Cardiff Community Safety Partnership

Domestic Homicide Review

Overview Report

‘Andrew’

Murdered June 2019

Chair : Carol Elwood Clarke

Author : Ged McManus

Date: September 2021

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1 Introduction

1.1 This report of a Domestic Homicide Review [DHR] examines agency responses and support given to Andrew[1] and his family, who were residents of Cardiff prior to his murder. The panel would like to offer their condolences to Andrew's family on their tragic loss.

1.2 During a violent domestic abuse incident in June 2019 in the family home, Andrew was stabbed with a kitchen knife by his stepson Barry[2]. Andrew was taken to hospital but died of his injuries later the same night. Barry was arrested and interviewed in relation to Andrew's murder, but a decision was taken by the Crown Prosecution Service that he would not be charged with any offence. The reason for this decision was that it was considered Barry had used reasonable force in protecting his mother who was being violently attacked by Andrew.

1.3 The Domestic Homicide Review (DHR) panel were keen to ensure that the review was holistic, taking into account the range of issues affecting the family. The report therefore examines agency responses and support given to all members of the family resident in the family home prior to Andrew's murder. Andrew's mother, Huong[3] who lived independently is also a subject of the review as early scoping information presented to the DHR panel indicated that some early incidents may have occurred at her home

1.4 All the subjects of the review are of Vietnamese heritage and all except Huong were known locally by English names which they chose. Pseudonyms for all people named in the review have therefore been selected by the panel reflecting how the subjects of the review were known in the local community.

1.5 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.6 The review will consider agencies contact and involvement with the family from 1 June 2009 to Andrew's murder in June 2019. This extensive period was chosen because of the unique circumstances of the case which involve Maggie, Andrew's second wife, her child Alex and Barry moving to the United Kingdom from Vietnam. The DHR panel were keen to ensure that the review did not miss any available learning by choosing an artificially short time period. At the same time the DHR panel was also aware that there had been significant changes in services in Cardiff during the ten year timescale of the review. The panel wished to use more

[1] A pseudonym chosen by the DHR panel.
[2] A pseudonym chosen by the DHR panel.
[3] A pseudonym chosen by the DHR panel

historic information as background and context to the review whilst focussing on more contemporary events in terms of learning.

1.7 The intention of the review is to ensure agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.8 **Note:**
It is not the purpose of this DHR to enquire into how Andrew died. That is a matter that has already been examined by the police investigation. An inquest was opened after Andrew's murder and was still to be concluded at the time of the conclusion of the of the DHR.

2 Timescales

2.1 The unusual nature of the case meant that a decision on whether to prosecute Barry was not taken until January 2020. It had not been felt appropriate to progress the Domestic Homicide Review before then as family members were key witnesses to the case and it was hoped to involve them in the DHR process.

2.2 Once the case had been finalised by the police, Cardiff Community Safety Partnership was able to progress the review. Delays were then experienced in sourcing and commissioning an independent chair and author for the review, in part due to the Covid – 19 pandemic. The first meeting of the review panel took place on 27 July 2020. Further relevant information is shown at paragraph 5.

2.3 The Chair of the Community Safety Partnership agreed for an extension of the timeframe for the DHR to be completed as a result of delays due to the criminal investigation and ongoing Covid-19 pandemic. The Home Office were notified of the extension.

2.4 The domestic homicide review was presented to Cardiff Community Safety Partnership on 13 September 2021 and concluded on 29 November 2021 when it was sent to the Home Office.

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including their support worker, during the review process.

3.2 Pseudonyms chosen by the panel have been used to protect the identity of all the subjects of the review.

4 Terms of Reference

4.1 The Panel settled on the following terms of reference at its first meeting on 27 July 2020.

4.2 The purpose of a DHR is to:

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

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

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

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

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

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

4.3 Timeframe under Review

The DHR covers the period 1 June 2009 to Andrew's murder in June 2019.

4.4 Case Specific Terms

Subjects of the DHR

Victim: Andrew - age 56
Perpetrator: Barry - age 18
Victim's wife: Maggie - age 42
Victim and his wife's children
Alex, primary school age
Jade, pre-school age
Victim's mother: Huong, age 84

Specific Terms

1. Were there any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects or given rise to other concerns or instigated other interventions?

2. What indicators of domestic abuse did your agency have that could have identified Andrew as a victim of domestic abuse and what was the response?

3. What knowledge did your agency have that indicated Barry might be a perpetrator of domestic abuse against Andrew and what was the response? Did that knowledge identify any controlling or coercive behaviour by Andrew?

4. When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about Andrew and Barry? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

5. When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

6. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

7. Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

8. Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective?

9. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

10. Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Andrew and/or Barry, or on your agency's ability to work effectively with other agencies?

11. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Andrew and/or Barry?

12. What learning has emerged for your agency?

13. Are there any examples of outstanding or innovative practice arising from this case?

14. Does the learning in this review appear in other domestic homicide reviews commissioned by Cardiff Community Safety Partnership?

5 Methodology

5.1 Following Andrew's murder, formal notification of the homicide was sent to Cardiff Community Safety Partnership by South Wales Police in August 2019. A virtual panel was consulted on 7 October 2019 and responded by 16 October 2019. The panel agreed to conduct a Domestic Homicide Review. The Home Office was informed on 23 October 2019. The review was not progressed immediately due to evidential considerations as family members were thought to be key witnesses in a potential trial. Following the decision not to prosecute Barry in January 2020, the Community Safety Partnership agreed to progress the review, but delays were then experienced in sourcing and commissioning an independent chair and author.

5.2 In 2019 Cardiff Council deemed it appropriate to carry out a new process in procuring DHR Chairs and enlisted on a system called NEPO, which the Council had not used before. As this was a pilot, Procurement and Community Safety were going through a learning process, assessing how this would work and completing necessary forms and procedures. Agreement was obtained from Procurement, Legal and the Head of Service to appoint an Independent Chair via NEPO. All of these factors contributed to the delay in appointing an Independent Chair for this review.

5.3 Carol Ellwood Clarke and Ged McManus were appointed as Chair and author respectively on 2 June 2020.

5.4 The review began in July 2020. The first meeting of the DHR panel determined the period the review would cover. The review panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce independent management reviews.

5.5 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations additional queries were identified and auxiliary information sought.

5.6 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed.

5.7 The panel met six times by video conference with further work being conducted by telephone, video conferencing and the exchange of documents.

6 Involvement of family, friends, work colleagues and wider community

6.1 Andrew's family

6.1.1 Andrew's family were sent letters inviting them to take part in the review, but no reply was received. The family were then approached on behalf of the DHR panel by a police Family Liaison Officer. They declined to take part in the review.

6.1.2 Two months later the family were approached again on behalf of the DHR panel but this time by a Victim Support homicide worker who had supported Maggie following Andrew's murder. The family again declined to take part in the review. Maggie and Barry said that if the law required them to take part in the review, then they would do so, but if it did not then they preferred to be private and would not do so. The DHR panel agreed to respect their decision.

6.1.3 The panel were told by their advisor on Vietnamese cultural issues that this response from the family was to be expected within Vietnamese culture. Generally, the family would cooperate with what they were required to do in law but Vietnam's background of conflict and as a communist country means that Vietnamese people tend not to engage with authority beyond what is absolutely necessary.

6.1.4 The panel considered whether to approach Andrew's mother but were advised that her current poor mental health meant that would not be appropriate.

6.1.5 At the conclusion of the review, the Family Liaison Officer delivered a copy of the report to Maggie and Barry. The family reaffirmed that they did not wish to contribute to the review. Contact details were provided to the family for the Chair.

6.1.6 The Family Liaison Officer and Victim Support homicide worker did not use an interpreter as they informed the Chair that they were confident that through their extensive contact with

Maggie and Barry it was not required and that communication was facilitated and understood. The report was provided in English. The panel were assured by the Family Liaison Officer and Victim Support homicide worker that Maggie could read and write in English. It was also known to the panel from information provided by schools that Barry was fluent in English both orally and in writing.

6.2 Employers

6.2.1 Andrew, Maggie and Barry all worked in a nail salon that was owned by Maggie. There was no external employer that the panel could engage with.

7 Contributors to the review/ Agencies submitting IMRs[4]

7.1

Agency	Contribution
South Wales Police	IMR
Cardiff Adult Social Services	IMR
Cardiff Children's Social Services	IMR
Welsh Ambulance Service NHS Trust	IMR
Primary school attended by Alex	Brief information
Secondary school attended by Barry	Brief information
RISE Cardiff Women's Aid	Brief information
Cardiff and Vale University Health Board	Information in relation to Andrew
Other agencies contacted	
National Probation Service	No information held
Wales Community Rehabilitation Company	No information held
BAWSO [Domestic abuse services]	Skeleton record only held
Education Psychology Service, Cardiff Council	No information held
Safer Wales [Domestic abuse services]	No information held

[4] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Andrew, Maggie and Barry.

