Domestic Homicide Review
Overview Report

Andrea

January 2016

Report produced by Martyn Jones Bsc (Hons)
Independent Chair and Author

April 2021

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A message from the Lewis family.

As a family, we are shocked and heartbroken at losing Andrea in such tragic circumstances.

Andrea died because of domestic violence.

This was so unnecessary.

We will always love and remember our Andrea.

Andrea was a wonderful daughter, mother, sister and friend.

Please do not let Andrea's death be in vain.

List of Abbreviations

AAFDA	Advocacy After Fatal Domestic Abuse
ABMUHB	Abertawe Bro Morgannwg University Health Board
A&E	Accident and Emergency Department at Hospital
CPS	Crown Prosecution Service
CCTV	Close Circuit Television
DAU	Domestic Abuse Unit
DASH	Domestic Abuse, Stalking and Honour Based Risk Assessment
DHR	Domestic Homicide Review
DA	Domestic Abuse
DWP	Department of Work and Pensions
DVDS	Domestic Violence Disclosure Scheme
DVPO	Domestic Violence Protection Order
IDVA	Independent Domestic Violence Advisor
IFSS	Integrated Family Support Service
GP	General Practitioner (Doctor)
G1	Grading given to Police Calls
HITS	Domestic Violence (Hurt, Insult, Threatened, Shouted) Health Assessment.
IMR	Individual Management Review
MARAC	Multi Agency Risk Assessment Conference
NPTCBC	Neath and Port Talbot County Borough Council
NICHE OEL	An Occurrence on the Police Record Management System
NSPIS	Police Command and Control System recording initial Police incident
PIN	Police Information Notice
PPD1	Police Public Protection Referral Department Form (Discontinued)
PPN	Public Protection Notification
PVPN	Police Violence Protection Notice
SIO	Senior Investigating Officer (Police)
SWP	South Wales Police
WAST	Welsh Ambulance Service Trust
WCADA	Welsh Centre for Action on Dependency and Addiction

INTRODUCTION AND BACKGROUND

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

It is the family's wish that Andrea be identified in this review. They declined the use of a pseudonym.

Introduction

1. This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Andrea Lewis a 51year old woman on 30th January 2016. Her partner (known as P) was arrested and charged with her murder. P appeared before the Crown Court in August 2016, and was convicted of manslaughter and sentenced to eight years' imprisonment. The Crown Prosecution Service appealed against sentence. The appeal was successful. In October, 2016 the Court of Appeal substituted the original sentence with an extended sentence of 12 years and 6 months, imprisonment with an extended licence of 4 years because he was deemed to be a dangerous offender.

Purpose of a Domestic Homicide Review

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

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

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

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

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

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

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016
[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.

been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

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

- Establish what lessons are to be learned from the homicide, regarding the way in which local professionals and organisations work individually and together, to safeguard victims;
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses, including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children, through improved intra and inter-agency working.
- To assist the victim's family in their meaningful healing process.
- Contribute to a better understanding of the nature of domestic violence and abuse: and
- Highlight good practice

Process of the Review

1.4 South Wales Police notified Neath and Port Talbot Community Safety Partnership of the homicide on 17th February 2016. The Crown Prosecution Service (CPS) had been advised of the death and concluded on 13th July 2016, that there were grounds to charge the P. Neath and Port Talbot Community Safety Partnership reviewed the circumstances of this case against the criteria set out in Government Guidance and recommended to the Chair that a Domestic Homicide Review should be undertaken. The Chair ratified the decision.

1.5 The Home Office was notified of the intention to conduct a DHR on 10th March 2016. An independent person was appointed to chair the DHR Panel. At the first review panel a terms of reference were drafted. On 30th November 2017, the Community Safety Partnership Board approved the final version of the Overview Report and its recommendations.

1.6 Home Office Guidance[4] requires that DHR's should be completed within 6 months of the date of the decision to proceed with the review.

Independent Chair and Author

1.7 Home Office Guidance[5] requires that;

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

1.8 Neath Port Talbot Community Safety Partnership decided in this case to appoint an Independent Chair and Author.

1.9 The Independent Chair and Author, Mr Martyn Jones, was appointed at an early stage to carry out this function. Mr Jones is a former Senior Detective Officer with South Wales Police, retiring in 2011, and has many years' experience as a homicide investigator and was once head of Public Protection for South Wales. Martyn Jones led on many policy reviews and public protection programmes across Wales and was experienced in carrying out many of the functions in relation to Domestic Homicide Reviews. Towards the end of his career Martyn Jones was a Senior Officer in the forces Professional Standards Directorate.

1.10 Martyn Jones is a consultant to the Winston Partnership Limited, and works closely with Mr Malcolm Ross an experienced DHR author. Malcolm Ross has completed numerous DHR's across the UK and advised on the process of this review. Mr Ross has received national recognition for previous DHR work.

Domestic Homicide Review (DHR) Panel

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

Name	Designation	Agency
Lisa Hedley-Collins	Strategic Business Manager	Western Bay Safeguarding Board
Dawn Burford	Planning and Partnership Support Manager	ABMU
Lynn Davison	Deputy Head of Safeguarding Adults	ABMU
Kay Rees	Business Administrator	Western Bay Safeguarding Board.
Sue Hurley	Independent Protecting Vulnerable Person Manager	South Wales Police

[4] Home Office Guidance 2016 pages 16 and 35
[5] Home Office Guidance 2016 page 12

Mark Windos	Manager	Neath & Port Talbot Homes
Debbie Osowicz	Deputy LDU Lead	National Probation Service
Lisa Shipton	Manager	WCADA
Julie Bowditch	Complaints Officer	NPT Social Services Department
Ifana Davies	Peripatetic Consultant Social Worker	NPT Social Services Department
Malcolm Ross	Independent Chair/Author	Winston Consultancy
Martyn Jones	Independent Chair/Author	Winston Consultancy
Julia Lewis	Domestic Abuse Coordinator	NPTCBC
Zoe Jones	Consultant Social Worker	NPT Social Services Department (Adult Safeguarding)
Ruth Allen	Head of Operations – South	Hafan Cymru

1.12 None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

1.13 The Panel was supported by an Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness, sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as, a result of this review having been undertaken. The panel met on ten occasions.

Parallel Proceedings

1.14 The Panel were aware that the following parallel proceedings were being undertaken:

- Neath Port Talbot Community Safety Partnership advised HM Coroner on 1st June 2016 that a DHR was being undertaken.
- The review was commenced in advance of criminal proceedings having been concluded and therefore proceeded with awareness of the issues of disclosure that may arise.

Time Period

1.15 It was decided that the review should focus on the period from 1st January 2011 up until the time of Andrea's death on 30th January 2016, unless it became apparent to the Independent Chair that the time frame in relation to some aspect of the review should be extended.

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

1.17 This is the Neath Port Talbot Community Safety Partnerships first experience of a Domestic Homicide Review.

Scoping the Review

1.18 The process began with an initial scoping exercise which was held on the 26th April 2016, followed by an IMR Author briefing on the 11th May 2016 and the first panel meeting on the 11th July 2016. The scoping exercise was completed by the Western Bay Safeguarding Board to identify agencies that had involvement with Andrea and P prior to the homicide.

1.19 The Western Bay Safeguarding Board is a support body set up by a number of neighbouring local authorities. A collaborative approach with a shared responsibility to ensure adults at risk of harm in the Western Bay region are safeguarded against all forms of abuse.

Individual Management Reports (IMR)

An Individual Management Report (IMR) and comprehensive chronology were received from the following organisations;

- Abertawe Bro Morgannwg University Health Board (ABMUHB)
- IDVA Neath Port Talbot
- Welsh Centre for Action on Dependency and Addiction (WCADA)
- Children's Services NPT Social Services Department.
- South Wales Police

In addition, reports were received from:

- Department of Work and Pensions (DWP)
- Welsh Ambulance Service Trust (WAST)

1.21 Guidance[6] was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

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

1.22 Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the reports. The Overview Author and the Panel support the recommendations.

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

[6] Home Office Guidance 2016 Page 20

The Area

1.24 Neath Port Talbot is a county borough and one of the unitary authority areas of Wales. Neath Port Talbot is the eighth most populous local authority area in Wales and the third most populous county borough. The actual population taken at the 2011 census was 139,812. The coastal areas are mainly English-speaking; however there are many Welsh-speaking communities in the Valleys to the north of the borough.

1.25 The county borough borders are with other principal areas of Bridgend and Rhondda Cynon Taf to the east, Powys and Carmarthenshire to the north and Swansea to the west. Its principal towns are Neath Port Talbot and Pontardawe.

1.26 The largest town is Neath with a population of 47,020, followed by Port Talbot (35,633), Briton Ferry (7,186), Pontardawe (5,035), and Glynneath (4,368). The majority of the population live in the coastal plain around Port Talbot and the land around the River Neath in the vicinity of Neath.

1.27 Manufacturing accounts for over 22% of jobs in the county borough compared to under 14% in Wales as a whole; just under 70% of local jobs are in services compared to a Welsh average of nearly 80%. Tata steel manufacturing is the largest employer with approximately 3,000 staff.

Summary

2.1 Andrea was born in Wales in July 1964 and was initially employed as a factory worker at a large manufacturing company. She had two children, a son, being the oldest, followed by a daughter some 11 years later.

2.2 The father of the children did not reside within the family unit. The family, who are all white European, reside in a former valley's mining community in an ex-local authority property.

2.3 P has come to the notice of the Police on several occasions, mainly for matters 2.involving drunkenness, public disorder and as a victim in street based violence. Police have also had contact with him due to calls to the Emergency Services as, a result of alcohol misuse.

2.4 P had come to the attention of other statutory authorities previously for Domestic Violence with previous partners, one of which participated in this review. Records indicate that in November 1995 P appeared before the Magistrates' Court after being involved in an incident of Domestic Abuse with a previous partner. P was charged with criminal damage but was subsequently found not guilty by the court. In another incident in September 2001, P was charged with assault on a girlfriend. He again appeared before the magistrate's court. P was found guilty and was bound over to keep the peace.

2.5 This previous partner who participated in this review can be identified as R1. R1 was interviewed on three occasions by the author of this report. R1 expressed a strong desire to support the review process. In or around 1996 R1 met P during a night out in

the Port Talbot area. R1 described P as “alright”, “he was hard working” and “he had money”. They entered into a relationship and lived together for some 20 years. It is evident that this relationship started at the time that R1 was subject to Domestic Abuse from a previous partner. At the time, various support networks were supporting her locally. R1 describes P has being very supportive during this difficult time.

