage to her home and the stolen house keys.

These offences, whilst clearly meeting the Home Office definition of domestic abuse, were dealt with and recorded as criminal damage; The Gwent Police IMR disputes this stating “the definition of domestic abuse would not have applied for example where damage to property occurred”

This narrow and flawed approach failed to identify Sharon and Chelsey whose property had been damaged as victims of domestic abuse, Chelsey was not spoken to.

As a result, a DASH assessment was not triggered and no domestic violence flag placed on police systems for this address.

The panel further noted that criminal damage is an essential but often overlooked element of emotional abuse in an abusive relationship.

According to the Police Officer who took the details from Sharon she did not see the full extent of the frequent and threatening texts being sent by Mr M. Chelsey, whose whereabouts were known, was not offered advice.

According to the IPCC report, the officer’s supervising Sergeant did not interrogate or scrutinise the frontline officer’s judgement and actions. As a result, Mr M was not apprehended or spoken to despite periodically living in a tent in the front garden of the family home. (A tent that, the visiting neonatal nurse has seen on her recent visit). .

Because the Police Officer who spoke with Sharon did not recognise the incident as domestic abuse and that the intent behind the damage caused by Mr M was to

frighten or control the family, she failed to acknowledge the threat, risk and harm involved.

Mr M's details should have been passed to the next shift and a search for Mr M as a priority and if located arrested by Gwent Police. The Gwent Police IMR states they would not have had sufficient evidence to charge Mr M on suspicion of causing the criminal damage; and that in their view the damage was not significant.

The Police IMR acknowledges they had sufficient cause to arrest him. All Domestic Abuse training recognises that domestic violence is not an offence per se it can take many forms and can present as a wide range of offence types and that coercive control through isolation, intimidation degradation and micro- regulation of everyday life are key tactics used by perpetrators.

The Gwent Police IMR whilst it accepts a DASH could have been completed on the 29th August 2012, second guesses the potential of this approach and takes the stance that it would not have afforded Sharon and Chelsey protection.

Earlier in the IMR their chronology states it provides "details of continual management and decision making in relation to risk management of offenders and victims of crime ".

This is clearly not the case each incident reported by Sharon was dealt with in a standalone manner and no domestic abuse risk assessments were undertaken.

This meant the context and pattern of Mr M's offending behaviour was missed and that they were unable to identify the escalation in the severity of abuse.

That the abuse had escalated from threats to premeditated and targeted damage of property intended to frighten and intimidate. The theft of the house keys meant Mr M could come and go as he pleased. There is no evidence of any consideration by Gwent Police of Mr M's intent.

The Officer believed that Sharon did not present as frightened of Mr M, demonstrating a lack of understanding of the nature of the dynamics of domestic abuse. This case is now used in training by Gwent Police.

The Officer responsible for apprehending Mr M spoke with Sharon again on the 10th September 2012 and agreed that the alleged victim should bring the alleged perpetrator of the Criminal Damage to the Police station; it seems extraordinary that a victim of crime was expected to do this.

However the Police have stated that their action to ask Sharon to invite him in for interview by them and not arrest is becoming common practice in non domestic incidents.

According to the Gwent Police report within the HMIC report March 2014 Everyone's business; improving the Police response to Domestic Abuse

"The force does not have a specific domestic abuse policy or procedural guidance in relation to the identification and response to incidents of domestic abuse.

The implementation of a specific policy would provide clarity, understanding and consistency in how the force responds to domestic abuse reports."

Risk assessment in isolation

The health visitor visited Chelsey at home on the 5th September 2012 and, according to the NHS IMR, was aware that Mr M had entered the home and cut the electrical cables.

The health visitor would have been aware that baby Mary would need oxygen on discharge. However the health visitor did not then check with the Police and Social Services to establish what action was being taken despite the fact that she would have been very aware of the imminent discharge of a very vulnerable baby to this address and family.

This is one clear example from this case of a professional assessing risk in isolation. The training staff receives on domestic abuse makes it very clear that multi-agency responses are the most effective.

From the chronologies available, it would appear that all three agencies - the Police, Social Services and NHS - were assessing risk in isolation.

The Independent Police Complaints Commission report outlines that the Police officer on duty who took the complaint dealt with it as a criminal damage rather than a domestic abuse incident. The officer did not make the appropriate checks on Police systems or perceive Sharon as a family member, or Chelsey as an intimate partner of the alleged offender; also because of Chelsey's age, the officer chose not to complete a DASH risk checklist.