7.2 As well as the IMRs, each agency provided a chronology of interaction with the subjects of the review including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference [TOR] and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of the subjects of the review nor had any involvement in the provision of services to them.

7.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to the subjects of the review and any other action taken.

7.4 It should also provide an analysis of events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why.

7.5 The IMRs in this case were of good quality and focussed on the issues facing the subjects of the review. They were quality assured by the original author, the respective agency and by the Panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.6 Cardiff and Vale University Health board provided information in relation to Andrew. The board declined to provide information in relation to the other subjects of the review without their consent. This is the board's policy following legal advice received. As the subjects did not engage with the review then it was not possible to obtain their consent.

7.7 An internal review of the records was conducted and the board provided an assurance to the DHR panel that there were no indicators of domestic abuse in the medical records within the review period.

7.8 **Information in relation to agencies contributing to the review**

7.9 **Cardiff and Vale University Health Board**

Cardiff and Vale University Health Board provides health services to residents and visitors within Cardiff and the Vale of Glamorgan. General Practice (GP services) are provided under the General Medical Services Contract 2004 this sits adjacent to the Primary Community and

Intermediate Care Board of Cardiff and Vale UHB. As an agency the services provided by health professionals are diverse and cover all medical specialties; most people are known to health services from birth to death, thus generating considerable recorded material.

Cardiff Women's Aid

Cardiff Women's Aid is a charity organisation which has worked for over 45 years to end all forms of violence against women, girls, children and young people. Since April 2018, Cardiff Women's Aid has worked in partnership with BAWSO[5] [BAWSO is the lead organisation in Wales providing practical and emotional support to black minority ethnic (BME) and migrant victims of domestic abuse, sexual violence, human trafficking, Female Genital Mutilation and forced marriage.] and Llamau[6] [Llamau is the leading homelessness charity in Wales, supporting the most vulnerable young people and women] to deliver the Violence Against Women, Domestic Abuse & Sexual Violence Service across Cardiff under the RISE-Cardiff[7] service. [RISE Cardiff provides independent personal advocates to support victims of domestic abuse or sexual abuse]

South Wales Police

South Wales Police provides a policing service to 1.3 million people covering 42% of Wales' population with around 49% of the total crime in Wales. The Force is developing ever closer partnerships to protect vulnerable people through multi-agency hubs. The Force has also introduced a tri-service centre with two Fire and Rescue Services and the Wales Ambulance Service Trust. The Force works with other forces and partners to deliver services collaboratively to the communities of South Wales. The force area includes 64 of the 100 most deprived communities in Wales and is a diverse region featuring rural, coastal and urban policing challenges including the two most populated cities in Wales, Swansea and the capital city, Cardiff, which attracts over 18 million visitors per year and is home to over 94,000 students.

Adult Services

Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the Government, local councils and providers of services to make sure that people who need care and support have the choice, flexibility and control to live their lives as they wish.

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[5] https://bawso.org.uk

[6] https://www.llamau.org.uk/

[7] https://rise-cardiff.cymru/

Cardiff Children's Services

Cardiff Children's Services provide support to children in need of help and protection. Services include statutory assessment and care planning for children at risk of significant harm, provision for looked after children and those leaving care, as well as fostering and adoption services.

The service delivers support for children with disabilities and their families that bring together health, social care and educational support. Services also include support for children with additional educational needs, educational psychology, therapies and emotional health and wellbeing support.

Welsh Ambulance Service NHS Trust

Welsh Ambulance Services NHS Trust (WAST) is the national ambulance service for Wales, providing services to over 3 million people across 8,000 square miles of diverse and challenging urban, coastal and rural landscape. We provide emergency clinical care and non-emergency hospital transport. Our call handlers deal with more than half a million calls every year, 24 hours a day, 7 days a week and 365 days of the year. We attend more than 250,000 emergency calls annually, over 50,000 urgent calls and transport over 1.3 million non-emergency patients. The Trust operates from 90 ambulance stations, 3 contact centres, 3 regional offices and 5 vehicle workshops. We are at the forefront of innovation in unplanned clinical care, providing thousands of patients a year with advice, support and signposting to the right services through our "*hear and treat*" services. The trust hosts the NHS111 Wales service, which is an amalgamation of NHS Direct Wales (a 24 hour health advice service and information for the public) and the front end call handling and clinical triage elements of the GP out-of-hours services.

8 The review panel members

Carol Ellwood Clarke	Independent Chair
Ged McManus	Independent support to chair and author
Quynh Nguyen	Vietnamese Family Partnership
Jenny Rogers	Community Safety Manager, Cardiff Council

Natalie Southgate	Improvement Project Manager-Gender Specific Services, Cardiff Council
Linda Hughes Jones/ Helen O'Sullivan	Head of Safeguarding, Cardiff & Vale University Health Board
John Lane/Beth Aynsley	Independent Protecting Vulnerable Persons Manager, South Wales Police
Nicola Winstanley	Business Manager, Cardiff Council
Nicola Jones	Domestic Abuse Co-ordinator, Cardiff Council
David Murray Dickson	Service Manager Safeguarding Services, Cardiff Council
Jade Harrison	Service Improvement & Strategy, Children's Services
Nikki Harvey	Head of Safeguarding, Welsh Ambulance Service NHS Trust [attended meeting 1 and 2]
Gwenan Jones-Parry	Safeguarding Specialist Paramedic, Welsh Ambulance Services NHS Trust [attended from 3rd panel meeting onwards]
Paula Hardy	Strategic Lead for Victims and Vulnerability Police and Crime Commissioner's Office, South Wales Police

8.1 The Chair of the Cardiff Community Safety Partnership was satisfied that the Panel Chair and author were independent. In turn, the Panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report. Panel members had not previously been involved with the subjects or line management of those who had.

8.2 At its first meeting the panel discussed the need to ensure that expertise and advice was available in relation to Vietnamese culture. Initial attempts to secure an appropriate community representative for the panel locally were unsuccessful. This led to a wider search

and the recruitment of Quynh Nguyen of the Vietnamese Family Partnership to the panel. Quynh has experience of working in the NHS, Sure Start and child protection. The Vietnamese Family Partnership is a London based charity which runs a family centre and language school promoting Vietnamese language and culture. The panel were satisfied that Quynh was appropriately qualified and experienced to provide expert advice on Vietnamese culture and attitudes.

8.3 The Community Safety Partnership were unable to secure the attendance of an independent domestic abuse professional at meetings for logistical reasons. However several members of the panel have extensive professional domestic abuse experience, for example the domestic abuse Co-ordinator for Cardiff Council and the Strategic Leads for Victim and Vulnerability for Crime Commissioner's Office, both of whom were independent of agencies involved in the review. The chair of the DHR panel was satisfied that the panel had sufficient relevant experience.

9 Author and Chair of the overview report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the chair and author were separate people.

9.2 Carol Ellwood Clarke was chosen as the chair of the review. She retired from public service [British policing – in England] in 2018 after thirty years during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017 she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives.

9.3 Ged McManus was chosen as author of the review. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board [not in Wales] and was judged to have the skills and experience for the role. He served for over thirty years in different police services in England. Prior to leaving the police service in 2016 he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

9.4 Between them they have undertaken over sixty reviews including; child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews, domestic homicide reviews and have completed the Home Office online

training for undertaking DHRs. They have also completed accredited training for DHR chairs provided by AAFDA[8].

9.5 Neither of them has previously worked for any agency involved in this review or had any involvement in previous Cardiff DHRs.

10 Parallel Reviews

10.1 An inquest was opened and adjourned immediately following Andrew's murder. The inquest had not been concluded when the DHR process was finalised.

10.2 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. There is no suggestion that any agency involved in the review has initiated any disciplinary action.

11 Equality and diversity

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].

[8] Advocacy After Fatal Domestic Abuse.

- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines ‘disability’ as:

(1) A person (P) has a disability if:

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

None of the subjects of the review is known to have had any diagnosed physical or mental impairment which would have defined them as disabled.

11.3 Domestic homicide and domestic abuse in particular is predominantly a crime affecting women with women by far making up the majority of victims, and by far the vast majority of perpetrators are male. A detailed breakdown of homicides reveals substantial gender

differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018 the Office of National Statistics homicide report[9] stated;

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner'.

'Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)'.

'Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)'.

The DHR panel reflected that the circumstances of this case with a stepson fatally injuring his stepfather were statistically unusual.

11.4 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.5 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Social Service and Well being Act [Wales] 2014 (care and support) assessment is completed.

The review found information that Andrew enjoyed drinking and visiting casinos. However, there was no information within his medical records to suggest that he was a problem drinker. Neither Andrew, Maggie or Barry ever came to the attention of Adult Social Care as clients and therefore there was no opportunity for Adult Social Care to consider whether a care and support assessment was appropriate.

11.6 Huong has historically been assessed as having care and support needs. She was supported throughout the period of the review by Adult Services and while she lived independently, she required the support of visiting carers to assist her with her everyday needs.

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9 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2018#which-groups-of-people-are-most-likely-to-be-victims-of-homicide

11.7 All of the subjects of the review are of Vietnamese heritage. Huong speaks little English and requires the services of an interpreter to communicate with agencies.