2.6 R1 and P had two children and they lived together in supported housing. The relationship later deteriorated. R1 explains that P became abusive and violent. These episodes of Domestic Violence were fuelled by alcohol misuse. From around 1998 to 2010, R1 will state there was a catalogue of incidents that involved physical assaults and threats to kill. One incident involved the Perpetrator covering himself in petrol and goading their young daughter to set him alight. Another involved a threat to kill by use of a firearm. On this occasion, police firearms units were deployed and R1 and her children were removed to a place of safety. Documented police response to these incidents is positive both in relation to the initial response and subsequent investigations. This is commented upon further in the report. Although R1 did not support formal prosecution against P, there were court appearances where P was convicted and he received community-based sentences. Additionally, the police utilised provisions contained within the Harassment Act by issuing P with warning notices. There was partnership support in place. The MARAC process provided support by way of coordination and victim led support. R1 ended her relationship with P in late 2010. P moved out from the family home.

2.7 In May 2011, South Wales Police attended a domestic incident where P was involved in a dispute with another female. This female was his partner at the time. There followed a series of domestic incidents where in September 2011, the female was later charged and convicted for Grievous Bodily Harm on P having admitted stabbing him with a knife. The female appeared before the Crown Court and received a suspended prison sentence. This relationship was violent and again often fuelled by alcohol misuse. The female involved in this relationship, although formally approached, declined to participate in the review. It is evident that this relationship came to an end in late 2011. In June 2011, P was arrested for being drunk, aggressive and abusive to uniform Police Officers. He was arrested and later charged. After pleading guilty at court he was convicted for being drunk and disorderly. He received a conditional discharge for a period of 12 months and court costs were awarded against him.

2.8 In April 2013, the first reported incident between Andrea and P is recorded. Andrea reported to Police Officers that P had slapped her and that she had locked herself in the bathroom to escape from him. P was escorted off the property and conveyed to another address. The incident was recorded as a verbal altercation. At this time, P was co-habiting with Andrea. Andrea’s daughter remained at the address, although her son had moved out from the family home and in with his maternal grandmother. The son has since stated that he could not have a relationship with P. He described P as abusive and aggressive.

2.9 There followed a series of reported domestic related incidents where on one occasion Andrea was found injured on the road outside her house. She was conveyed to hospital and after receiving initial treatment, discharged herself. The police report that there was no information to support that these injuries were caused as a result of a Domestic Abuse incident. Alcohol misuse was evident in the majority, of incidents. Andrea would often be seen by family members to have facial bruising, although this was masked by Andrea of having fallen whilst under the influence of alcohol. At this time, Andrea was diagnosed with breast cancer and was receiving specialist Oncology support. There was intrusive and specialist medical support in place. Andrea overcame this life-

threatening condition. It then follows that in December 2015 Andrea ends her relationship with the P. The Victims family are made aware that P has moved out from the home, and that the locks are changed at the address. P then moves back in with a friend, identified in this review as FP.

2.10 During the early morning of the 30th January 2016 the emergency services are called to an address where P is residing with FP. Andrea was found at the address in an unresponsive state. The emergency services were informed by P that Andrea was found outside the property partially clothed and with facial bruising. Andrea died at the scene. Both P and FP were later arrested, cautioned and interviewed by the Police. After advice from the Crown Prosecution Service, P was charged with the murder of Andrea. No proceedings were taken against FP.

2.11 P was subsequently convicted of manslaughter and received an eight-year term of imprisonment. The Crown Prosecution Service appealed, and as previously outlined, the Court of Appeal reviewed the sentence and substituted the custodial term to twelve years and six months imprisonment, with an extended licence of 4 years, because he was deemed to be a dangerous offender.

Terms of Reference for the Review

2.12 The aim of the 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;
- Clearly identify what the lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses, including changes to the policies and procedures as appropriate;
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working,
- Contribute to a better understanding of the nature of domestic violence and abuse: and
- Highlight good practice

A generic terms of reference document was provided to panel members prior to the preparation and presentation of Individual Management Reports.

Additionally the panel decided to review information outside of the agreed time frame, having decided that there was relevant information regarding a previous partner of the perpetrator.

The panel also recognised family representations to look specifically at two issues which are identified and explainbeen ed further in the report.

Process

2.13 An Independent Chair/Author has been commissioned to manage the process and compile the report. Membership of the Domestic Homicide Review Panel will include representatives from relevant agencies.

Confidentiality and Dissemination

2.14 The findings of this overview report are restricted. Information is available only to participating officers, professionals and their line managers until after the review has been approved for publication by the Home Office Quality Assurance Panel.

2.15 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms were considered, however it was the expressed wish of the family and those who supported the review that Andrea be identified within the review.

2.16 Confidentiality and Dissemination has not prevented agencies from taking action on the findings of this review in advance of publication.

2.17 Subsequent to permission being granted by the Home Office to publish, this report will be published on the Neath Port Talbot Community Safety Partnership web-site.

2.18 Wider dissemination will be made through the Western Bay Safeguarding Board and the Domestic Abuse local leadership board.

2.19 A number of learning events with relevant professionals have been planned with bespoke and targeted briefings to those specialists involved in the delivery of domestic and sexual abuse services.

Individual Needs

2.20 Home Office Guidance[7] requires consideration of individual needs and specifically:

> 'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'

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

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

[7] Home Office Guidance 2016 page 36

2.22 The review gave due consideration to all of the Protected Characteristics under the Act.

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

2.24 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act. However, evidence of P's previous history of aggressive behaviour towards his former female partners was an important consideration when gathering evidence for the review.

Family Involvement

2.25 Home Office Guidance[8] requires that:

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

2.26 The 2016 Guidance[9] illustrates the benefits of involving family members, friend and other support networks as:

> a) assisting the victim's family with the healing process, which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as, long as, they need after the homicide;
>
> b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on the victims and perpetrator's perspectives rather than just agency views.
>
> c) helping families satisfy the often, expressed need to contribute to the prevention of other domestic homicides.
>
> d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of the victim and/or perpetrator in order, to see the homicide through the eyes of the victim and/or perpetrator. This approach can help the panel understand the decisions and choices the victim and/or perpetrator made.
>
> e) obtaining relevant information held by family members, friends and colleagues that is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide information as well as testimony to the emotional effect of the

[8] Home Office Guidance 2016 page 18
[9] Home Office Guidance 2016 Pages 17 - 18

homicide. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

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

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

2.27 In this case, the Overview Report Author made contact with the Senior Investigating Officer (SIO) and the Family Liaison Officer (FLO) from South Wales Police at an early stage. Contact with the family was initially made by letter, dated 14th July 2016, which was hand-delivered by the Police FLO to Andrea's mother, explaining the review process and inviting her and her family to contribute to the review, should they wish to do so.

2.28 There then followed an introductory visit where the FLO introduced the Author of the report to various family members. A series of meetings then took place between the Author and various family members.

2.29 The Author has kept the family informed of the process throughout. The Author has met with Andrea's mother, sister and son. They have all made valuable contributions to the overview report. As previously outlined, they have declined the use of a pseudonym. They have all been signposted to AAFDA for independent specialist support. An invitation was made for the family to meet the panel members as per 2016 guidance[10]. Although this was welcomed and appreciated, the family chose not to accept this invitation.

2.30 Comments made by the family members have been included and referred to in this report. This is contained in the section 'Family Views'.

2.31 A letter inviting P to contribute to this review was sent to him and his solicitor whilst P was in HM Prison on remand. He has not acknowledged the letter or indicated that he wishes to be, seen as part of the review. He has not replied to a request for the review to have access to his medical records.

2.26 The Author has also written to FP inviting him to participate in the review. FP has not responded or indicated that he wishes to be seen as part of the review.

2.27 Additionally, the Author has written to four former partners of P. Only one former partner has responded. This person can be identified in this report as R1.

2.28 Family members have been supplied with a copy of the Overview report.

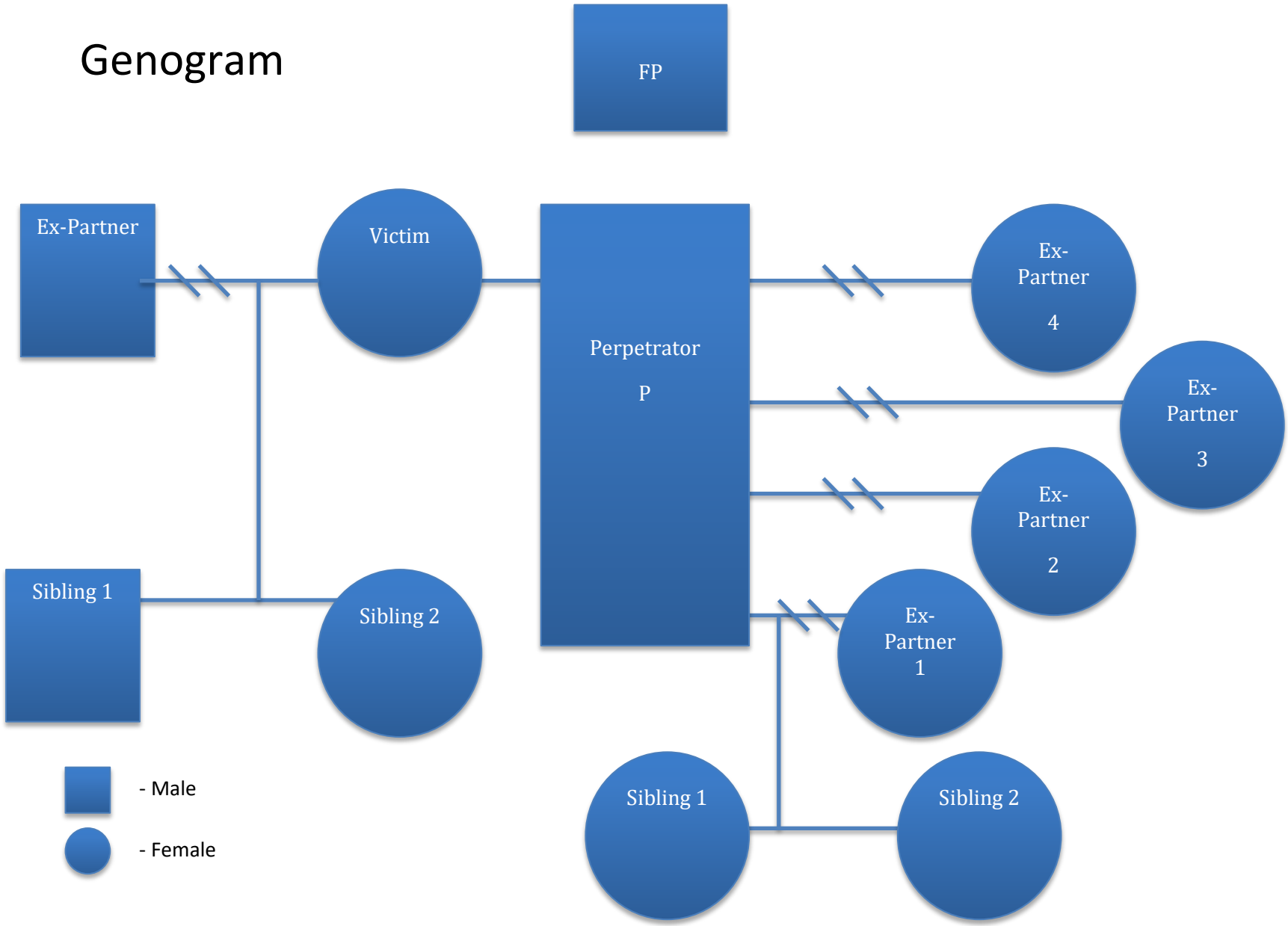
[10] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office – December 2016 para 53 (b) page 17