We have no knowledge of what Sharon did say when making the report. According to family and friends; Sharon was very worried about what Mr M would do next. However this is not borne out by the statement Sharon gave to the Police.

The officer responded to this by obtaining a statement, submitting a crime complaint and believing a proportionate safety plan was put in place, which included new locks being fitted to the address the same day.

The officer then briefed her acting Sergeant but the case was not prioritised and remained in the hands of the officer who took the complaint.

The Independent Police Complaints Commission (IPCC) report identifies the failure to check Police systems and the lack of scrutiny by the supervisor as leading to a police response that was inappropriate and insufficient.

Gwent Police Independent Management Review disagrees with the findings of the IPCC stating that the Police Officers response was proportionate to the information disclosed by Sharon whilst they accept the Officer failed to understand the wider context.

In the process of conducting this review I have received a one to one presentation on the Police National Database and to search a full background check on Mr M by an experienced user would take over 3 hours, this means it cannot provide real-time informed responses at incidents such as domestic abuse. For example the alleged play fight between Chelsey and Mr M may have been responded to differently had the Officer attending known his background. The newly adopted NICHE system could within five minutes provide a pattern of local calls and alert an Officer to patterns of risky behaviour. Currently I understand Niche is in 16 Police Forces.

- **Information sharing**

Sharon B provided agencies with enough information for a domestic abuse risk assessment (DASH) to have been triggered.

DASH questions act as both an aide memoire to the professional about risk in a domestic context, can be powerful in helping to highlight the level of risk for that professional and can be a trigger to those answering as to their level of risk.

Social Services and Police staff dealing with the offences of 29th August 2012 did not apply their knowledge, experience or skills to identify the dynamics of domestic abuse. The Police Officer who spoke with Sharon was a Probationer (a newly qualified Police Officer).

The Social Worker failed to recognise the risks the situation presented or identify Chelsey as also a child. The Social Worker who spoke with Sharon appeared reassured that the Police were going to be dealing with the risks and that Bron Afon Community Housing was to secure the property.

The HMIC report in March 2014 Everyone's business, improving the Police response to domestic abuse states that domestic abuse is linked to 8% of crimes, as core business for the Police Force it should be that all operational staff can competently identify domestic abuse and manage the risks it poses.

Information sharing appears incomplete, existing intelligence was not accessed on every occasion possible, and an INI check was completed but not followed up as the process was time consuming so the information did not shape the response.

As a result, information on the pattern and evolution of abuse by Mr M was not effectively captured, shared or analysed.

As a result of that, the service response offered to Sharon and Chelsey - and the management of Mr M– was inadequate. Information sharing is effective when used to provide an intelligence-led approach, whereby professionals use their judgement to identify risk and act on it, such as educating/ asking and offering support to Chelsey and her family, and challenging the perpetrator's behaviour.

Conclusion and Recommendations

These recommendations are made unanimously by the review panel. Although we cannot say they would have prevented this tragedy, it is our professional judgement that once instigated these changes would reduce the likelihood and risk of a similar tragedy happening again.

Gwent has a strong history in training professionals to identify domestic abuse; however this tragedy highlights that procedures such as the DASH Risk Assessment and Multi-Agency Risk Assessment Conferencing were not considered.

This review indicates training and the procedures to manage domestic abuse threat risk and harm were not comprehensively adopted in frontline staff's practice, in managers' oversight of that practice, nor in leadership's scrutiny of policies and procedures.

Sharon believed Mr M was abusive to her, her daughter and threatened her son and according to Mrs S she feared for her granddaughter if brought up by him. She shared some information and sought help but was not versed in the language of child sexual exploitation or domestic abuse.

Chelsey may not have believed Mr M was abusive, but Chelsey was a child and a victim. Our role as professionals is to use our knowledge and skills to inform our professional judgement, to provide information about risk, and to manage risk even when victims are not seen as cooperative.

The panel recognise that amongst its frontline staff there is a range of experience and that those with limited experience should be encouraged to seek advice and support with these complex cases.

That the role of managers is to ensure staff are professionally curious and able to identify the dynamics of domestic abuse and know what to do and where and when to seek specialist advice.

Victims of abuse normalise to abusive behaviours and often cannot acknowledge the abuse they live with day in, day out. Other victims may recognise they are abused but are afraid to seek safety, and/or have little faith in our ability to make them safe.

All services must be proactive if we are to overcome the barriers to improving the safety of victims and their families.