Andrew was able to speak English in order to deal with everyday routine issues. He was provided with an interpreter on some occasions , for example a police interview.

Maggie was unable to speak English when she first arrived in Cardiff. In her early interactions with agencies, she was provided with an interpreter. As time progressed her English improved and she was able to communicate more easily in day to day matters, but was provided with an interpreter for the purposes of police interviews and witness statements.

Maggie's three children all speak, read and write English and do not have any communication barriers. None of the subjects of the review speak Welsh.

11.8 Barry first enrolled in school in Cardiff as a year 10 student. He quickly adapted to school life in Cardiff and he quickly became fluent in English both orally and in writing. He made good progress in his studies and teachers described him as 'a pleasure to have in class'. The panel acknowledged that the effects of moving from Vietnam to a new country and an abusive household must have had a negative impact on him but were unable to quantify it.

11.9 All of the subjects have UK citizenship. When Maggie first came to the UK in 2009, she had a temporary visa sponsored by Andrew. There is some evidence that he used this fact to threaten her that she would not be able to stay in the country if she did not maintain their relationship. Maggie obtained UK citizenship in 2012.

11.10 In July 2019, the Home Office committed to conducting a Migrant Victims Review, which in 2020 concluded that further evidence was needed to identify which groups of migrants are likely to be most in need of support, how well existing arrangements may address their needs, how long the group might need support for, and how they could be supported to move on from safe accommodation. In early 2021, the Domestic Abuse Commissioner commissioned the University of Suffolk to consider and assess the evidence provided to the Home Office in their Migrant Victims Review, to help identify evidence gaps and share key learning for future evidence gathering.

In 2021, the Domestic Abuse Commissioner published a report: 'Safety before Status. Improving pathways to support migrant victims of domestic abuse'[10]. This report makes the case for a better understanding at a national and local level of the rights and routes to support for migrant victims. A greater awareness of how perpetrators can use their victim's insecure status to further control and abuse them – defined in this report as immigration

[10] https://domesticabusecommissioner.uk/wp-content/uploads/2021/10/Safety-Before-Status-Report-2021.pdf

abuse.

The report highlights the following key areas – 'Victims and survivors of domestic abuse with insecure immigration status face significant barriers to accessing the support and protection they need. The no recourse to public funds (NRPF) status means many are prevented from accessing refuge and other safe accommodation. Many victims and survivors are also afraid of reporting to the police or public services due to the fear that their data will be shared with Immigration.

Enforcement. In turn, perpetrators use their victim's insecure immigration status a tool for coercive control'.

'Home Office VAWG National Statement of Expectations indicates that victims and survivors with protected characteristics, such as Black and minoritised victims and those with insecure immigration status, are best served by specialist 'by and for' services, which are run by highly specialist staff, whose work is designed to meet their specific needs. These services are often the only place that victims with insecure immigration status can turn to: DAC commissioned research by the Angelou Centre identified that women with NRPF and/or uncertain immigration status had consistently made up over 65% of referrals for specialist 'by and for' services; for three of the 12 organisations consulted it was over 80%'.

In respect of this case, the landscape and support available to Maggie, over ten years ago, was led by individual services interpretation of referral support. It is most likely that NRPF (A national network safeguarding the welfare of destitute families, adults and care leavers who are unable to access benefits to their immigration status), was a services known to be used then. Since this case there has been legislative and policy changes in respect of NRPF and Local Partners continue to support women on a 'case by case' basis.

As detailed at paragraph 13.1.9 BAWSO the domestic abuse agency supporting the victim no longer hold any detail of their support to or interaction with Maggie during that period due to their document retention policy.

12 DISSEMINATION

Cardiff CSP
All agencies contributing to the review
South Wales Police and Crime Commissioner
Domestic Abuse Commissioner
Cardiff Public Services Board
Cardiff Regional Safeguarding Board
Welsh Government – Single Unified Safeguarding Review

13 Background, Overview and Chronology

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the family and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies. In particular reference is made to information provided by Maggie during the investigation into Andrew's murder.

13.1 Relevant information prior to the review period

13.1.1 Andrew and his mother Huong are known as long term residents of the Cardiff area. Huong's history prior to arriving in Cardiff is not known. Although she has been engaged with Adult Services over a number of years, she has consistently declined to discuss her past life. Andrew told staff at Barry's school that as a young man he had travelled from Vietnam to Hong Kong on a boat with other people as a refugee and had then been allowed to settle in the United Kingdom in 1981. He was given UK citizenship.

13.1.2 In May 1986, Andrew's first wife moved to Cardiff having arrived in the United Kingdom a few months earlier from Vietnam. She soon met Andrew, their relationship progressed very quickly and they were married within two months. The couple went on to have two children together.

13.1.3 During the investigation into Andrew's murder the police interviewed his first wife as a witness. She told them that there had been domestic abuse in their relationship and that Andrew would often spend their money on gambling and alcohol.

13.1.4 In 1999, an incident occurred when Andrew visited his wife at her place of work which was a takeaway food store. Andrew wanted money and when his wife refused, he became angry went into the kitchen and threatened her with a knife. His wife had never reported his behaviour before but on this occasion she went to the police. Andrew was arrested and the court later granted a restraining order against him. His first wife instigated divorce proceedings against him and the couple's relationship was terminated.

13.1.5 Andrew did not see his children from this relationship again or make any financial contribution to their upbringing.

13.1.6 In 2004, Andrew and Maggie met on the internet. She was living with her mother in her home province in Vietnam and was a single mother with her son Barry. They were a poor family and life was difficult. After a couple of months of communicating via the internet

Andrew went to Vietnam to visit Maggie. Andrew told her that he was a chef, owned shares in a restaurant and lived with his mother in Cardiff. The visit lasted for two weeks after which Andrew returned to Cardiff.

13.1.7 The couple continued with their internet communication until 2007, when they agreed to marry and Andrew returned to Vietnam for six weeks. The couple were married during this time and Maggie became pregnant with their oldest child Alex. Andrew returned to Cardiff alone with the intention of securing a visa so that Maggie could join him. The visa process took until March 2009 when Maggie and Alex were then able to move to Cardiff where they lived initially with Andrew and his mother Huong in a property which she rented. Barry stayed in Vietnam and was looked after by his grandmother with the intention that he would join the rest of the family in the UK sometime later.

Relevant information during the review period

13.1.8 On 28 June 2009, Maggie and Alex were found sheltering in Cardiff town centre and taken to a police station where officers could use the language line service as Maggie's English was limited. Maggie said that she was not getting on with Huong and had therefore left the home for a while. She was taken home by officers who spoke to Andrew. He said that he had not been aware of any argument.

13.1.9 In July 2009, Maggie made allegations of domestic abuse from Huong and Andrew to an adult social worker who was visiting Huong. A referral was made to Children's Social Care which resulted in Maggie being supported to leave the home and move into a refuge with Alex. Maggie was interviewed by the police and said that Andrew had slapped her twice when she had argued with her mother-in-law, that he was a gang member and owned a gun although she had not seen it. [Andrew had previously held a firearms certificate, but this was revoked in 1998 and the weapon surrendered to police, there is no evidence that he had a gun after 1998]. A referral to MARAC was made. Records from the MARAC meeting indicate that BAWSO were tasked with providing ongoing support for Maggie. Given the passage of time and in line with their document retention policy, BAWSO no longer hold any detail of their support to or interaction with Maggie.

13.1.10 Maggie and Alex stayed at the refuge until 27 July 2009, when they returned to the family home. A joint home visit was undertaken by police and Children's Services as a result of concerns for Alex's safety. Both Andrew and Maggie were aggressive and were arrested for breach of the peace. Andrew was also arrested for assault as Maggie had disclosed to the police that he had again assaulted her by slapping her in the face. Alex was removed from their parents' care under the powers of police protection and placed into the care of a Local Authority foster carer. Maggie returned to the refuge.

13.1.11 Maggie declined to make a complaint in relation to the assault on her by Andrew, explaining that this was part of their culture. He was interviewed but denied the assault and was released without charge. The panel's cultural advisor told the panel that a man slapping his partner to show his disapproval of something and assert his dominance, was very common practice in Vietnamese communities, particularly those from poorer rural areas.

13.1.12 Following a number of strategy meetings, a decision was made for Alex to return to her mother's care in the refuge. Alex was returned to Maggie's care on 30 July 2009. During an initial child protection conference on 25 August 2009, Maggie said she had not been truthful when she engaged with the police. She added she had made up her allegations, because she believed this would assist her and her husband to be re-housed away from her mother-in-law. She intended to be reunited with her husband and for them to get a house together. Alex's name was placed on the Child Protection Register under the dual categories of Emotional and Physical abuse.