Subjects of the Review

2.29 The following genogram identifies the family members in this case, as represented by the following key;

Known as	Description of relationship to Victim
Andrea	Victim
P	Perpetrator ex - partner of Andrea
FP	Friend of P
R1	Ex- partner of P
R2	Ex -partner of P
R3	Ex- partner of P
R4	Ex- partner of P

Genogram


FP
Ex-Partner
Victim
Perpetrator
P
Ex-
Partner
4
Ex-
Partner
3
Ex-
Partner
2
Ex-
Partner
1
Sibling 1
Sibling 2
Sibling 1
Sibling 2
- Male
- Female

Summary of Key Events

3.1 R1 is the mother of six children. The family originate from the West Country. Her family moved to Port Talbot in South Wales after her father obtained employment constructing the M4 motorway through Port Talbot.

3.2 R1 married her husband in 1976 and they had two children. They divorced in 1981 and their children, now mature adults, have families of their own. R1 then had a relationship with another man that ended after twenty years. They did not marry, but had two children who are also now mature adults with their own families.

3.3 This second relationship involved a series of violent domestic incidents that involved her partner being convicted and sentenced to imprisonment for wilful neglect of their children. Her partner at the time received a three-year term of imprisonment. Consequently, R1 moved away from Wales to escape the violence. R1 has stated that at the time she was well supported by Women's Aid, who found her accommodation in a refuge in England.

3.4 Due to family connections, R1 moved back to Port Talbot and was found accommodation in a local Women's Aid refuge. R1 will state she was well supported by the Local Authority Social Services department and a Local Housing Association. Additionally, R1 commented positively on South Wales Police management and support to her family at the time that her partner was subject to investigation and the subsequent criminal justice process.

3.5 In or around 1996, R1 whilst residing in protected accommodation for vulnerable people in the Port Talbot area, went out for a social evening with residents from the Women's Aid Refuge. They visited a local public house. This is where R1 first met P.

3.6 R1 describes P as "He was alright", "He was hard working," "He worked in a local factory and had money." R1 states that they got on very well and they subsequently entered into a relationship. R1 recalls that P was living in the factory where he worked at the time.

3.7 R1 explains that her relationship with P developed and he moved in with her. R1 comments "P entered my life at the time my house was being protected from my previous partner" They both lived at this address for some four to five years and then moved to her current address. They had two children, who are now both teenagers. R1 describes P as initially being supportive and understanding of her previous experiences with a violent ex-partner.

3.8 Unfortunately, this relationship deteriorated and became abusive. R1 will explain that P was drinking heavily and had decided to work away from home. P took little interest in their children and would often befriend other women and embarrass R1 with his sexual exploits. R1 found this to be emotional abuse. There followed a catalogue of incidents that involved Domestic Abuse with Police involvement.

3.9 In June 2003, R1 explains how she was beaten by P, who smashed a mirror over her. R1 received hospital treatment to a serious leg wound. The Police were informed and an investigation was undertaken. P was arrested for the assault, which proceeded to court. R1 decided to withdraw her complaint, a court process continued and P was bound over to keep the peace.

3.10 R1 will state that in January 2007, P doused himself with petrol and gave their youngest daughter a lighter and goaded her to set him alight. Both the Police and the Fire Service attended at their home address. P was taken away by the Police and conveyed to a friend's home address, believed to be the home of FP. R1 will state there were no follow up enquiries or investigations by the Police. R1 is unsure if the Social Services were involved. Police records of the incident differ in that they confirm that P was arrested for a Breach of the Peace and the incident was referred to a MARAC process. A referral was also made to Children's Services and R1 chose not to engage with Women's Aid. Whereas these incidents are recorded in Police and Social Services records, the details in agency records differ from the account given by R1. For example, Police records contain no mention of P goading either R1 or the child to set him alight.

3.11 On another occasion, P attempted to start a chainsaw in the lounge of their home threatening to damage their furniture. At the time, a friend was present. P was drunk, and both R1 and her friend feared for their safety. R1 telephoned FP and asked him to collect P, which he did. There is no record of this incident being reported to the police, although Police records do confirm that it was from the chainsaw that P had taken the petrol in respect of the previous recorded incident involving a cigarette lighter.

3.12 In November 2009, P threatened to shoot R1. This was after R1 had kicked P out of the family home. R1 states her young daughter had informed her that she had seen P with a firearm. Threats to kill were made during a telephone conversation. R1 contacted the Police who took the situation seriously. Firearms officers were deployed and R1 and her daughters were taken to the Police Station as a place of safety. They were interviewed by Police officers and made a written witness statement. They were then offered hotel accommodation that night whilst the Police searched for P. R1 is aware that P was arrested that night. During P's interview, he stated that he had been so drunk he could not recall the incident. A full search was conducted of his premises and no firearms were recovered.

3.13 R1 was not made aware of what Police follow up action was taken. R1 received no follow up visits from the Police. Police records indicate that P was investigated for these threats. Consultation with the Crown Prosecution Service took place who advised that P should be released without charge. The Police however, served a First Warning notice under the provisions of the Harassment Act. It is worth noting that the use of such warning notices have, since this time, significantly changed and where there is a full offence, as there would have been in this case, a warning notice will not be issued unless advice dictated otherwise. This illustrated positive Police action, even though the Crown Prosecution Service decided not to criminally prosecute.

3.14 R1 describes her relationship with P as 'horrific'. P would often beat her, demand sexual contact and seek to embarrass her whenever possible. He would spend his money on alcohol and was often drunk. He would be unpleasant to his children and often ridicule them in front of others. These incidents took place at the time that R1 was described by authorities as vulnerable and living in protected accommodation. R1, on reflection, feels she was too afraid to seek support from the authorities. R1 did not want to return to the circumstances that she endured with her ex-husband.

3.15 R1 claims P used the local Police as a taxi service. They would collect him from her home and convey him to the home of FP. This is considered to be positive action by the Police in that if no offences are disclosed, then action to defuse a situation may

involve conveying one party to another address. After they finally ended their relationship, R1 believes that P went to live with FP and then entered into a relationship with another female. This was before his relationship with Andrea.

3.16 R1 fully cooperated with the Police investigation into the death of Andrea. She provided a detailed witness statement to detectives investigating the death and was prepared to attend court to tell her story.

3.17 R1 was also made aware by her daughters that P had received a serious wound to his back after sustaining a stab wound during an altercation with another female. This incident resulted in a court case.

3.18 The other female is identified as R2. R2 declined to participate in this review. It is a matter of public record that in August 2012 she appeared before the Crown Court and pleaded guilty to Grievous Bodily Harm. R2 was sentenced to a custodial sentence of fifty weeks that was suspended for two years. R2 was also subject to a Restraining Order.

3.19 This was a domestic incident that was fuelled with alcohol abuse. The incident was referred to MARAC in October 2011 where R2 was identified as the perpetrator and P was identified as the victim.

3.20 Andrea first met P in a public house in Neath in August 2012. This was at the time that R2 was awaiting trial for the assault on P.

3.21 Andrea's mother recalls their relationship developed and that P moved in with Andrea at her home. This occurred around Christmas time in 2012. Andrea's mother was surprised this happened so quickly. They later got engaged. P did not appear to be Andrea's type. Soon after Andrea's eldest child, her son, moved out from the family home and moved in with his grandmother. He could not get on with P. It was felt within the family that P was not a family man and did not want to live with children. The second child soon followed and both grandchildren permanently moved in to live with their grandmother. Andrea remained at her home cohabiting with P. This was a private family arrangement.

3.22 Andrea's mother stated that P was often drunk and frequently used foul language. Andrea would often have facial bruises but when challenged, she would inform her mother that she had fallen. Andrea never disclosed that P had beaten her. The family were aware that the Police had been called to Andrea's home lots of times, but it was believed that only verbal altercations had taken place.

3.23 On 1st April 2013, the Police were called to the address after Andrea had reported that P had slapped her across the face and that she had locked herself in the bathroom to escape him. The incident was graded as G1, an Emergency Response, with officers on arrival reporting both Andrea and P sitting together in the sitting room. No complaints of assault were made and officers reported that Andrea had stated it was only a verbal altercation. Andrea signed the officer's notebook to this effect and P was taken out from the house and conveyed to another location.

3.24 The Officer submitted a PPD1 form. In line with force policy, the matter was not risk assessed, as the incident was recorded as a verbal argument with no offences being disclosed. There had not been any previous incidents between Andrea and P,

therefore the details of the incident were not required to be shared with other partner agencies. This was in accordance with policy at that time.

3.25 On 25th May 2013, the Police received another call to this address. The call was made via the 999 Emergency Call facility and included details of a domestic incident between Andrea and P. Officers found Andrea with blood on her hands and claims by P that she had attacked him after a heated argument in the kitchen area of the house. P had sustained a hand injury that was bleeding profusely. Andrea had initially informed the Police call handler that her boyfriend P had "gone nuts" and was kicking the backdoor in. On the basis of identification of P from previous domestic related incidents, the Police were able to identify warning markers for P and respond to the call swiftly.