The Review Panel is keen to ensure that the recommendations are simple, practical and measurable. It is our desire that implementing these recommendations will be straightforward and that impact can be appropriately evidenced.

The NHS and Bron Afon Community Housing have already made changes to improve their internal practices around domestic abuse.

Bron Afon Community Housing has ensured all Police requests for target hardening for domestic abuse are referred on, and is leading the way for Welsh Registered Social Landlords in the training of its maintenance staff to identify and refer domestic abuse.

The NHS has ensured that NICU staff now contact the Lead Nurse for Safeguarding when they come across children known to Social Services, and are to integrate child sexual exploitation awareness into their Safeguarding training.

Kaleidoscope the Substance Abuse Service Mr M was referred to have agreed to review its documentation about risk in both the questions they ask of referrers and how they alert referrers to a service user's engagement and response. They will also now, monitor their cross referrals with specialist domestic abuse services.

The expressed concern over the lack of perpetrator programmes available, an issue I am aware will be discussed within the Local Service Board.

Gwent Police In April 2014 acknowledged the missed opportunities to identify Child Sexual Exploitation they will now include this case into their Child Sexual Exploitation training "confronting the issue of inappropriate age relationships".

They also acknowledge the missed opportunities to identify domestic abuse and complete the DASH risk assessment especially around coercive controlling behaviour and are reflecting on how they can address this gap in Officers knowledge and behaviour.

The HMIC recommendations for Gwent Police include 'that the Force should provide clarity when a DASH is completed and improve the supervision of DASH forms.

National-UK

Recommendation 1 - Flagging of perpetrators who use fire as a weapon

That the Home Office reviews the existing system of flagging of perpetrators using guns and knives on the Police National Computer and the Police National Database and to extend the flagging system to include perpetrators who use fire as a weapon in a domestic context.

Victims of domestic abuse consistently report the threat of arson by partners and ex-partners as a significant concern.

The Fire and Rescue Service offers safety advice to victims of domestic abuse and attends MARAC in many areas. Adopting this recommendation will enable perpetrators who use fire in a domestic context to be monitored across all Police force areas in England and Wales, ensuring that when a perpetrator moves around the country this intelligence will follow them and inform multi-agency safety planning.

Recommendation 2

Future revisions of the Domestic Abuse, Stalking and Honour Based Violence Risk checklist (DASH) are revised to include the threat of arson or history of fire setting..

Recommendation 3

That the NICHE system be recommended for National roll out to ensure information between forces is shared in an accessible and format which allows it to inform real time Police responses to offenders.

National-Wales and Gwent wide

Recommendation 4 – Safeguarding of third parties

That the Welsh Government's Christmas domestic abuse TV campaign that focussed on third party reporting by a family member is re-run as and when finance permits.

The materials from 10,000 Safer Lives the Welsh Government domestic abuse campaign should also now be used in all current Welsh Government family intervention programmes and in schools, forming part of the healthy schools package delivered by the All Wales Schools Programme, which reaches 98% of schools across Wales.

The uptake of its Safer Relationships module varies significantly across Wales and Torfaen should identify which Secondary Schools so far have not taken up this offer of free materials and inputs for schools.

Local domestic abuse service providers have significant material which should be displayed in all settings where young people are present.

That domestic abuse service providers ensure their promotional / advice literature and websites are clear that concerned relatives can access advice, information and support and identifies the risk this poses to them as individuals.

Cultural change

We acknowledge that throughout this review the family sought help on many occasions and were cooperative with agencies. This report identifies the need for cultural change across all agencies in their response to domestic abuse, and we wish to create a culture that is open, encourages learning and that makes the service user/citizen more demanding of services.

The assurance that public service leaders have received on staffs' ability to identify and act on domestic abuse is challenged by the facts set out in this report.

In order to create a positive culture for the identification and management of domestic abuse for victims, their families and perpetrators, we need to have a confident and competent workforce who put into practice the training they have received.

We require a climate where it is seen as good to acknowledge our limitations and to seek advice from line management and specialist services - and we need a zero tolerance to target-driven behaviours that lack compassion.

For this positive culture to permeate organisations, staff at all levels including the leadership should question our ability to listen to victims, provide realistic responses based on professional judgement and approved risk assessment tools, and to act robustly to manage alleged offenders.

Recommendation 5- cultural change through education

That young people's resilience is developed through education so they can better face domestic abuse, sexual abuse and sexual exploitation both in the online and offline world.