13.1.13 On 15 September 2009, carers attending to Huong reported that when they arrived, she was in bed and moaning in pain, and it was noted that she had bruising on her arm. When questioned about this, Andrew said that Huong had "just developed the bruising". The GP was contacted, who requested Andrew take his mother to the surgery, but he refused. The matter was progressed to a strategy meeting under the then Protection of Vulnerable Adults Procedures (POVA) which was held on the following day. It was determined that the bruising to Huong's arm had occurred when she had intervened in an argument between her son and daughter-in-law. The panel's cultural advisor told the panel that it was very common for there to be tension between a mother and daughter in law.

13.1.14 On 23 October 2009, Maggie moved from the refuge back to live with Andrew and Huong against the advice of Children's Services. This resulted in Alex being removed from their parents using police powers of protection and being placed in foster care by Children's Services. Maggie was unable to move back to the refuge as its location had been compromised and she was found alternative accommodation. An Emergency Protection Order in respect of Alex was granted on 27 October 2009 and an Interim Care Order was subsequently granted on 10 November 2009.

13.1.15 On 11 November 2009, following a request from Huong she was visited at home by a social worker. It was noted during this visit that Andrew and Maggie had asked her to move out of the flat. Huong was advised that she had the tenancy and she did not have to go, she could ask the couple to go and the landlord could assist this request. Huong was angry and upset about the lack of financial support from Andrew and requested that the social worker find alternative accommodation for Andrew and Maggie.

13.1.16 On 8 January 2010, concerns were expressed by Huong's carers regarding bruising witnessed on Huong and that she had said her son had hit her. A social worker visited Huong and offered her a place of safety, which she initially accepted but then declined. She attended a day centre later that day and the bruising was observed on her shoulder. It later emerged that Andrew and Maggie were having a disagreement and Huong was accidentally struck. The matter was progressed via the POVA process, and following a strategy meeting and further intervention, the POVA team visited Huong on 26 January at the day centre. A number of actions to safeguard Huong were agreed. Huong was offered an Adult Protection Plan Case Conference meeting but declined this. She stated there was no need to have the meeting as her only request was for the couple to move out as soon as possible, so she did not have to see them fighting.

13.1.17 Information from the police investigation into Andrew's murder

In April 2010, Maggie moved out of Huong's flat into her own property, she was later joined by Andrew. Maggie told the police during the investigation into Andrew's murder that during their time in this property Andrew regularly assaulted her. Maggie felt she couldn't leave him as she was still dependant on him for her visa. If she reported the incidents to the police Maggie was afraid she wouldn't get Alex back. Andrew would threaten to kill Maggie and tell her that she owed him as he had sponsored her to live in the UK.

13.1.18 On 23 August 2010, a joint visit by the POVA Designated Lead Manager (DLM) and a social worker to see Huong took place. She said there had been a row between Andrew and Maggie last week. She had got in between them and Maggie had pushed her causing her to fall over. Maggie had also slapped Andrew's face at one point. Huong was again offered accommodation or a place of safety if she felt afraid.

13.1.19 On 5 September 2010, Huong's carers contacted the police reporting that during an argument Maggie had thrown a plate at Huong which had caused her to fall to the floor. When officers attended Huong said that Maggie had pushed her. Maggie was arrested and interviewed in relation to the alleged assault and denied that anything had happened. Andrew also denied that anything had happened when spoken to by officers. Maggie was released from police custody as there was insufficient evidence to charge her with any offence. Information was shared appropriately with Adult Services.

13.1.20 In March 2012, the Court decided that Alex would return home to their parents and they returned to their parents care on 17 April 2012. A 12 month Supervision Order was granted on 11 July 2012. Following Alex's return home, there were no further reports of incidents of domestic abuse. Concerns were raised by their school, particularly following Alex's return

from a trip to Vietnam in February and March 2013. The school reported that since returning, Alex presented as very quiet and withdrawn, whereas prior to going away they were chatty and outgoing. The school also made a referral following an incident of sexualised behaviour. The panel's cultural advisor indicated that sexualised behaviour was unusual amongst Vietnamese children. Alex went to Vietnam again just before Christmas 2013 and there were no concerns reported from school following their return. It was subsequently felt that there was no further role for Children's Services and the case was closed in February 2014.

13.1.21 Information from the police investigation into Andrew's murder

After Alex was returned to Andrew and Maggie's care the family moved to a new house which was owned by Andrew's employer. They were able to rent it at a good price and the rent was taken directly from Andrew's wages. Maggie would pay for food and all the utility bills. Even though Maggie had United Kingdom citizenship granted in December 2012, she still felt she couldn't leave Andrew as she was still unable to speak English, he refused to divorce Maggie and she wasn't aware that she could apply for a divorce herself. She just put up with what was happening in her life.

13.1.22 Information from the police investigation into Andrew's murder

Maggie became self-employed doing nail treatments and rented a space in a local hairdresser. She told police that life was fine with Andrew for a few months and she became pregnant with Jade. Andrew had left his job following an argument which meant they had to look for somewhere else to live and Maggie was the only one working so she started to teach Andrew how to do nails.

13.1.23 During 2014 a Health Visitor saw the family on a number of occasions. Andrew was always present and was used as an interpreter when there were any difficulties in communication. As a result of this there was no routine enquiry into the possibility of domestic abuse.

13.1.24 On 4 March 2015, Huong's carers reported that she had been left without support whilst Andrew was in Vietnam for six weeks. It is thought that the purpose of Andrew's trip was to collect Barry and bring him to live in the UK with the rest of the family.

13.1.25 Information from the police investigation into Andrew's murder

During March 2015 whilst Maggie was heavily pregnant, the family moved to a new house which was rented via an estate agent. She continued to work throughout the pregnancy and took one week off when Jade was born. Andrew would not contribute to anything and Maggie was paying for everything.

13.1.26 On 19 May 2015, Barry enrolled at a comprehensive school in Cardiff in year 10. Andrew attended the initial meetings with school and signed all the necessary paperwork.

13.1.27 Information from the police investigation into Andrew's murder

Maggie told the police that in June 2015 she won a prize of £112,000 on the euro millions lottery. Andrew dealt with communication with the lottery as he spoke better English and the money was paid into his bank account. Maggie asked Andrew to buy her a shop with the money and in October 2015, Maggie began to rent a shop for £700 a month. Andrew transferred either £30,000 or £40,000 to Maggie's account and she spent £20,000 renovating the shop into a nail bar. Both Andrew and Maggie worked there doing nail treatments. Andrew started gambling in betting shops and going to a casino. Maggie said that Andrew was a good father to the children, however when Jade was about 8 months old he assaulted Maggie in front of Alex. Maggie didn't tell anyone and she didn't leave as Andrew threatened to kill her.

Staff at Alex's school noticed that Andrew who had sometimes appeared to be quite shabbily dressed suddenly began wearing designer clothing and had a new car at about this time.

13.1.28 Information from the police investigation into Andrew's murder

The family moved to a new privately rented four bedroom house as Maggie had sponsored Barry to come to the UK. When Barry arrived in Cardiff and obtained a school place Maggie started to train him to do nails after school. When Barry was sixteen and obtained his national insurance number, he began working part time at the shop and when he turned seventeen, he worked there full time. When the three of them were working at the shop doing nails, if Andrew had not done a very good job on a customer's nails, Maggie would complain to him about it and he would stand up and kick the chair and table whilst customers were present. Andrew would go to the betting shop when he was supposed to be working and then reduced his hours and would only manage any correspondence relating to the shop.

13.1.29 Barry quickly adapted to school life in Cardiff and his English language skills which were basic on entry to the school quickly improved. He made good progress in his studies and teachers described him as 'a pleasure to have in class'. He was part of a good and supportive friendship group and there were no negative issues at school. As he progressed to sixth form studies, school staff knew that Barry was working in the family nail salon on a part time basis on Friday and Saturday. His lessons were confined to Monday to Thursday. During his second year of sixth form, Barry's attendance became less regular and by May 2018 he stopped attending altogether. He did not complete his A level exams. Many calls were made to Maggie to try to address the situation, but this was unsuccessful.

13.1.30 On 14 August 2018, Alex rang 999 to the police. She said that Andrew was throwing knives at her mother. Maggie then took over the call and stated she was outside the house with the children. Maggie said that Andrew had put the knives on the table, but he had been drinking a lot of brandy. When officers attended Maggie told them that Andrew had been drinking and had left in his car to go to the shops to buy cigarettes. Maggie said that when Andrew came home from work, they engaged in a verbal argument. He went into the kitchen area to chop up some vegetables with a knife and was facing her. As a result, she ran from the house together with her two children, as she thought Andrew may have gone towards her with the knife. Maggie confirmed to the officer at no stage did her husband threaten her or her children with a knife and declined to make any complaint. Whilst officers were still at the house Andrew returned in his car and was arrested on suspicion of drink driving. An extendable baton was found in the door pocket of the car.

13.1.31 Following a review of the call made by Alex and another call from a third party Andrew was arrested in relation to the suspected domestic incident. He was interviewed but denied any offences. A decision was made that there was insufficient evidence to charge him with an offence in relation to the domestic incident and tests showed that he was not over the prescribed limit of alcohol for driving. He was charged with possession of an offensive weapon in relation to his possession of the extendable baton.