3.26 Although the Police were initially faced with a complaint of assault by P against Andrea and that she was arrested, the investigating officers did not lose sight of the fact that during her arrest and after being cautioned by Police investigators, Andrea stated "He (P) gets drunk and hurts me, I had to stab him." During the Police interview, Andrea provided details of incidents where P had assaulted her, but she declined to make an official complaint against him.

3.27 A Police investigation concluded with P withdrawing a complaint of assault. P provided the Police with an alternative series of events in that he claimed Andrea had tried to remove a knife from him to prevent him injuring himself whilst he was in the process of piercing a tin can in the kitchen. P confirmed that Andrea did not make any threats towards him and did not cause the injuries to his hand. Following consultation with the Crown Prosecution Service, no further action was taken.

3.28 Following the incident, the Investigating Officer submitted a PPD1 and his observations were recorded as "It would appear that the injured party in this incident is usually the aggressor. It would appear to be a volatile situation with both parties drinking heavily. In my opinion, there will be further incidents" The officer also identified that P had been subject to previous MARAC referrals with two previous partners. The PPD1 document was immediately shared with the relevant partner agencies, including IDVA, Probation and VA.

3.29 The Police Public Protection Department appropriately referred the incident to MARAC and the following was put in place

- Andrea was risk assessed as High
- Police warning markers were created and placed on P's nominal record on the Police command and control (NICHE) system. He was recorded as being a victim to Domestic Abuse.
- This marker was also created in respect of Andrea who was recorded as being violent as a result of the incident on the 25th May 2013.
- Police Watch was commenced at Andrea's home address that included regular Police patrols to monitor all situations.
- Information regarding this incident was shared with Probation, and IDVA service.
- A MARAC was convened on the 11th June 2013 and no further actions were identified.

3.30 The IDVA service attempted to make contact with P, by way of a series of phone calls and written correspondence. The service records illustrate that P did not respond.

3.31 On the 19th July 2013, both Andrea and P were involved in disorderly behaviour in Neath town centre. The incident occurred at night and CCTV footage records both fighting with each other. Police response was immediate and officers found both Andrea and P extremely intoxicated. The officers established that neither person had sustained injuries. They were both given appropriate advice.

3.32 Police records indicate that officers completed a PPD1 form that contained information of this incident. The information was shared with Probation and IDVA on the 21st July 2013. All PPD1's are routinely shared amongst partners. The National Probation Service then checks all records, including those held by the Community Rehabilitation Company (CRC). This is to ascertain if either the victim or perpetrator are currently active with either service. In this instance, neither was a current case and so the information was not retained in accordance with Probation policy and Data Protection requirements.

3.33 The Police Domestic Abuse Unit assessed the incident as "High Risk" due to the previous incidents and the fact they had recently been referred to MARAC.

3.34 The IDVA service attempted to make contact with Andrea by a series of phone calls, including leaving a message on Andrea's voicemail facility.

3.35 Neither the Police DAU or IDVA service referred the incident back to MARAC, although the Police record that the reason why the incident was recorded as high risk was because the persons involved had recently been referred to MARAC.

3.36 At 12.45hrs, 15th August 2013, R2 contacted the Police to report that her ex-partner P had attempted to contact the children. Due to previous incidents, R2 reported that the children were scared of P and it was believed that P was driving around the streets close to R2's home and that he had made enquiries with a neighbour about their daughter.

3.37 The Police dealt with this incident as a "Concern for Safety" and arrangements were made to interview R2 at a Police Station the following day. R2 informed Police that she had concerns regarding P. The local sightings of P had upset the children, even though they had not been in contact with each other for a period of two years. R2 is recorded as informing Police of previous violent behaviour by P, towards her.

3.38 The incident was dealt with as a "Concern for Safety" and officers made significant enquiries to trace P. The officer intended to deal with the matter by way of serving a Police Information Notice (PIN) on P, which would have been an appropriate way of dealing with this incident. This Information was not shared with other partner agencies.

3.39 Due to the Police having difficulty in tracing P, the officer made further contact with R2 who advised that no further sightings of P had occurred and that R2 did not wish any further Police action.

3.40 At 19.15hrs on 15th August 2013, the same day as the incident with R2, the Police received a call to attend a Domestic Argument at the home address of Andrea. The call was made via the 999 Emergency Call Facility to a BT Operator. It was recorded

that “Female distressed, asking for Police to come straight away” The line was cleared before the call was directed to the Police.

3.41 At 19.25hrs a further call was received from the same number that had now been traced to Andrea’s home address. The incident was graded as a G1 Emergency Response with officers being deployed. During this call, it is reported that Andrea informed the Police call handler that P had threatened to strangle her and that she was expecting her young daughter home soon.

3.42 Upon arrival Police Officers report that P was calm and sober. P explained that Andrea had “gone off on one” having returned home in a drunken state. Andrea informed officers that P had not done anything and that she just wanted him out of her home. The Panel considered that this may be an example of coercive, controlling and manipulative behaviour. Andrea decided not to take this issue further.

3.43 Police Officers escorted P out from the premises and conveyed him to the home of FP. Police records indicate that a PPD1 form was submitted. It was also recorded on the Police NICHE OEL that the child referred to was not at the premises at the time of the incident.

3.44 The PPU officer receiving the PPD1 form identified previous incidents between P and Andrea. The Officer considered previous risk assessments in relation to these other incidents. This incident was considered to be a verbal altercation. It was not considered for a further MARAC referral.

3.45 On 20th August 2013, information regarding this incident was shared with other partner agencies.

3.46 At 01.02hrs on the 16th August 2013 the Welsh Ambulance Service Trust received a call that recorded “Female, can’t wake her” The call was made by P from his home address and the call related to an incident at the home of Andrea. P informed the WAST call handler that he had spoken to Andrea’s daughter at the address and that she had informed him that she could not wake her mother. WAST shared this information with the Police who attended the address. WAST report that the Police attended the scene and advised control that an ambulance was not required. There had been a domestic at the address; the caller had mistakenly thought that his daughter could not wake Andrea when in fact she did not want to wake her due to the hour of his call.

3.47 The IDVA service record that they had no response to attempts to contact Andrea by way of telephone and written correspondence. An information pack was sent out.

3.48 At 20.12hrs on 1st September 2013, South Wales Police responded to a domestic incident at the home address of Andrea. The call was again made via the 999 Emergency Call to a BT operator. The nature of the call included allegations of assault by P on Andrea and information that P had been drinking. It was also reported that Andrea’s twelve year old daughter was present. The Police graded the incident as a G1 Emergency Response.

3.49 WAST were also in attendance and they administered first aid to P who had sustained a minor wound to his arm. WAST record that a laceration to his left forearm caused during a domestic incident. P was treated at the scene and then removed from the property by the Police.

3.50 P was conveyed by the Police to another address after no complaints of assault were made. Police records indicate that Andrea had disclosed that her daughter was not present at the address during the domestic altercation.

3.51 The Police Officers submitted a PPD1 form and the officers recorded that there had been a "Violent History" between P and Andrea. The document also contained the details of Andrea's daughter albeit, it was recorded that the child had not been present at the time of the incident. Officer(s) within the local Domestic Abuse Unit endorsed the form with details of previous incidents between Andrea and P, together with the risk assessments in relation to P and other partners. As no offences had been disclosed, it was not considered for a further MARAC referral. The information contained within the PPD1 was shown to have been shared with the Probation Service, Social Services and IDVA service on the 2nd September 2013.

3.52 On 2nd September 2013, having received information regarding the domestic incident, Children Services opened an Initial Assessment the same day. This was in relation to information that suggested Andrea's daughter was present at the time of the domestic. This assessment included the following:

- Identified that both Andrea and P had been in a relationship since April 2011 a period of approximately eighteen months.
- Andrea has acknowledged that P had assaulted her in March 2013 that resulted in her sustaining a black eye.
- Andrea attempted to hide her black eye from her work and that she would end the relationship with P if he ever hurt her again.
- Andrea disclosed that physical DOMESTIC ABUSE occurs when her daughter is not present.
- The MARAC meeting held on the 11th June 2013 did not consider that Andrea had a child living at home.
- The Initial Assessment was completed on the 11th September 2013 within time scale and was signed off by management.

3.53 During the course of the Initial Assessment, Social Workers visited Andrea at her home address. They met with Andrea and outlined the impact that Domestic Abuse has on children. Andrea was signposted to various support agencies for Domestic Abuse and alcohol misuse. Information leaflets were left with Andrea regarding support from WCADA and Women's Aid. There were several Social Service contacts made with Andrea. A telephone contact is recorded for the 6th September 2013. An appointment for a home visit to speak with Andrea's daughter was made for the 9th September 2013 and a home visit was made on the 19th September 2013. The information to share the findings of the assessment and to provide feedback with Andrea took place on the 2nd October 2013. This coincided with offers to engage with the IDVA service.

3.54 At 00.32hrs on 5th October 2013, ABMU report that Andrea is admitted to Accident and Emergency at a local hospital. Andrea is described as being intoxicated and allegedly fallen, sustaining a head injury / laceration to the back of her head. There was a loss of consciousness and Andrea reported to medical staff that she had no memory of the fall. Andrea received a CT scan that reported no injury.

3.55 Medical staff report that Andrea's son arrived at the hospital and became agitated towards her, implying that P had caused the injury. Staff spoke with Andrea regarding

this allegation and she is asked directly about DA. Andrea refuses to accept this stating she had fallen over and hit her head and that her son was being protective of her. There is no further information to suggest the details of this incident were shared with other partner agencies.

3.56 On 23rd October 2013 the IDVA service reviewed their support to Andrea and P. There was no engagement from either and no further information available, so the case was closed. A review by the IDVA service and the Panel identified that the case was closed in line with relevant policy and procedure. An evaluation of compliance to this policy and procedure, and the policy itself, met the test of independent panel scrutiny.

3.57 At 23.32hrs on 13th December 2013, another domestic argument occurred at Andrea's home address. The circumstances of this incident replicate others in that the call was graded an Immediate Response. Officers attended and found both Andrea and P intoxicated and involved in a verbal altercation. P was again escorted out from the premises and conveyed by Police to another address. No offences were disclosed and a PPD1 was submitted.

3.58 The DAU assessed the incident and on the basis that both Andrea and P were equally to blame, the incident was not referred to MARAC. The DAU stated an intention to monitor the situation and share information with other partner agencies.