The proposed Gender-based Violence, Domestic Abuse and Sexual Violence (Wales) legislation for Wales plans to take this forward through a 'whole school' approach.

The current All Wales Schools Programme, although well regarded, is both expensive and limited in its capacity to deliver as it is staffed by Police Officers.

In order to increase capacity and to recognise that many young people will not feel comfortable with disclosing information that could lead to the arrest of a parent or intimate partner to a Police Officer, the voluntary sector should be considered as a delivery mechanism for the future delivery of this programme.

That Gwent undertakes a pilot of this approach in schools, colleges, pupil referral units and youth service settings and does not wait for the legislation.

A wide range of agencies have existing 'healthy relationships' packages but need staff for pilots. We are aware that there are cost implications when increasing the frequency of delivery - but the costs of not informing young people are more significant.

An 'invest to save' bid could be considered as this proposal fits the criteria of a prevention approach.

Recommendation 6- cultural change in public agencies

That Gwent agencies, which have a good history of training around domestic abuse and the use of the Domestic Abuse Stalking and Honour (DASH) assessment tool, immediately ensure that all agencies need to have procedures in place to ensure a DASH form is completed for all identified victims of domestic abuse. Once completed, a victim could be referred to MARAC and /or a standardised safety planning tool may be used.

The proposed Gender-based Violence, Domestic Abuse and Sexual Violence (Wales) legislation will place a duty on Wales' public bodies for staff to 'ask and act' about domestic abuse.

All professionals will be required to pro-actively enquire about domestic abuse and act upon information in order to seek to protect the victims they are in contact with, whatever the context of their relationship with that victim.

All agencies need to have procedures in place that ensure a DASH form is completed for all identified victims of domestic abuse.

This case highlights that agencies and professionals do not have access to a standardised safety planning tool and we recommend that this is developed and piloted by the pan Gwent Domestic Abuse Forum. This will ensure consistency across services for victims, whoever they choose to disclose to.

Recommendation 7 - Cultural change in leadership

Torfaen Local Safeguarding Children Board (superseded by the South East Wales Safeguarding Children Board in April 2013) states it had undertaken a proactive approach to Child Sexual Exploitation from late 2011 with the then Operation Artemis.

Their IMR notes that training to identify grooming was cascaded from 2008 onwards although grooming was identified in this case no appropriate action was taken to address it.

That an appropriate response to Child Sexual Exploitation using the Grooming training or SERAF model was fully operational was the responsibility of the then Local Safeguarding Children Board and ultimately the Local Service Board in Torfaen.

We recommend that future revisions of or additions to the All Wales Child Protection Procedures which are not being delivered systematically in Torfaen are identified by agencies as a risk and made known to the South East Wales Safeguarding Children Board and the Local Service Board this will ensure the LSB Executive Leadership

Group can review risk, understand what measures are in place to mitigate risk and ultimately hold agencies to account.

Gwent Police according to the HMIC March 2014 Domestic Abuse Inspection report identified that the force does not have a specific domestic abuse policy or procedural guidance in relation to the identification and response to incidents of domestic abuse.

That this gap in policy and procedure is addressed to ensure frontline Police Officers and staff has clarity, middle managers have a process to scrutinise and the leadership a clear and publically well defined position.

Recommendation 8 Mandatory training

Despite extensive domestic abuse awareness and DASH training availability in Gwent (more so than in the rest of Wales), existing courses are undersubscribed wasting valuable resource. The Social Services Department are now undertaking DASH Training and Gwent Police are incorporating details from this case into their training to ensure Domestic Abuse is identified.

Agencies must ensure all staff receive appropriate fit for purpose training and monitor attendance. A systematic approach to ensure all staff is appropriately trained is a management responsibility.

Recommendation 9 Cultural change with focussed training outcomes which address alleged perpetrators and ensure victims are referred to specialist services

The failure of services to engage the alleged perpetrator of domestic abuse in this case suggests that this is a skill that needs to be embedded in existing training.

The skills of engaging and challenging perpetrators are already present in the criminal justice workforce and these should be translated to the social care, substance abuse and other relevant public service workforce.

This creates a culture where all staff feels confident and are skilled to engage alleged perpetrators, both safely and constructively (for themselves as well as for victims and their families).

That the resources and content of training be reviewed to ensure that the outcome is an increase in referrals and relevant and proportionate information sharing in domestic abuse cases. That this review addresses

- The identification and management of perpetrators
- How management can provide effective monitoring and oversight of practice

Recommendation 10 Intervening early for vulnerable children and young people

Sharon expressed her concerns about her daughter frequently to agencies. We consider that these were perceived as low risk because at no point was a risk assessment generated.