13.1.32 A PPN form [including a DASH risk assessment] was submitted to the police public protection unit by the officer dealing with the matter. A risk assessment was undertaken and the risk graded as medium. The risk assessor noted that there was 'no DV history'. The PPN was reviewed by a specialist police officer and social worker within the Multi Agency Safeguarding Hub [MASH] and it was recorded that the PPN would not be shared with Children's Services as Maggie had removed herself from the verbal argument, no offences had occurred and there were no safeguarding concerns for the children. The PPN was shared with RISE-Cardiff [Cardiff Women's Aid].

13.1.33 Following the referral from the police an IDVA from RISE-Cardiff tried to contact Maggie on four occasions by telephone and was unsuccessful. The policy is to attempt contact four times and then close the case if there has been no success. The policy was followed in this case and therefore no contact was made with Maggie to offer her support.

13.1.34 On 5 September 2018, Andrew appeared at court charged with possession of an offensive weapon and received a fine.

13.1.35 Information from the police investigation into Andrew's murder

In May 2019 at Maggie's instigation, Maggie and Andrew discussed obtaining a divorce and they agreed to do so. Andrew downloaded a form from the internet which cost £37. Although Maggie paid for the form she was unsure if Andrew did anything with it.

13.1.36 In June 2019, an argument took place between Andrew and Maggie in the kitchen of their home. Andrew attacked Maggie with a large pestle, striking her to the head. Alerted by the disturbance, Barry who was upstairs went to the kitchen to find Andrew attacking his mother Maggie. Barry used a kitchen knife to stab Andrew causing fatal injuries. Barry was arrested on suspicion of murder. An investigation was undertaken and evidence provided to the Crown Prosecution Service who made the decision that no further action would be taken against Barry.

13.1.37 Information from the police investigation into Andrew's murder

Maggie said that she was assaulted by Andrew on many occasions. He would frequently strangle her and slap her to the face which would leave slight reddening. Maggie said that Andrew was trained in martial arts and assaults often wouldn't leave visible marks. Andrew told Maggie he associated with gangsters from Hong Kong. He would threaten Maggie that if she messed with him or left him, his gangster friends would find her wherever she went in the UK and that they would kill her.

13.1.38 Information from the police investigation into Andrew's murder

During their investigation the police saw a number of customers from Maggie's nail bar. They gave accounts of Andrew behaving aggressively towards Maggie and speaking to her in a rude and aggressive manner. Sometimes this would be in English and sometimes in Vietnamese. Some customers recall seeing injuries on Maggie's arms, face neck and legs. Maggie told customers that she was unhappy in her marriage. Customers described Maggie's English as broken, but they could communicate with her and both parties to the

conversation would understand everything. The customers have not been approached by the DHR. Extracts from their statements are shown in the below paragraphs.

Witness 1

The older male [Andrew] started to pace back and forth behind me and started to raise his voice towards Maggie. He was speaking with Maggie in a foreign language and was becoming more and more agitated and aggressive in his manner as the conversation continued. I was feeling slightly uneasy being present whilst they were arguing and his behaviour was escalating. The older male was getting louder and louder until Maggie has said to him in English, "BE QUIET WE'VE GOT CUSTOMERS, FUCK OFF". The older male has continued to shout in the foreign language and Maggie has repeated her comments until the older male left the nail bar. The younger male [Barry] who was doing my nails did not do or say anything whilst this argument was taking place. After the male had left I have over heard Maggie speaking with her client explaining the argument was over an outstanding electric bill and that I heard her mention that she had been trying to divorce her husband over several years. Maggie appeared to remain calm following the argument and she appeared embarrassed that it had taken place in the shop.

Witness 2

When I would visit the bar and have my nails done, I felt sorry for Maggie as Andrew was never very nice to her. It has got worse over the last two years. When I say he wasn't very nice, I mean he would raise his voice and shout at her in front of clients, he would glare at her and look angry and I believe he was jealous of her because she is a very attractive woman with a great sense of humour. Maggie would get embarrassed and upset and I would ask her what he was shouting to her as he would speak in their own language. Maggie would just reply "HE’S JUST BEING NASTY, HE'S NOT A VERY NICE MAN." [redacted-gives statement makers experience of domestic abuse] I could just see the signs straight away. I would say to Maggie that she needed to leave Andrew as he wasn't a very nice person and she would reply "HE WON’T LET ME LEAVE." Maggie also informed me that Andrew was very controlling, taking all her money and that he would waste it on gambling.

I have on occasion saw injuries to Maggie, normally on her arms and hands. These would be bruises and I would ask her what they were from. Maggie never disclosed that Andrew had assaulted her and would make up an excuse that she had bumped into something. I didn't believe her as the bruises would look like finger marks, as if she had been grabbed. This happened on a few occasions the last being a few months ago.

Back last year I did see that Maggie had a red mark, like a slap mark on the right hand side of her face. I asked Maggie about it, however she changed the subject so I didn't get to find out what it was from.

When I saw Maggie on Wednesday this week (June 2019), she told me she had some news and that she was finally getting a divorce. This was all she said as the bar was busy but she did seem very happy about it. Maggie appeared to look like a massive weight had been lifted off her shoulder.

Witness 3

On many occasions when I have been at the salon, Andrew would be quite hostile towards Maggie and would shout at her and speak to her sharply, even when customers were present. This would happen quite often, and although I didn't really know what he was saying, as he generally spoke in Vietnamese, I could feel the tension. Maggie wouldn't argue back with him, and seemed petrified of him, and it was clear that their marriage was under stress.

Due to the relationship I had developed with her, Maggie would often drop hints to me that she was unhappy in her marriage. She would make facial expressions and say, "URGH" when she referred to Andrew, as if she was disgusted by him. She also said to me, "ME NO LIKE HIM. ME NO LIKE," in a jokey way but I always felt that there was a lot of truth in it, and it seemed as if she couldn't get away from him. I asked her, "WHY DON'T YOU LEAVE HIM THEN MAGGIE?" and she would just answer, "KIDS. KIDS."

Often I would speak to Maggie about things when Andrew was in the salon and she would urgently try to quieten me by saying, "SH!" as if she didn't want him hearing anything about what she was saying, and was scared of the consequences if he found out what she was talking about. Also she often said to me, "MY BUSINESS, MY MONEY. I EARN ALL THE MONEY FOR HIM."

I have never witnessed Andrew be physically violent with Maggie, but I have often seen her with reddening on various parts of her body, including her neck, arms and legs. These marks didn't look like bruises, but more like the sort of reddening you'd have if you'd been grabbed forcefully by someone's hands, like friction marks. She would have them one week and then they would have faded when I saw her a fortnight later, only to then reappear on another part of her body weeks down the line. At first I thought Maggie had psoriasis. Initially I didn't ask Maggie how she'd got the frequent reddening, but I did ask my friend [name redacted] who also attends the salon. [name redacted] told me, "BECAUSE HE

BATTERS HER," and I assume that Maggie had mentioned something to [name redacted] or [name redacted] had witnessed something violent.

14 ANALYSIS

14.1 Were there any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects or given rise to other concerns or instigated other interventions?

14.1.1 Andrew had a history of domestic abuse in his first marriage and his wife instigated a divorce because of the abuse. Once Maggie arrived in Cardiff in 2009 after their marriage in 2007, it took only a few months for problems in their relationship to come to the attention of agencies. In July 2009 Maggie made an allegation of assault against Andrew and his mother Huong. The allegation set in motion a series of events which led to the couple's child Alex being removed from their care for three years. Maggie later said that she had made up the allegation of assault by Andrew in the hope of improving their housing situation.

14.1.2 During 2009 and 2010, a number of incidents were reported to Adult Services which indicated that Huong may be at risk of harm from Andrew and Maggie. Maggie was arrested on one occasion following a direct allegation of assault by Huong. There was insufficient evidence to prove any assault. These incidents were investigated under the then Protection of Vulnerable Adults Procedures. Huong repeatedly said that all she wanted was for the couple to move out of her flat into their own accommodation and this was achieved in April 2010. Although there were other incidents in 2010 there were no significant matters raising concern for Huong's personal safety after September 2010. She continued to receive regular visits from carers which gave her the opportunity to report any issues as they arose.

14.1.3 The Protection of Vulnerable Adults Procedures were superseded by the Social Service and Well being Act [Wales] 2014 and the introduction of new procedures. The panel therefore thought that it was unproductive to engage in a detailed analysis of incidents which were dealt with under now defunct procedures. The panel did however think it important to recognise the incidents in the report as they contribute to a picture of the turmoil in the relationship between Andrew and Maggie.