3.59 At 10.15hrs on 3rd February 2014, P was admitted to A&E with a minor injury. He claimed he sustained the injury whilst out drinking with friends. He was treated and later discharged. P was not asked about DA.

3.60 At 11.17hrs on 24th February 2014, P reported to Police that he had been assaulted in the Neath area by culprit(s) unknown. He received hospital treatment for a fractured jaw. The circumstances of the incident as reported by P, involved an altercation at a taxi rank in Neath town centre with another male. Andrea accompanied P at the time and they had both been out drinking. The assault was investigated by the Police who were unable to identify and trace the culprit(s). The Police did not feel this was a domestic incident but a town centre incident.

3.61 At 02.26hrs on 27th May 2014, an incident occurred at Andrea's home, where it had been reported to WAST that a neighbour had assaulted P. The Police were contacted and attended as a G1 Emergency Response. Both WAST and the Police attended. They found P to have sustained a swollen ankle and cuts to his face. Police officers record that P did not wish to make a formal complaint of assault and he signed the officer's notebook to that effect. Police officers record that both Andrea and P were intoxicated.

3.62 WAST report that P was conveyed to the local A&E with an injury requiring surgical intervention. ABMU report that P later discharged himself against medical advice. This was not treated as a Domestic Abuse incident.

3.63 At 22.04hrs on 5th December 2014, South Wales Police attended the home of Andrea in response to a Domestic Incident. The call was again made via the 999 Emergency Call Facility and was graded as a G1 Emergency Response. Andrea complained that P had locked her and two thirteen-year-old girls, one of whom was identified as her daughter, out of her home. The officers noted that both Andrea and P were intoxicated.

3.64 This incident was dealt with by officers conveying Andrea to her sister's home to stay the night and Andrea's daughter would stay with her grandmother. Officers submitted a PPD1 form that was later assessed by the DAU.

3.65 A PPU officer recorded a subsequent risk assessment as "medium" on the basis that the previous recorded incident was on 13th December 2013. The DAU recorded that alcohol seemed to be the main factor and both were volatile when they had been drinking. Information regarding the involvement of the two young girls was shared with Children's Services at Social Services.

3.66 Children's Services received this for information purposes only. The information available from the Police regarding the two girls' presence was not specifically recorded in the PPD1.

3.67 In February 2015, Andrea was diagnosed with suspected breast cancer. Over a period of eleven months, Andrea received specialist intensive support from ABMU HB. During this process, there was no mention or discussion of Domestic Abuse recorded by specialist medical staff.

3.68 At 23.47hrs on 27th February 2015, South Wales Police were called to the home of Andrea who had requested that P be removed from her address. The incident was recorded as a domestic argument. The call was made via the 999 Emergency Call Facility and responded to by a G1 Emergency response. Andrea informed the Police Officers that she wanted P out of the house, but provided no reason for that request. The Officers record that both had consumed alcohol.

3.69 Police call handlers record the following comments from Andrea; "if he kills me, it's on your head". Whilst there does not appear to have been any specific investigation into these comments, there was confirmation from her during Police discussions that nothing had happened between them that night. The officers submitted a PPN form, recorded the risk assessment as "High" and conveyed P out of the home. P was conveyed to Neath town centre to meet with friends.

3.70 The DAU again reviewed the incident and did not refer the incident to MARAC. The DAU would monitor the situation and were satisfied that safety measures were in place. There is no information available to suggest that this information was shared with other agencies.

3.71 On 20th May 2015, P is again admitted to A & E. ABMU report that P had disclosed that he had split from his partner Andrea, who was receiving treatment for cancer. P disclosed that he was secretly seeing Andrea and wanted to care for her, however her family were providing care in his place. P accepts that he drinks large amounts of alcohol. This incident appears to be treated in isolation with no reference to Domestic Abuse. P had provided ABMU Health Board with Andrea's details as his next of kin.

3.72 At 22.36hrs on 17th October 2015, South Wales Police received a call from a member of the public, stating that a female was reportedly collapsed in the middle of the road with a head injury. The female was said to be in a semi-conscious state and required an ambulance. The call was made via the 999 Emergency Call Facility and was responded to as a G1 Emergency Response. Officers found the female to be Andrea, who was highly intoxicated, but uninjured. WAST also attended and deemed she was well and not injured. Police Officers conveyed Andrea to her mother's address and no further Police action was taken.

3.73 At 01.39hrs on 12th November 2015, a member of the public reported to South Wales Police via the 999 Emergency Call Facility that "There is a lady on the road, she is half undressed. I think she has been thrown from a car. The location is the bottom of the Fairyland Road." The incident was graded G1 Emergency Response.

3.74 Police Officers attended within four minutes of taking the call. It has been established that the officers spoke to the person reporting the incident at the scene. Furthermore, it has also been confirmed that the reporting person stopped his vehicle when he saw Andrea in the roadway, but he did not witness anything else. Officers record that they had identified Andrea as the injured person and that the street where she was found was outside the home address of P. The Officers hypothesis of what had occurred was that Andrea, whilst under the influence of alcohol, had fallen on an unlit roadway and sustained head injuries. P was at home at the time and he too was found to be intoxicated. Officers record that P had disclosed that both he and Andrea had been drinking and decided to go to bed a short while later. He had heard a vehicle stopped outside and he went outside to discover Andrea lying in the roadway. The explanation of P, in respect of this incident, is corroborated to some extent by the reporting person.

3.75 Andrea was conveyed to the local hospital where the following Domestic Abuse HITS (Hurt, Insult, Threatened, Shouted) Assessment was conducted by medical staff. This assessment is standard practice and is carried out on arrival within the hospital triage unit. This process identified that Andrea had disclosed feelings of insult, being threatened and shouted at.

Andrea's injuries were later identified as follows:

- Body map revealed several sites of bruising.
- Bruising around left eye.
- Swelling to left side of forehead.
- Scratches and abrasions to right lower leg.
- Fractured nose and depression.
- Pain and discomfort to buttocks and right thigh.

3.76 Andrea initially disclosed that the injuries were caused after she had fallen, over whilst under the influence of alcohol. Medical staff record that clinicians had doubt regarding causation of the injuries.

3.77 Medical records indicate that issues of Domestic Abuse were discussed with Andrea who, in addition to the HITS Assessment, disclosed that she was in a violent relationship with P. A referral and explanation of the support role of MARAC was provided and it is documented that Andrea supported this course of action. It is recorded that Andrea had stated she had been in a violent relationship for a few years and has attempted to end the relationship on several occasions, but that P had continued to harass her until she took him back.

3.78 A DASH Risk Assessment form was submitted by a Nursing Sister to the Police DAU. Additionally, a referral was made to Social Services regarding potential safeguarding issues concerning Andrea's daughter. The Police panel advises that the DASH Risk Assessment form is more of a quantitative document with a set of tick box questions which are process driven, rather than a qualitative document containing information to inform risk. This is supported by the fact that although the Risk assessment document was submitted to the DAU, it did not include an explanation regarding the concern about the causation of the injuries to Andrea. If this had been included in the information provided to the Police, then this would have been considered as "new" information and would have prompted both a review of a criminal investigation into the incident and also a route into the MARAC arena.

3.79 This DASH Risk Assessment form is used by non-police agencies for MARAC case identification. This document records that Andrea did not disclose how her injuries were

caused. The Nursing Sister records that Andrea was frightened of P. The Nursing Sister offers a professional judgement that Andrea is high risk.

3.80 P visited Andrea whilst she was being treated at the hospital for her injuries. Privately, Andrea was asked for her permission before the visit took place and if she was comfortable with this situation, to which the following response is recorded, "Not really, but he was so drunk last night he probably does not remember events either" and "she doesn't want him here, she will end it tomorrow."

3.81 The Police officers who attended the initial incident closed the incident as a "Verbal Altercation" although there is no indication that there was a verbal altercation. No PPN was submitted, even though there was a history of high risk incidents involving both Andrea and P, and that there was a history of domestic related incidents. Initial Police action is recorded as "There are no known aggravating factors / threats of violence or concerns for any children present at this address. No real concern, drunken female had fallen over in wet conditions." The Police analysis of this initial response identified that, given the relationship between Andrea and P, a PPN should have been submitted. A procedure is now in place with a requirement to submit a PPN in every case of reported Domestic Abuse or concern.

3.82 The attending officer was satisfied from his initial assessment of the scene, and from speaking to the reporting person and P, that Andrea had left his premises in an intoxicated condition and fallen in an unlit road. Based on the information obtained by the attending officers, there were no further enquiries because the condition in which Andrea was found was consistent with the explanation provided at the time. The officers omitted to record on the incident that they had spoken to the reporting person at the scene, however there is information contained in the subsequent investigation to support that this did happen.

3.83 The Police DAU received the DASH referral from medical professionals and decided not to refer the incident to MARAC. The rationale, dated the 18th November 2015, states that "The original incident leading to this referral was attended by Police and was shown to have involved the subject of the referral as having fallen over, intoxicated in the street" The DAU screened out the incident from MARAC and did not uphold the referral received from the Nursing Sister. The DAU felt no additional information was presented to confirm that the injuries sustained by Andrea were a result of a domestic incident and that there was a paucity of information to support increased risk. The referral was returned to the MARAC Coordinator who informed the Nursing Sister of the decision.

3.84 The Nursing Sister has no recollection of the referral being returned. There is no record on any health maintenance records to show the referral had been returned.

3.85 The Police will state the medical professional would have had the opportunity to provide further information to support the referral, or challenge that decision, and neither were forthcoming. There is no information available to suggest that the Police considered taking active steps to personally make contact with hospital staff, or interview Andrea, whilst she was in a coherent state and away from P. This was identified during the Police review of the incident and outlined in the chronology of events. The Police arranged patrols in the vicinity of Andrea's home as part of a Police Watch support service. A record is made of a telephone conversation with Andrea on the 23rd November 2015. The Police report that Andrea had stated she was no longer in a relationship with P, she was provided with the officer's details and with reassurance and advice. Police report that Andrea was happy with that response.

3.86 Children's Services received the referral from medical professionals and arranged for an Initial Assessment. Records indicate that Social Services were concerned those incidents of Domestic Abuse were under reported and that the risk is increased as a mother is trying to separate from her partner. A clear action plan was put in place and a referral to Team Around the Family (TAF) recommended low level voluntary involvement with a support service. Andrea had stated the relationship with P was over and had ended in February 2015, although they maintained contact socially. The social worker had highlighted the information provided by Andrea was 'vague and confusing' in respect of this continued contact. It was noted that Andrea's daughter had voiced her concerns during the assessment and cross referencing with other agencies did take place. It was established from the daughter that P did not live at their home, he had moved out and that her mother and P were not together.