Managing these high volume low risk concerns is a recognised challenge, but effective models do exist. For example, in Northern Ireland, the Early Authoritative Intervention adversity matrix is a model where the threshold to intervene lowers as the frequency of concerns increases, thereby ensuring that low-risk-high-volume cases are not ignored.

In Gwent the nearest model to this is the Gwent Missing Children Hub.

We recommend that the Gwent Missing Children Hub model is expanded to address teen domestic abuse and child sexual exploitation cases, where a child or young person may not be missing but where there are frequent concerns expressed by Recommendation agencies or families.

Recommendation11 Provision of a Young Person's Independent Domestic Abuse Adviser role

Correspondingly, the multi-agency nature of the response and the specialist CSE input by Barnardos into the Hub will need to be enhanced by the addition of a Young Persons Independent Domestic Abuse Advocate.

We recognise this will require funding but at present much agency time is spent in an uncoordinated response to these young people, and a coordinated response promises far greater efficacy.

Recommendation 12– Routine Enquiry audit

Within the ABU Health Board the All Wales Routine Enquiry is fully embedded in practice.

An audit to be undertaken on the extent to which Routine Enquiry has been implemented and an action plan developed to address any issues identified.

The Health IMR acknowledges there is no evidence that the All Wales Domestic Abuse Antenatal Care Pathway was followed. The panel acknowledges that, had Mary been asked if she were experiencing abuse, she was unlikely to have identified it herself.

However the questions recommended by the pathway are subtler than a direct enquiry and are designed to provoke thought and encourage disclosure.

Recommendation 13 - SERAF

We recommend that a SERAF assessment is undertaken on all women under the age of 18 years presenting in pregnancy.

Appendix 1: membership of the review panel

Agency Representative	Name	Role
NSPCC	Jan Pickles	Independent Chair and author
Torfaen County Borough Council	David Yeowell	Elected Member and Chair of the CSP
Torfaen County Borough Council	Lyndon Puddy	Head of Public Services Support Unit
Torfaen County Borough Council	Karen Kerslake	Information and Communications Manager (minute taker)
Torfaen County Borough Council	Bernadette Anderton	Group Manager Social Services
Torfaen County Borough Council	Deborah Davies	Safeguarding Manager
Torfaen County Borough Council	Immy Lee	Domestic Abuse and Sexual Violence coordinator
Torfaen County Borough Council	Julia Allen	Independent Domestic Violence Adviser
South Wales Fire and Rescue Service	Martin Henderson then Alison Kibblewhite	Head of Risk Reduction/Group Manager Resilience and Planning Temp Area Manager Head of Risk Reduction
Gwent Police	William Davies	Det Superintendent
Gwent Police	Paul Evans	Superintendent
Aneurin Bevan University Health Board	Jayne Elias and then Linda Brown	Safeguarding Lead
National Probation Service (Wales)	Andrew Bush	Deputy Head (Local Delivery Unit Gwent)
Bron Afon Community Housing	Liz Evans	Head of Community Housing

Appendix 2: methodology for the overview report

On being appointed to chair this review I informed the Coroner, the Independent Police Complaints Commission, the Serious Case Review Chair and author and the relevant agencies involved of my role. The SCR Chair and author agreed that we seek to reduce any distress to family members by where possible undertaking joint interviews. This approach proved possible when we interviewed the mother of the perpetrator at her home in the North of England.

Context

The deaths of Sharon, Chelsey and Mary involve five different but related inquiries, making it complex for the family and wider community to understand the processes and differing outcomes. These inquiries are:-

- The Criminal Investigation
- The Coroner's Inquest
- The Independent Police Complaints investigation
- The Serious Case Review (SCR)
- The Domestic Homicide Review

The timelines and interdependencies of these reports are complex and it was intended that this Domestic Homicide Review was to be published after the Independent Police Complaints Commissioner had reported and preferably at the same time as the SCR.

Data gathering

Reports and documentation accessed

This report is based on the IMRs commissioned from professionals who are independent from any involvement with the victim, her family or the alleged perpetrator. The IMR author has indicated whether there is confidence in the findings of an IMR. The IMRs have been signed off by a responsible officer in each organisation. The agencies' Individual Management Reports were integrated into an overarching chronology of events that led to the fire and resulting deaths of Sharon, Chelsey and Mary. To avoid duplication the chronology was the same as that used in the SCR.