14.1.4 There were no further significant events which pointed to domestic abuse reported to agencies until 14 August 2018, when Alex called the police on 999. On this occasion it was alleged that Andrew had threatened Maggie with a knife. Maggie later minimised the incident and although Andrew was arrested there was insufficient evidence to take any

action in relation to domestic abuse. Alex and Barry who were known to be present were not spoken to directly. Speaking to both children was a reasonable line of enquiry which should have been completed. A risk assessment was undertaken by the public protection unit following the submission of information on a PPN form [this form includes a DASH risk identification check list]. The risk was graded as medium and the risk assessor noted that there was 'no DV history'. This was clearly incorrect and was caused by the fact that Maggie who had previously been recorded under her Vietnamese name, gave police her English name on this occasion. The risk assessor has been spoken to by the police IMR author and stated that if they had been aware of the history, this would not have changed their risk grading because Maggie had denied any assault or threats and the previous incidents had taken place nine years previously.

This is a learning point [panel learning 1] and leads to panel recommendation 1.

14.1.5 The PPN was also reviewed by a specialist police officer and a social worker within the Multi Agency Safeguarding Hub [MASH]. It was recorded that this was 'in accordance with the screening checklist' and that the PPN would not be shared with Children's Services as mother had removed herself from the verbal argument, no offences had occurred and there were no safeguarding concerns for the children. This decision in effect meant that there were no safeguarding concerns. The initial report that knives had been thrown, father's suspected drink driving and the possession of an extendable baton, could have indicated safeguarding concerns for the children aged ten and four. It does not appear to have been considered that Maggie may have been minimising what had occurred. The social worker would have had access to historic information in relation to the family, but records do not indicate if this was checked or taken into account. This is a learning point which is addressed in the Children's services single agency action plan.

14.1.6 The 'screening checklist' was a checklist devised by Children's Services within the Cardiff MASH in response to what was seen by Children's Services as the unnecessary sharing of PPNs by Police where no safeguarding concerns had been identified and to improve the data quality of those PPNs being submitted. This involved a police representative and a social services representative within the MASH looking through PPNs involving children and using the checklist to make a decision as to whether the PPN needed to be shared. This process is no longer in place and the panel were assured that new processes have more robust management oversight.

14.1.7 Victims of long term domestic abuse do not find it easy to seek help for a number of reasons including lack of self-confidence, fear, intimidation, financial dependence and guilt. It was also reported that Alex had previously been told not to say anything about home or

she would have to go into care. These issues may have resulted in family members not disclosing the level of abuse within the family home.

Information from the police investigation into Andrew's murder

14.1.8 Maggie told the police during the investigation into Andrew's murder that when she moved to her own flat in 2010 and Alex was a looked after child, Andrew regularly assaulted her and she was afraid that if she reported the incidents to the police she wouldn't get Alex back. As the review has been unable to engage with Maggie no further details of her concerns are known.

14.2 **What indicators of domestic abuse did your agency have that could have identified Andrew as a victim of domestic abuse and what was the response?**

14.2.1 There were no indicators to suggest that Andrew was a victim of domestic abuse. The limited records in this case indicate that prior to his murder Andrew was suspected on several occasions of domestic abuse towards Maggie. There was a significant gap in reports between 2010 and 2018.

14.2.2 Andrew was also named in several safeguarding enquires in 2009 and 2010 in relation to potential harm to his mother Huong.

14.3 **What knowledge did your agency have that indicated Barry might be a perpetrator of domestic abuse against Andrew and what was the response? Did that knowledge identify any controlling or coercive behaviour within the family?**

14.3.1 Barry was not known to the police or any other agency in Cardiff. There was no indication known that he may be a perpetrator of abuse against Andrew.

14.3.2 The Serious Crime Act 2015, received royal assent on 3 March 2015. The Act created a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closed a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both. The new offence, which does not have retrospective effect, came into force on 29 December 2015. The events of 2009 and 2010 were not therefore covered by the legislation. The offence does not apply where the behaviour is perpetrated against a child under 16 by someone aged 16 or over who has responsibility for that child, because the criminal law already covers such behaviour, e.g., an offence of child cruelty and neglect.

14.3.3 Little was known about the family after the closure of Alex's case to Children's Services in 2014. Only the single incident in 2018 came to the attention of agencies and there was no information held by any agency to indicate controlling or coercive behaviour by Andrew after the introduction of the legislation in 2015.

14.3.4 Information from the police investigation into Andrew's murder suggests that there was controlling and coercive behaviour by him towards Maggie. For example, he claimed a substantial lottery prize and kept a significant amount of money for himself. Maggie worked to support the family whilst Andrew contributed less over the years and was disruptive at work in the nail salon, as a result of which Maggie asked him to stay at home and look after the children whilst she worked. In the early years after Maggie came to the UK, Andrew used the fact that she had a temporary visa against her to prevent her from establishing her independence. None of this information was known to agencies prior to Andrew's murder.

14.3.5 The panel noted that Maggie had been isolated, subjected to domestic abuse and potentially had a lack of understanding around her visa situation and residency in the UK, which Andrew exploited. The panel's cultural adviser told the panel that in these circumstances it would be common for a woman to follow what her husband said through fear of losing her visa. This is a learning point [panel learning 2] and leads to panel recommendation 2.

14.4 **When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about Andrew and Barry? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?**

14.4.1 In 2009 and 2010 it would have been expected that that Huong would have been supported as a victim of both domestic abuse and as a vulnerable adult [referred to now under current legislation as an adult at risk]. Staff would have been aware of domestic abuse concerns, but at the time, within the then legislative framework, would not necessarily have seen Huong as a direct domestic abuse victim. This matter has been escalated over recent years and reporting mechanisms strengthened as a result of revised legislation and the involvement of the Older People's Commissioner Wales into the often hidden domestic abuse of older people.

14.4.2 In 2009, a MARAC referral was made following disclosures from Maggie that Andrew had mentioned a gun and that he associated with gangsters. That was appropriate given the level of risk. Records from the MARAC meeting indicate that BAWSO were tasked with providing ongoing support for Maggie. Given the passage of time and in line with their document retention policy, BAWSO no longer hold any detail of their support to or interaction with Maggie. When Maggie made disclosures of domestic abuse appropriate

safeguarding action was taken. Following the 2018 incident the DASH risk assessment which forms part of the PPN was completed and information was shared with specialist domestic abuse agencies. The panel were told that Andrew had a firearms licence revoked following his arrest for domestic abuse on his first wife in 1998, the weapon was surrendered to police and that there was no evidence that he had possession of a firearm after that.

14.4.3 The panel discussed whether the actions taken to protect Alex from domestic abuse in the family in 2009 and 2010, which resulted in them being placed in foster care may have affected Maggie's later interaction with services. During the police investigation into Andrew's murder Maggie said that she had not reported incidents whilst Alex was in foster care as she feared that if she did so Alex would not be returned to her. The panel thought that Maggie's experiences may have affected her willingness to report domestic abuse for fear of losing her children again and may also have affected Maggie's ability to bring Barry to the UK. The panel's cultural advisor told the panel that it was likely Maggie would have been assaulted again by Andrew if she had reported anything in order to show his disapproval and assert his dominance. This is a learning point linked to panel learning 2 and contributes to panel recommendation 2.

14.4.4 During 2014, a Health Visitor saw the family on a number of occasions. Andrew was always present and was used as an interpreter when there were any difficulties in communication with Maggie. As a result of this there was no routine enquiry into the possibility of domestic abuse and therefore the opportunity for a disclosure by Maggie or a discussion around domestic abuse was lost.

This is a learning point linked to panel learning 3 and leads to panel recommendation 3.

14.4.5 The panel reflected that although not known to agencies at the time there are indicators that Andrew financially abused both Maggie and his first wife.

His first wife told police during the murder investigation that he spent their money on gambling and alcohol, visited her at work demanding money then threatened her with a knife when she refused, and did not pay any child maintenance when the relationship ended.

During the police investigation into Andrew's death, Maggie told police that Andrew did not contribute, and she paid for everything . In June 2015, Maggie won £112,000 on the lottery and the money was paid into Andrew's bank account and he did not give her it all. Andrew gambled in betting shops and casinos, including when he was supposed to be working.

Maggie told clients Andrew was controlling, taking her money and spending it on gambling, and that 'I earn all the money for him'.

The UK charity Surviving Economic Abuse[11] says

Economic abuse can include exerting control over income, spending, bank accounts, bills and borrowing. It can also include controlling access to and use of things like transport and technology, which allow us to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs.

This type of abuse is a form of coercive and controlling behaviour. It can continue long after a leaving and can have lifelong effects.

Economic abuse and financial abuse involve similar behaviours, but it can be helpful to think of financial abuse as a subcategory of economic abuse. Economic abuse encompasses the many ways that an abuser may control someone's economic situation, including employment and housing, for example controlling finances, stealing money or coercing someone into debt.

14.4.6 Research shows that men who gamble are more likely to act violently towards others – with the most addicted gamblers, the most prone to serious violence.

The study, published in the journal *Addiction,* found that gambling in any capacity: pathological, problem, or so-called 'casual gambling', related to significantly increased risk of violence, including domestic abuse.

The researchers found a statistically significant link between gambling and violent behaviour: the more severe the gambling habit, the greater chance of violence. Just over half of pathological gamblers, 45 per cent of problem gamblers, and 28 per cent of 'casual gamblers', reported some form of physical fight in the past five years.