3.87 On 25th November 2015, Children's Services record that the Initial Assessment (IA) has been completed. The IA included interviews with both Andrea and her daughter. These interviews revealed that:

- Andrea disclosed the Domestic Abuse is getting worse.
- Andrea had visited hospital on two occasions, as a result of Domestic Abuse related injuries. This being on the 12th November 2015 and again on the 26th November 2015.
- Andrea acknowledged that she had been drinking to excess, but never when her daughter is present.
- Her relationship with P has come to an end; in fact, it ended some nine months previously, at the time she was diagnosed with cancer.
- Andrea confirmed that she does see P, but only at social events as they share the same group of friends.
- Her daughter disclosed that she has not personally witnessed Domestic Abuse between her mother and P.
- She is aware that her mother drinks too much, but has never seen her drunk.
- She does not like P and she is glad that he is out of their lives.
- Andrea confirmed that she still receives unpleasant text messages from P.
- Andrea declined support and was independent.
- Various family support options were offered to Andrea but she declined.

3.88 During the course of the assessment, the social worker made contact with the grandmother but had not recorded any information. No contact was made with Andrea's son or sister on the basis of a potential breach of confidentiality.

3.89 The conclusion of the Assessment dated the 30th November 2015, identified that Andrea was signposted for specialist support. Counselling support to address the alcohol abuse was available and could be accessed through her GP. Similarly, support from WCADA and Women's Aid could also be accessed. Additionally, support from Team Around the Family could have been put in place to offer support in a sensitive manner, but it is subject to the family's willingness to engage.

3.90 At 22.49hrs on the 25th November 2015, Police Officers attended a local Public House regarding a "Concern for Safety". Officers found Andrea intoxicated and drifting in and out of consciousness and required hospital treatment. An Ambulance was requested

and Andrea was conveyed to a local hospital where she was found to be unable to stand or walk. At 04.45hrs Andrea walked out of the hospital. She denied any form of injury and Domestic Abuse was not discussed.

3.91 At 07.44hrs on the 30th January 2016, WAST receive a call that a female was found outside on the driveway of the home address of FP. An immediate response was made and paramedics found a female, later identified as Andrea, in a collapsed and unresponsive state, making no respiratory or circulatory effort. The crew identified that Andrea had facial bruising to the right side of her face. The crew record that Andrea had died at the scene.

3.92 The Police attended the scene and a formal criminal investigation was made.

3.93 P made an initial disclosure that both he and Andrea had been drinking. They went to bed. During the night, he woke to find Andrea outside. He dragged her into the kitchen, ripping her clothes in the process and in an attempt to rouse her, slapped her face. Present in the house was FP.

3.94 The subsequent post mortem revealed that Andrea had sustained forty-one injuries that were consistent with a severe and pro-longed, sustained assault. Her body contained evidence of footprint kicking. There was evidence of blunt head injuries, including a fractured skull and swollen brain.

3.95 Both P and FP were arrested and interviewed by Police Officers. The Crown Prosecution Service took a decision to Charge P with Murder. No further action was taken against FP.

3.96 As outlined previously in this report, P appeared before the Crown Court on the 11th of August 2016 where he was found guilty of the manslaughter of Andrea. He was sentenced to an eight-year term of imprisonment. The trial judge described the assault on Andrea as “brutal and sustained’’ and that P is “A serious risk to the public”.

3.97 The CPS appealed against the sentence with regards to the leniency shown by the trial judge, whilst accepting a guilty plea. The Court of Appeal reviewed the original sentence and substituted the sentence to 12 years and 6 months imprisonment with an extended license of 4 years, because he was deemed to be a dangerous offender.

Analysis and Recommendations

4.1 In completing this review report, the author has seen numerous people who were connected in some way with either Andrea or P and they are able to give background information about the family life and the individuals concerned. Their comments are included within the report at various stages and it is made clear to the reader when their comments are referred to.

4.2 Andrea clearly had lots of challenges throughout her life. Her father died suddenly of a stroke in 2011. She brought up her children alone and sadly had to confront a breast cancer prognosis that involved long term treatment and an eventual mastectomy. Andrea liked to socialise, although both her mother and sister had difficulty in identifying any close friends that Andrea would talk about. Her friends appeared to be within a group who enjoyed socialising within the local pubs and clubs. Clearly Andrea had difficulty in managing her alcohol intake. However, it is well recognised that this is usually a coping mechanism for many victims of Domestic Abuse. The panel identified the NICE 2014 guidelines and the reference that excessive alcohol intake is sometimes

linked to Domestic Abuse. Andrea was offered support for managing her alcohol intake, but felt unable to engage.

4.3 Andrea worked in a local hotel, sometimes on receptionist duties, but was often utilised for backroom duties when management identified facial injuries. These injuries would always be excused as being due to a fall. Her family commented that Andrea often used heavy facial makeup to disguise bruising. She had never disclosed to them that P would beat her.

4.4 Andrea's son disclosed to the author that he had witnessed facial bruising, but this was explained that it was as a result of a fall. He had witnessed P verbally abusing his sister over minor domestic matters and had informed his mother of this. He could not get on with P, so he left the family home in 2013 and moved in with his maternal grandmother.

4.5 He also disclosed that he visited the hospital in November 2015 after learning that his mother had been admitted with injuries having been found on the road. He states he was aware that P was seen shouting at his mother whilst she was lying in the roadway. Whilst at the hospital, Andrea made comments to him that suggested that P had assaulted her. He was angry and upset. There is no information available to suggest that this was disclosed to the Police, which could have instigated further enquiries.

4.6 He was aware that there were numerous incidents where the Police had been called to his mum's home to deal with incidents involving P.

4.7 The Police would often bring Andrea to his grandmother's home, where it was clear she was drunk and had been locked out of her own home by P. He recalls one Police Officer stating that they were aware there had been domestic disputes, but they could not take it forward because Andrea would not co-operate. He was never interviewed personally by the police regarding his knowledge of his mother's relationship with P. Furthermore, other than providing an explanation for conveying Andrea to her mother's home, no other close family members were ever subsequently interviewed by the Police.

Police Involvement

4.8 South Wales Police were well-aware of P. They had detailed knowledge of his behaviour that would suggest he was a serial offender of Domestic Abuse. He was classified as high risk, both as an offender and a victim. Both are intrinsically linked. He was known to have issues with alcohol that fuel a propensity to become involved in violence with both male and females.

4.9 On one occasion, as, a consequence of information from R1, to suggest that P had a firearm and was going to use it on her and the children, Senior Officers having regard to risk management were prepared to authorise the deployment of Police firearms officers to protect R1 and her family and to facilitate the arrest of P.

4.10 It is evident from the information in this review, that the police dealt with each reported incident at the time involving R1 and involved multi agencies to assist in managing the situation. The Author believes that R1 had the strength of character to take control after these incidents and terminate the relationship.

4.11 Shortly afterwards, the Police were aware of similar Domestic Abuse concerns with a partner identified as R4. A serious incident of assault took place involving a knife. There

was a criminal investigation and an eventual Crown Court hearing. In this case, P was identified as the victim. This incident was clearly Domestic Abuse.

4.12 Within a very short time frame, within the same Police Division, P became involved in a relationship with Andrea. There is no doubt this relationship was sometimes violent, with both displaying acts of aggression towards each other. They were rightly identified as High Risk at a very early stage of their involvement with the Police. This was even more complex by the fact that excessive alcohol abuse by both Andrea and P was a factor in the incidents that took place.

4.13 From the period of 1st April 2013 to 30th January 2016, there are nineteen Police incidents recorded as Domestic Related or Cause for Concern. All involve Andrea and P. The majority of incidents are classified as immediate response by Police Command and Control. Call handlers importantly identify that both Andrea and P have been classified as High Risk. It is also well documented that First Response Officers responded within the G1 Emergency Response Times. The Police IMR states that there had been no Police contact with Andrea prior to her becoming involved with P.

4.14 Police initial response management is consistent in nature. The review has found that officers all identified that either Andrea or P were intoxicated, or they were both intoxicated. Even though one or both had visible injuries, neither wished to make a complaint of assault against the other. In some situations, Andrea or P were invited to sign a Police Officers notebook to confirm this. Force policy in terms of submitting a Public Protection document was complied with in most cases and submitted to the local Police and the PPU to be disseminated to the DAU and relevant partner agencies. It is at this point that a decision is taken to progress to MARAC. The Police appear to have autonomy in this decision-making process. The Head of the Police PPU chairs the MARAC meetings.

4.15 As outlined previously in this report both Andrea and P were referred to MARAC in June 2013. Of course, P had been previously referred to MARAC in similar circumstances with other partners. Although there was a series of incidents thereafter, there is no information available to suggest that the couple were again referred to MARAC. These other incidents were managed tactically by the DAU separately and risk assessed in accordance with South Wales Police policy and procedure.

4.16 DAU officers relied heavily on initial response reports that stated there were no offences disclosed and that there were no complaints of assault, which is normal practice. There is no information available to suggest the DAU took a holistic approach to investigate the series of Domestic Abuse incidents. South Wales Police, in a clear attempt to improve public protection responsibilities, have recently implemented Operation Liberty. This is a force-wide initiative to protect vulnerable people. A more robust flagging and tasking process is now in place, so that all relevant information can be captured and considered.

4.17 The Police advised the review panel that Andrea was consistently reluctant to make a complaint and engage with police officers.

4.18 This is demonstrated by a situation where a police officer made telephone contact with Andrea, on 23rd November 2015, after she was discharged from hospital. The circumstances of her visit to the hospital was discussed, but no complaint of assault was forthcoming. This conversation was eleven days after the hospital visit.