The Chair has also had sight of the Fire Service investigation report prepared by Andy Peterson, Group Manager Fire Safety of the South Wales Fire Service, on the 13.11.12. The report included the statements made by Forensic Investigators.

The Chair has not had sight of the digital profile that we understand outlines Chelsey and Mr M contact via social media from Gwent Police despite several requests for this information.

Interview questions

In order to gather the most useful data, the following questions were asked of the agencies involved:

1. Describe how practitioners ascertained and were sensitive to the victim's needs?

2. Explain how and when your agency considered the feelings and wishes of the victims?

3. What policies and procedures does your agency have in place to identify domestic abuse and issues regarding the safeguarding of children and young people and how where these applied to the case?

4. What policies and procedures does your agency have in place that enables domestic abuse risk assessment to be undertaken and how where they applied to this case?

5. Explain what opportunities have been explored by your agency to gather relevant information in order to identify domestic abuse risk factors and assess the risks posed in this case?

6. Identify what risk information or evidence was shared with other agencies in accordance with local protocols and procedures and where that information and/or evidence was not shared in accordance with best professional practice by your agency?

7. What policies and procedures are in place to identify and respond to high risk victims of domestic abuse and how where these implemented?

8. What policies and procedures are in place to identify potential perpetrators of domestic abuse and how where these implemented?

9. What concerns/issues/referrals were made by your agency?

10. What agencies actively responded by taking appropriate action to any issues/concerns/referrals made by your agency?

11. What agencies do you consider did not take any issues raised seriously and failed to take appropriate actions to any issues/concerns/referrals made by your agency?

12. What preventative measures are available and were they implemented by your agency?

13. Identify at what appropriate points with this case were senior managers and other agencies professional involved?

14. What are your recommendations for ways of working, training, management and supervision or for working in partnership in future with other agencies?

15. What are your recommendations for change in policy or practice to safeguard victims or manage potential perpetrators?

16. Provide examples of agencies effective policy and practice, which it is, felt safeguards victims and manage potential perpetrators?

- **Data analysis**

The panel then used Appreciative Inquiry as an approach to the analysis of the information provided.

Appreciative Inquiry is an approach that focuses on strengths rather than faults as a route to improvement. Appreciative Inquiry does this in an inclusive and collaborative way, which involves participants in reflective learning. Appreciative Inquiry creates a space where we can begin a conversation about what we think we can do differently and seek ideas about how things can change. The outcomes from this process have formed the basis of the review recommendations.

It has to be acknowledged that any review opens up anxieties but it was the Panels intention to create a culture of accountability and learning not of culpability or blame. The review panel were unanimous in wanting to value the actions and approaches that worked well, whilst facing the tough issues of what else could or should have been offered. This was so as to produce effective recommendations which seek to make others confronted by these difficult situations safer.

In order to look at the timeline of events that lead to these tragic deaths we used four phases

- Before Chelsey B met Mr M
- Before A and Mary were born
- Before the fire
- Post the fire

The analytical questions posed to the review panel were designed to open discussion and encourage a frank exchange of opinions so as to enable real learning:

- What did we do right?
- What are things we valued about the way things were done and the way people worked together?
- With the benefit of hindsight and reflection, what could/should we have done differently?
- What will we use to enhance our practice in the future?

This process shaped the review recommendations. It is a generative process which encouraged us to ask the aspirational question – 'what would a safe system look like?'

- **Encouraging open and shared learning beyond the panel**

A meeting of the panel was held in January 2014 in the community. This meeting included an open 'drop in' opportunity for other family and friends to meet with the chair and other panel members to learn about the review and to inform the final report. The event was advertised by flyers distributed a week before to 200 houses in the locality and provided the name and contact numbers of the chair to encourage any further disclosure which may aid the review process and protect others in the future. This meeting was only attended by Mrs S.

The chair wished to adopt a 'no surprises' approach, to encourage meaningful discussion and to air differences of opinion. The draft overview report was circulated to the panel and marked 'restricted'. Until final comments were received the panel members had the right to share the draft report with those participating professionals and their line managers who have a pre-declared interest in the review.

The Home Office guidelines require the report in full to remain **RESTRICTED** and must only be disseminated with the agreement of the Chair of the Domestic Homicide Review Panel.

Appendix 3

The HM Government definition of Domestic Abuse March 2013

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members[1] regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

• psychological
• physical
• sexual
• financial
• emotional

'Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'