The study also found that pathological and problem gamblers are more likely to have hit a child: with almost 10 per cent of pathological gamblers and just over 6 per cent of problem gamblers admitting to such behaviour. Those with likely pathological gambling problems also had increased odds of committing violent behaviour against a partner.

The study was led by psychologists from the University of Lincoln, UK, working with researchers from Queen Mary University, University College Cork, University of East London, Imperial College London, and AUT University in New Zealand.

[11] https://survivingeconomicabuse.org/what-is-economic-abuse/

14.4.7 Agencies had no knowledge of any issues between Andrew and Barry prior to Andrew's murder.

14.5 **When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?**[12]

14.5.1 There were clear language and cultural barriers in this case which may have affected how Huong, Andrew and Maggie understood the role of agencies and the services that were available to them.

14.5.3 Interpreters were provided and the Language Line service which provides an immediate interpreter service via telephone was used on many occasions by practitioners. Adult Services feel that this made it challenging for Huong's wishes and feelings to be formally understood and actioned, although she was able to make it clear that she wished Andrew and Maggie to move out of her home.

14.5.4 Maggie declined to make a complaint to police in 2010 after Andrew had slapped her as she said that behaviour was part of their culture. She was supported by BAWSO [The lead organisation in Wales providing practical and emotional support to black minority ethnic (BME) and migrant victims of domestic abuse, sexual violence, human trafficking, Female Genital Mutilation and forced marriage]. BAWSO were contacted as part of the information search for the review. Although they have a skeleton record confirming that Maggie was known to BAWSO and did stay in a BAWSO run refuge for a time, the organisations document retention policy means that detailed records in relation to BAWSO's involvement with Maggie are no longer available.

14.6 **What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?**

14.6.1 The panel did not think it appropriate to review assessments and decisions from 2009 and 2010 given the significant changes in working practices and legislation since then.

14.6.2 The incident of 14 August 2018, when Andrew was alleged to have threatened Maggie with a knife was the most significant opportunity for assessment in this case in that it was less than a year before the fatal incident. All other reported incidents had ceased after 2010. As

[12] https://www.lincoln.ac.uk/news/2016/09/1262.asp

discussed at paragraphs 14.1.4 to 14.1.6 the incident was risk assessed appropriately albeit that historic information was not taken into account. Information about the incident was not passed to Children's Services for assessment as a result of the process that was in place at that time. Had Children's Services assessed the information it is likely that Maggie would have been contacted and there would have been a further opportunity for her to discuss the support available.

14.6.3 Children's Services have reflected that the closure of the family's case in 2019 may have been premature. Whilst a strategy meeting was held and a section 47 investigation undertaken, a Well-being Assessment was not completed alongside this (in line with current practice). This would have provided an opportunity to explore the children's emotional health and wellbeing and any additional wider risks from Andrew's lifestyle. Consideration could also have been given to what support, therapy etc Barry might have needed after what had happened. However, the family did not consent to progress this or receive further support. The threshold to proceed without consent was not met and therefore the case was closed. The panel were told that the issue of Well-being Assessments being completed alongside Section 47 enquiries, is already being progressed as a priority for Children's Services during 2021.

14.6.4 The panels cultural advisor told the panel that there were significant issues in achieving proper engagement with Vietnamese communities using telephone translation services. Technical matters such as risk assessments for example are difficult to understand. Her view expressed to the panel is that agencies would significantly improve engagement by using face to face interpreters where possible.
This is a learning point linked to panel learning 4 and leads to panel recommendation 4.

14.7 Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

14.7.1 Agencies were not in contact with the family after Children's Services closed their case in 2014. The only contact was the 2018 incident discussed in previous paragraphs.

14.7.2 In March 2015, Huong's carers reported that she had been left without family support whilst Andrew was in Vietnam for six weeks. Huong did have the support of carers during this period. Intervention by Adult Social Care was not required.

14.7.3 Alex and Barry both attended local schools. Alex's school reported concerns about their behaviour to Children's Services in 2013, those concerns were known by Children's Service's before the case was closed in 2014. Children's Services acknowledge that the concerns raised by the school were not responded to appropriately. There was a lack of evidence

within records of home visits being completed from March onwards and it does not appear that contact was made with the family between July – October 2013, this was further impacted as the case was reallocated twice during this time and the family had moved. A social worker did visit the home and spoke to Alex and Andrew in January 2014. Alex was very quiet during the visit and only answered questions with one word answers. Andrew stated that Alex was very worried about children's services being involved and feared being taken away again. The panel agreed that consideration should have been given to what Alex may have been trying to communicate by the behaviour. It is not evident that Alex was spoken to alone during this visit. This is an area of learning which has been addressed in a single agency recommendation by Children's Services.

14.7.4 Barry's school had no concerns about him until his poor attendance in 2018. Both schools noted that Andrew was the adult with whom they had most contact and that he would drop off and pick up both Alex and Barry on most days. This was considered to be appropriate as it was known that Maggie worked full time at her nail salon and so it did not raise any concerns.

14.7.5 Paragraph 14.1.4 has already set out the police response to an incident in which the police should have spoken to children and did not do so. It is not repeated in full here.

14.8 Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective?

14.8.1 Agencies involved have had policies and procedures for domestic abuse and safeguarding throughout the time period of the review. The panel recognised that there have been many developments over the ten years of the review. For example, The Social Services & Well-being (Wales) Act 2014 has strengthened the adult safeguarding process, thus aiming to ensure a more robust and active ongoing involvement with adults at risk and escalation processes even where consent has been declined.

14.8.2 The development of new policies over the ten years of the review meant that the panel did not feel it was appropriate to comment on policies that had now been replaced. The panel saw that polices had been applied as was appropriate at the time but practice and policy may now have changed. Gaps in practice have been highlighted in previous paragraphs.

14.8.3 Risk assessments in relation to domestic abuse were undertaken using the DASH risk assessment [encompassed in the PPN used by South Wales Police] and were appropriate to the circumstances.

14.9 **Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?**

14.9.1 The panel focussed on the 2018 incident as that was the closest incident to Andrew's murder. The panel did not think it appropriate to comment in detail under this term of reference on Adult or Children's Services involvement with the family given the significant changes in practice and legislation since those events.

14.9.2 Following the 2018 incident a DASH risk assessment recorded a medium risk. The information was shared with Cardiff Women's Centre who were the central point of triage for domestic abuse PPNs at that time. Maggie minimised the incident and said that Andrew had not threatened her. Attempts by Cardiff Women's centre to contact Maggie to offer support were unsuccessful. The fact that information on the incident was not passed to Children's Services for assessment and was not shared with health meant that there was no further exploration of the family circumstances. As discussed at paragraphs 14.1.4 to 14.1.6 and 14.6.2 the incident was risk assessed appropriately albeit that historic information was not taken into account. Information about the incident was not passed to Children's Services for assessment as a result of the process that was in place at that time. Had Children's Services assessed the information it is likely that Maggie would have been contacted and there would have been a further opportunity for her to discuss the support available.

14.9.4 Andrew was never perceived to be a victim by any service and there was therefore no risk assessment or risk management plan relevant to him as victim.

14.10 **Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Andrew and/or Barry, or on your agency's ability to work effectively with other agencies?**

14.10.1 No agency has indicated that capacity or resource issues affected their work with any of the subjects of the review.

14.11 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Andrew and/or Barry?**

14.11.1 Cardiff Council is a partner organisation with the Wales Interpretation & Translation Service (WITS). WITS is a not-for-profit service for the public sector in Wales and was established in 2010. The service offers Braille, signing, large print, transcription services and face to face interpreting. There is evidence within case recordings of interpreters and Language Line being used and records of documents being translated into Vietnamese.

14.11.2 There is no evidence of consideration being given to Maggie's level of dependency on Andrew in relation to finance and immigration status, particularly in her early years in Cardiff.

14.11.3 Adult Services consistently accessed language line to support Huong but found it difficult to understand her history, culture, wishes and feelings. This appears to be as a direct result of the language barrier.

14.11.4 Beyond the use of interpreters and language line there is limited evidence of agencies taking into account racial, cultural, linguistic, faith or other diversity issues. Maggie appeared to tolerate domestic abuse from Andrew, stating this was part of their culture. This was not fully explored by agencies. Separately Andrew was used as an interpreter during health visitor appointments removing the opportunity for any discussion about domestic abuse. These are learning points which lead to panel recommendation 2 and 3 respectively.

14.12 **What learning has emerged for your agency?**

The agencies learning is taken directly from their IMRs.

Children's Services

- Domestic abuse training needs to be reviewed to include knowledge of coercive and controlling behaviour. Fear concerning shame, as well as dependence on others (i.e., immigration issues) need to be considered in the context of a family's cultural and ethnic origin.

- Assessment and analysis of risk must include the role and presence of new partners / any other significant adult within the household. They should include critical analytical reflection and ensure that parental issues do not overshadow children's needs and should include professional curiosity.