4.19 Children's Services Initial Assessment dated 25th November 2015 included a personal interview with Andrea. The author of this report states that Andrea had disclosed that

Domestic Abuse with P had got worse and that she had ended the relationship in February 2015. Her daughter had confirmed the relationship had ended. The daughter was interviewed in school, away from her mother. Liaison with Education and her grandmother did take place as part of the assessment. A consultation with Integrated Family Support Service is also recorded. The IFSS is a multi-agency team within children's services. IFSS offers support to parents that experience alcohol and drug misuse that impact upon parenting. IFSS also have experience in supporting victims of domestic abuse. IFSS offered advice and guidance regarding the support offered to Andrea. The assessment also identified issues of confidentiality in that there was no consent from Andrea to share information with other family members. Andrea's daughter had confirmed that P had moved out from the family home and that her mother had ended the relationship. The risk to the daughter was therefore assessed as minimal. There is no information to suggest risk or likelihood of significant harm. No safeguarding investigation was required. As there was no MARAC after this assessment, this information was not shared with other agencies, including the Police.

4.20 For MARAC to be able to work dynamically, it needs to be in a position to consider all relevant information. Health professionals do not routinely participate in MARAC, so the information they obtained regarding Andrea was passed to another agency for consideration. This agency, South Wales Police, decided in November 2015, two months before Andrea's murder, not to refer to MARAC due to their interpretation of the DASH risk assessment document they had received from health. The review panel Police representative explained that this document contains a quantitative aggregate of risk factors and not a qualitative explanation of what the risk is. There was a variation in a tick box sequence of information that was inconsistent when assessing risk. Although the minimum threshold of risk was met, this did not justify a referral to MARAC, but a necessity for further information from health.

Children's Services

4.21 Andrea did not have any involvement from CYPS when she was a child or young person. Andrea's daughter did not have any involvement from CYPS before she went to secondary school. CYPS involvement was principally on the basis of being notified that Andrea was involved in a series of Domestic Abuse incidents with P and that her young daughter was exposed to the impact of Domestic Abuse within her own home.

4.22 When CYPS became aware that Andrea had a child at the home address, support was offered under Child in Need Services. This relied on Andrea agreeing to this assistance.

4.23 CYPS had no direct involvement with P as a child or young person. There is historical archived documentation within the department regarding P and his involvement with another partner. That is outside the scope of this review. This information however is presented to the review by R2.

4.24 Managerial consultation in respect of the case, advised that support from a social worker from the Integrated Family Support Services (IFSS) be sought. Independent advice on the family as part of the social services assessment process to ensure the assessment was thorough. The IMR outlined the process that was undertaken and the information that was obtained.

4.25 The Assessment carried out the following activities:

- Enquiries were made with a local Community School.
- The daughter was privately interviewed by a suitably qualified social worker.
- Further liaison with Health Care Professionals.
- Confirmation that Andrea had arrived at hospital with facial injuries
- Andrea was under the influence of alcohol and had difficulty in being able to stand.
- Denied that P had assaulted her.
- When sober, Andrea had disclosed to medical staff that Domestic Abuse was getting worse. Andrea was afraid of P.
- Confirmation that a MARAC Assessment form was completed.
- A social worker interviewed Andrea and her daughter together. Andrea disclosed that she had thrown P out of the home.

4.26 Andrea was offered a range of support services and she was appropriately signposted.

4.27 The CYPS Assessment was subject to management oversight that identified further actions for a social worker to follow up. These actions were addressed. The assessment also identified that consistent intervention and support services were offered to Andrea and her family but were declined.

During the course of this review, analysis of CYPS case files were undertaken. The following comments are recorded in the IMR,

"There was a pattern of Andrea reporting and agreeing there was Domestic Abuse in her relationship with P when under the influence of alcohol, but minimising the Domestic Abuse when sober. Also, it is unlikely the daughter would have disclosed to any professional that she was witnessing further Domestic Abuse whilst in the care of her mother, due to family loyalty and she may have also lacked a full understanding in terms of what a healthy relationship constitutes".

"Multiple research findings however, are clear in respect of Domestic Abuse and that the victim is often not able to fully disclose the extent of the violence within the relationship. Andrea's reticence to be fully open and honest in working in partnership with Children's Services may have been down to the impact of Domestic Abuse upon Andrea's self- esteem, coupled with the fear that her daughter may be removed from her care if full disclosure of the violence is made."

The IMR authors' analysis of CYPS case files had the benefit of hindsight and enabled them to question whether the interventions and assessments completed could have been more systematic and robust. However, the new Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 may have required more time to fully embed within social care practice given the wider definition of domestic violence.

4.28 The IMR authors also identified that there were some missed opportunities to fully cross reference with other professionals to marry up the self-reported information provided as part of the CYPS assessment.

4.29 The IMR includes a number of recommendations that are included in a separate bespoke directorate action plan.

Medical Support

4.30 Primary care services are provided by General Practitioner Services and Secondary services by the ABMU Emergency Care.

4.31 Andrea received support from both services. With regards to the provision of GP services, the IMR states;

"A thorough review of her medical record does not reveal any evidence of domestic violence. There was no record of her disclosing evidence of domestic violence"

This was after discussions with Andrea about Domestic Abuse.
Furthermore, the IMR adds:

"Discussion between the medical staff feel that they are confident in managing cases involving domestic violence and are aware of the appropriate agencies which can offer further support, including the Police"

4.32 The IMR makes no reference to the relationship between the GP and the secondary health care sector that treated Andrea during her visits to the Emergency Care Unit.

The secondary health care representative on the review panel has explained that it is the standard practice, for many years, that Emergency Care send a letter to a patients GP informing them of every new attendance.

4.33 The GP services IMR makes no reference to the practices responsibility to the Welsh Governments Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. This Act provides direction to develop a process of targeted enquiry for Violence Against Women, Domestic Abuse and Sexual Violence; 'Ask and Act'.

4.34 ABMU HB Emergency Care provided detailed knowledge and understanding of the Ask and Act responsibility. The IMR presented a menu of both strategic and tactical support mechanisms to staff, which included; regular training sessions and managerial access to support staff with risk assessment processes for potential MARAC referrals. This support is under continued review and contained within a bespoke action plan.

4.35 Evidence of compliance with this can be found with a MARAC referral made by a senior nursing sister on 22nd November 2015, when Andrea was being treated at the Emergency Department. The referral concluded that there was "Visible High Risk". This was in addition to the HITS Assessment carried out at the triage unit. Although there was a variance in opinion between professionals regarding escalating the matter to MARAC, the process does provide evidence of early intervention regarding the identification of Domestic Abuse and could be considered to be evidence of best practice. However, as referred to in paragraph 3.78, it is apparent that the MARAC referral made by health, could have included the detail of the concern surrounding the causation of the injuries. This qualitative detail would have made a difference to the subsequent Police decision-making process to support Andrea.

4.36 Andrea received specialist clinical support for breast cancer from the AMBU HB Oncology Department. This was delivered in an environment of complex needs. The IMR identified that Macmillan Support involved a holistic assessment that is a key point of a care plan. All cancer diagnosis should have holistic needs assessments.

4.37 The IMR could not identify if this holistic needs assessment was completed. This would have been opportune to share relationship concerns. The IMR accepts this was a missed opportunity.

4.38 P has chosen not to participate in this review. This would also include consent to access his medical records. Those records may hold significant information that would have been valuable to this review.

4.39 Written correspondence was sent to both P and his representing solicitors.

4.40 Neither P nor his solicitor have responded to the correspondence. Health professionals who form part of the DHR panel have made representations that their legal position is not to disclose medical information without the required consent from P. This decision is made on the understanding that health professionals are fully cognisant of the new Home Office Guidance.

4.41 The revised Home Office Guidance on Domestic Homicide Reviews was published on 8th December 2016. Section 10 of the guidance, 'Data Protection' deals with the release of medical information and requires the Department of Health to:

"encourage clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and, where appropriate, the individual who caused their death, unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:

a) The review team should be informed about the existence of information relevant to an inquiry in all cases; and

b) The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.

The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set-aside in the greater public interest.

The Department of Health recognises that DHRs have a strong parallel with Child Serious Case Reviews. (Child Practice Reviews in Wales) Guidance advises doctors that they should participate fully in these reviews when the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent. The Department of Health believes it is reasonable that this should be the principle that doctors should follow in cooperating with DHR's." (Paragraphs 99 and 100 refer)"

4.42 This new section of the guidance appears to be the avenue by which medical information regarding perpetrators, such as P in this case, could be made available to the review process, even when the perpetrator declines to give permission. The Panel is of the opinion that this needs further explanation by the Home Office, especially those who have not been resident in the UK. Some panel members consider that to do so without permission is still breaching the Data Protection Act and even Human Rights of the Perpetrator.

4.43 It is considered that before any proactive action is taken regarding this part of the new guidance, a more detailed explanation is required, as well as a sample template letter that could be used nationally so that every DHR approaches this sensitive issue from an identical position. This observation is one of two strategic recommendations that are included later in the report.

Additional Specialist Support

4.44 The Community Safety Partnership for Neath Port Talbot provide an Independent Domestic Violence Advisor service (IDVA).

4.45 The IDVA service was first introduced to both Andrea and P in May 2013, after receiving a formal PPD1 notification from South Wales Police. The notification stated that an assault had taken place on P by Andrea, although the report went on to state it was unclear who the aggressor was. The case was listed for MARAC the following month, in June 2013.

4.46 IDVA records indicate that attempts were made to contact P on three occasions, by way of telephone and written correspondence, but no response had been received. This was reported to MARAC and no further actions were received for this service.

4.47 The IDVA service received another notification from South Wales Police in July 2013 that stated that both Andrea and P had been involved in an altercation. Information identified P and A as High Risk. Records indicate that the IDVA service made five attempts to contact Andrea, with no response. An information pack was posted to Andrea's home address.

4.48 On 3rd September 2013, the IDVA service received notification from the Police of the Domestic Incident on 1st September 2013. The PPD1 outlined the circumstances of the incident that included no complaints and no offences disclosed. IDVA records indicate that further attempts were made to contact Andrea, but received no response.

4.49 On 18th October 2013, after a case review process, the IDVA service closed its case in respect of support for P.

4.50 On 23rd October 2013, again after a case review process, the IDVA service closed its case in respect of support for Andrea.

4.51 IDVA service records indicate that they were not made aware of the situation of Andrea's treatment at Emergency Care on 12th November 2015. The incident was referred by hospital staff to MARAC. A subsequent Police decision was taken not to proceed to MARAC.

4.52 The IDVA IMR outlines that their analysis of involvement was in accordance with guidelines, especially in relation to engagement with both Andrea and P.

4.53 The Welsh Centre for Action on Dependency and Addiction (WCADA) provides a bespoke service to those who would like information and/or advice in relation to alcohol and/or drugs.