- Practitioners need to ensure that identified concerns lead to effective assessment, clear analysis, evaluation and robust interventions.

- Specifically, the importance of gathering all information and looking for patterns of behaviour rather than viewing each incident in isolation through the use of chronologies and reflective supervision.

- The voice of the child is paramount and all opportunities should be made to understand the likely impact/lived experience on the child. Consideration should be given to what children may be trying to communicate by their behaviour and

whether what may be described as challenging behaviour is an indication of unmet needs.

- Frequent change in social worker and lengthy gaps between visits to children reduces the opportunity for children to develop a relationship with a trusted professional outside of their family whom they can talk to about their experiences.

- Consistent and comprehensive record keeping is crucial in ensuring appropriate continuity of care and an integrated response. Clear recording outlining the rationale for any delay in visiting also needs to be documented along with managers decisions and all meetings.

- The need for Well-being Assessment to be completed as part of Section 47 enquiries.

Adult Services

- The need for improved communication streams to understand fully the cultural needs of the individual adult at risk.

- Strengthened housing options or move on arrangements for perpetrators. The inference in Huong's case was that, at times, she should be moved from her own home as opposed to the perpetrator.

- The need for improved chronology report mechanisms within the care record systems.

South Wales Police

- There were two records that existed for Maggie under different names and these were not merged until 2019. Therefore, the domestic abuse incidents that occurred in 2009 were not known about when conducting the risk assessment in 2018. Although the risk assessor has confirmed that even if she was aware of the previous involvement of social services and previous history of DVA, her assessment would have been the same, it is crucial that risk assessments are based on accurate and full information and this is an area of learning for SWP.

- A more effective investigation could have been carried out in relation to the 2018 incident. Whilst it is appreciated that Maggie denied any assault had taken place and

denied that any threats had been made towards her, speaking with the children who made the original reports and were also present could have provided additional information and corroboration and a different perspective on the situation within the household.

14.13 **Are there any examples of outstanding or innovative practice arising from this case?**

14.13.1 The panel did not identify outstanding or innovative practice in this case

14.14 **Does the learning in this review appear in other domestic homicide reviews commissioned by Cardiff Community Safety Partnership?**

14.14.1 The panel were provided with recommendations from previous Cardiff DHRs. Although there were no directly corresponding recommendations the panel saw that there were some which may be indirectly relevant.

2014 – Ensure BAME victims of violence against women, domestic abuse and sexual violence are confident to access services.

2016 – Ensure that local commissioned VAWDASV specialist services engage with all BAME communities.

- Require commissioned services to actively engage and liaise with community representatives to ensure that their services are inclusive.
- Actively seek engagement and input from victims and survivors that represent all protected characteristics and crime types.

2016 - Awareness raising about domestic abuse, how and to whom to report it and the associated services that are available to victims [for overseas students in particular] should be commissioned.

2016 – That agencies work to raise awareness of coercive and controlling behaviour, especially amongst young people and their families.

2014 – GP practices to use health promotion information to raise public awareness of domestic abuse and how to access services.

14.14.2 The panel acknowledged the previous recommendations and considered that because they were between five and seven years old that new recommendations specific to this review should be made.

15 CONCLUSIONS

15.1 The DHR panel wish to reiterate that Andrew was the victim of a homicide and his murder is the reason for this Domestic Homicide Review. The panel could not find any evidence to suggest that Andrew was a victim of domestic abuse prior to his murder. The panel did find evidence that Andrew had been a perpetrator of domestic abuse prior to his murder and during the incident which led to his murder.

15.2 There were significant problems in the family following Andrew and Maggie's marriage in 2007 and her move from Vietnam to Cardiff in 2009, when they lived with Huong. Allegations of domestic abuse in the family led to Maggie living in a refuge and ultimately her child Alex being removed when Maggie moved back to the family home against Children's Services advice. It is likely that this had a lasting effect on Maggie in terms of her willingness to engage with services.

15.3 Tension in the family also lead to a number of safeguarding issues being raised with Adult Services in relation to Huong. The core of those issues appears to have been challenges over the family living arrangements which were resolved when Maggie and later Andrew moved out of his mother's home in 2010.

15.4 Alex was placed in foster care as a result of domestic abuse involving Andrew, Maggie and Huong. She returned to Maggie and Andrew's care in 2012 and her case was closed to Children's Services in 2014. That marked the end of agency concerns about the family until a single domestic abuse incident was reported in 2018. Although Andrew was arrested and interviewed by the police there was insufficient evidence to take action.

15.5 The investigation into the 2018 incident could have been more effective. Although Maggie minimised the incident and denied any threats or assault speaking with Barry or Alex who had made the original call could have provided the police with additional information.

15.6 Although there was no agency knowledge of recent domestic abuse in the household other than this one incident, the police spoke to a number of witnesses after Andrew's murder who were aware of abuse in Maggie and Andrew's relationship and were aware that she often had injuries consistent with domestic abuse.

15.7 On the day of the fatal incident, Andrew attacked and injured Maggie. Barry intervened to protect his mother and fatally stabbed Andrew. There had been no previous indication to any agency of issues arising between Barry and Andrew. Barry was previously unknown to the police or any other agency in Cardiff.

15.8 Barry and Maggie did not engage with the review and it has therefore not been possible to reflect their views or hear the voice of Maggie's two younger children.

16 LEARNING

This learning arises following debate within the DHR panel.

16.1 Narrative

Maggie's name changed over the time that she was in Cardiff as she stopped using her Vietnamese name and used an English name. Later interactions with agencies did not take into account historic information recorded under her Vietnamese name.

Learning

It is important that names are checked and historic information accessed in order to ensure that full and accurate risk assessments take into account all of the information recorded.

Recommendation 1 applies.

16.2 Narrative

Maggie was a victim of domestic abuse. The panel were informed by a cultural expert that Vietnamese culture was a barrier to Maggie reporting abuse or accessing services. In addition, to this, Maggie was uncertain of the security of her residency in the UK and this was exploited by Andrew.

Learning

Diverse cultural attitudes can result in people who are living in the United Kingdom being subjected to domestic abuse within their relationships. Information needs to be available to help those individuals to understand the support and accessibility to services that they can access to prevent the abuse.

Recommendation 2 applies.

16.3 Narrative

Andrew was sometimes use as an interpreter for Maggie. Using family and friends as interpreters in order to aid communication with Professionals can present significant risks to victims of domestic abuse.

Learning

Using an intimate partner as an interpreter removes the opportunity for a discussion about or disclosure of domestic abuse. Engagement with victims of domestic abuse, whose first

language is not English should be undertaken with the use of interpretation services.

Recommendation 3 applies.

16.4 **Narrative**

The use of telephone translation services is helpful but is sometimes not capable of dealing with complex technical issues.

Learning

Face to face translation services may have more success in gaining victim engagement and ensuring that complex issues, for example risk assessments are dealt with effectively.

Recommendation 4 applies.

16.5 **Narrative**

The homicide investigation identified that many people outside of the family knew that Maggie was being abused by Andrew. This finding is consistent with many other DHRs.

Learning

The absence of clear guidance on what members of the public can do when they know or suspect that someone is a victim of domestic abuse, could contribute to the abuse enduring and/or placing the victim in greater danger. The panel felt that this illustrated a cultural acceptance of domestic abuse within some neighbourhoods of Cardiff and that action was required in order to address the cultural issue. This may need to go beyond publicity as Cardiff CSP already conducts extensive publicity around domestic abuse.

Recommendations 5 and 6 apply.

16.6 **Narrative**

Barry was unknown to services after he stopped attending school.

Learning

Children and Young People from minoritised communities may have limited understanding of how to access services if they are not in the school system.

Recommendation 7 applies

17 RECOMMENDATIONS

DHR Panel

These recommendations have been developed in partnership with the panel.

17.1 Cardiff Community Safety Partnership should receive assurance from all agencies that the learning in relation to use and recording of different names in this review has been disseminated to and understood by staff.

17.2 Cardiff Community Safety Partnership should review and if necessary, enhance the information and support available to its diverse communities to promote healthy relationships and deny abusers the cover of cultural acceptance.

17.3 Cardiff Community Safety Partnership should receive assurance from all agencies that family members are not used as interpreters as this prevents the disclosure of domestic abuse.

17.4 Cardiff Community Safety Partnership and its partners to consider the need for face to face victim engagement when requiring translation services.

17.5 Cardiff Community Safety Partnership should review the effectiveness and if necessary, strengthen the information provided to family, friends, neighbours and diverse communities about recognising the signs of domestic abuse and where they can go, if necessary anonymously, with such information.

17.6 That Cardiff Community Safety Partnership ensures that the Regional VAWDASV Strategy details how it will respond to the cultural acceptance of domestic abuse and improve the confidence of victims and witnesses to report abuse.

17.7 The Community Safety Partnership should review how children and young people from minoritised communities are informed about where they can seek support, particularly if they are not in the school system.

17.8 **Single agency recommendations**

17.9 Single agency recommendations are contained within the Action Plan.