4.54 Within the timeframe of this review, the organisation identified support for R4, identified as an ex-partner of P.

4.55 The review identified that the service was not utilised for either Andrea or P. There were a number of gateway opportunities to access this service that were missed. This review has previously identified recommendations that could include engagement with WCADA.

Family Views

5.1 In accordance with the Home Office Guidance, members of Andrea's family were written to at an early stage of the process, explaining the purpose of the review and offering them the opportunity to contribute to the review, should they wish to do so. There was an initial joint visit between the Police FLO and the Author. During conversations, the support network of AAFDA was discussed and offered.

5.2 When invited to do so by the author of this report the family were asked if there were any specific questions they would like the review to focus on. They responded by presenting the following:

1: How many partners did P have and how many involved domestic violence?

2: Was Andrea supported when she was being treated for her injuries?

Both matters will be addressed in the conclusion section of the report.

5.3 Andrea's mother, sister and son were interviewed and all actively engaged. Details of what they told the Overview Author are recorded within this report. Additionally, the family were later provided with a copy of a draft report and over a period of two weeks they were able to review the content of the report privately, at their own convenience. A subsequent follow up visit by the report Author then allowed the family to query and offer additional information. This was essential to allow the family some time to understand not only the review process, but the programme of work undertaken by the panel. The family, in particular Andrea's mother and sister, wish to put on record their appreciation of this opportunity. The family also declined an opportunity to meet with the panel.

5.4 As outlined, a previous partner of P, identified as R1, was also contacted and met with the Author on three occasions. This was a particularly difficult experience for R1 who in some detail outlined a catalogue of events that she had experienced, whilst at the same time attempting to personally negotiate the circumstances of Andrea's death. R1 expressed strong views to the Author of this report that her experiences be shared with others.

5.5 As stated above, P and his solicitor were written to at the beginning of this review process, inviting P to participate. He did not respond.

5.6 This Overview Report is therefore submitted without the benefit of the views of P and without any personal disclosures of his medical or mental history that may have assisted in formulating conclusions.

5.7 Additionally, three other ex-partners of P were contacted, as well as a close friend identified as FP, and invited to participate in the review. They did not respond to the invitation. Andrea's ex-partner and the father of her children is also aware of the review but has chosen not to contribute.

Conclusions

6.1 Significantly, Andrea had no involvement with any of the agencies identified in this report until she entered into a relationship with P. Andrea was a single parent who took responsibility for her children, managed her own home and regularly worked to provide for her family. There was no acrimony between the father of her children and herself. In fact, he was always welcomed into the family environment and he took an active interest and responsibility for his children.

6.2 This review has identified that P led a chaotic lifestyle that was fuelled by alcohol abuse. The series of incidents identified within this review, especially with previous partners R4 and R2, would indicate that he was repeatedly involved in instances of Domestic Abuse, either as a victim or as a perpetrator. The common denominator being that P was in that relationship. This review believes that P displayed typical characteristics and predictable behaviour patterns that suggest he could be defined as a serial offender. It is acknowledged that the police had flagged P as being violent and he had been subject of MARAC. However, even with that in place, it is difficult to progress any criminal proceedings without a complaint, or evidence to proceed with a victimless prosecution. It would be accurate to say that there was no reliable third party evidence identified at the time of investigation of the respective incidents. P was subject to a police "flagging" process, being identified as being violent and he was subject to MARAC discussion.

6.3 Although P entered the Criminal Justice System, this was for minor offences. Therefore, the opportunity for inclusion in an Offender Management Programme was not available.

6.4 In terms of perpetrator management, consideration could have been taken to issue a Domestic Violence Police Notice (DVPN) and subsequent Domestic Violence Protection Order (DVPO), which were introduced across England and Wales in March 2014.

A DVPN is an emergency non-molestation and eviction notice, which can be issued by the Police, to a perpetrator, when attending to a Domestic Abuse incident.

A DVPO is a Police issued notice, effective from the time of issue, giving the victim the immediate support they require in such a situation. Events recorded on 12th November 2015, where information is shared between Police and Health if further pursued, could have met the criteria for such action. Within 48 hours of the DVPN being served on the perpetrator, an application by Police to a Magistrates Court for a DVPO could have been considered. This would have allowed Andrea a degree of breathing space to consider her options with the help of support agencies. Both the DVPN and DVPO could contain a condition prohibiting P from potentially further molesting Andrea and provide the Police with a power of arrest, if there was a breach.

In addition to the above, Police could have advised Andrea of the Clare's Law Domestic Violence Disclosure Scheme (DVDS). However, there is nothing to suggest that this was discussed with Andrea or that any such request was undertaken.

6.5 How many partners did P have and how many involved in domestic violence?

In response to the family concerns of P's previous involvement with ex-partners and domestic violence, this review has identified that Andrea was one of at least three other ex-partners involved in reported incidents of Domestic Abuse. These incidents illustrate that P was identified as both a victim and perpetrator.

6.6 Did Andrea receive support?

The review identified numerous instances where support was offered from various agencies. It is documented that Andrea was reticent to receive such support. The Initial Assessment carried out by Children's Services provides us with some clarity of Andrea's position, in that she presents herself as independent and focused on terminating her relationship with P.

6.7 In December 2015, Andrea along with her daughter, her mother and sister, enjoyed a "Turkey and Tinsel" Christmas holiday. Her family describe her as being happy and relieved that she had beaten cancer and had terminated her relationship with P.

6.8 The following month, January 2016, P attacked Andrea and that led to his appearance at the Crown Court in August 2016 where he was convicted of her manslaughter.

6.9 There is no documented court evidence of a response from P. It is recorded that the trial judge commented "Andrea became dominated by you, she felt unable to break ties with you and there is no doubt that you hit her regularly. Her friends and work colleagues saw injuries on her that she tried to disguise. The attack on her was violent and protracted. Andrea was vulnerable and effectively defenceless"

6.10 The review has identified numerous opportunities for Andrea to engage with agencies and take forward a victim based prosecution against P. However, clearly Andrea felt she was unable to do so at that time. What is evident is that alcohol was a significant factor in respect of the incidents where injuries were sustained by Andrea. Family members were not aware of Andrea's personal struggle with alcohol and her relationship with P. As previously mentioned in this report, it is well recognised that many victims of Domestic Abuse use alcohol as a coping mechanism.

6.11 The DHR acknowledges that Safer NPT is a commissioning body and therefore, whilst the recommendations can be considered by the Community Safety Partnership, they may require implementation via other strategic partnerships such as the Safeguarding Boards. The review further acknowledges that the Welsh Government hold devolved authority in respect of Health, Education and Social Care. Therefore, recommendations and reports submitted to the Home Office should also be copied to Welsh Government.

6.12 In summary, this Domestic Homicide Review concludes that the death of Andrea Lewis on 30th January 2016 was a tragedy. As part of the review process it appears that all agencies complied with their own Domestic Abuse policies and practice requirements in place at the time of their interventions. However, the following strategic and policy/practice recommendations have been identified;

6.13 The panel recognises that the Western Bay Safeguarding Board has both a leadership and influential role within its geographical area of responsibility, especially in the development of corporate MARAC arrangements. Therefore, in addition to the Action Plan (attached as Appendix 1) the panel makes the following strategic recommendations;

Recommendation One

This review report is owned by the Neath Port Talbot Community Partnership but should be shared with the Western Bay Safeguarding Board.

6.14 The Neath Port Talbot Community Partnership have developed a local strategic plan to develop working practices to tackle Domestic Abuse. Therefore, the panel recommends:

Recommendation Two

The Neath Port Talbot 'Healthy Relationship for Stronger Communities Strategy' (implementing the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015) sets out an action plan to conduct a review of high risk victim management which includes the MARAC process and considers the following;

- **Key elements to the success of MARAC should be defined. These include agency roles and responsibilities to act as conduits for exchange and implementation of MARAC action for the agency they represent.**
- **Agencies should ensure consistent, appropriate representatives at MARAC, with designated authority for decision making.**
- **Agencies to work collaboratively around the design of a MARAC referral form for it to be more qualitative than quantitative.**

The panel identified that the Community Safety Partnership had already reviewed its current working practices to tackle domestic abuse as part of a focus to strengthen local partnership relationships. The strategy and action plan provided evidence that this was work in progress.

6.15 The issue of non-disclosure of the perpetrators medical history relevant to the review can be captured with the following recommendation.

Recommendation Three

The independent chair of this DHR submits a request to the Home Office for further clarification of paragraphs 99 and 100 of the new Home Office Guidance for the Conduct of Domestic Homicide Reviews, dated December 2016. This is regarding the term *'The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest'* and for the Home Office to produce a sample template letter that could be used nationally, informing the perpetrators that their medical information relevant to the review is to be disclosed as well as advising health agencies of the process, irrespective that permission has not been obtained from the perpetrator.

This is critical to those perpetrators who have been convicted and are serving substantial custodial sentences.

The panel raise this issue on the basis, of the perpetrators reluctance to co-operate with the review and the Health position not to disclose without perpetrator consent. The panel is aware that this situation is consistent throughout Wales and is a matter subject to national discussion.

6.16 In relation to local policy and practice, the panel recommends the following for key partnership agencies to consider, especially in terms of the provision of both primary and secondary health care.

Recommendation Four

In response to the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, Neath Port Talbot County Council and Abertawe Bro Morgannwg University Health Board roles out its training programme in accordance with the Welsh Government National Training Framework, including 'Ask & Act'.

This will equip all staff to respond appropriately to all victims of Domestic Abuse.

6.17 The review panel acknowledges that there has been significant strategic development in Wales with Welsh Governments focus on the Violence Against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015. This legislation provides focus in many associated matters, including a requirement to deliver training and awareness raising within relevant partnership agencies.

6.18 It is evident that the Neath Port Talbot Community Safety Partnership have incorporated learning from the findings of this review and its responsibilities under the Welsh legislation. The creation and implementation of a bespoke local strategic plan illustrates this commitment, in addition to working in collaboration with the Western Bay Safeguarding Board

6.19 This initiative to develop a strategic plan is in addition to the subsequent DHR action plan developed after this review.

6.20 The Chair and Author of this report would like to thank all agencies including panel members for their participation and support to this review.

List of Recommendations

Recommendation One

The Review report is owned by the Neath Port Talbot Community Partnership but should be shared with the Western Bay Safeguarding Board.

Recommendation Two

The Neath Port Talbot Healthy Relationship for Stronger Communities Strategy implementing the Violence Against Women, Domestic Abuse and Sexual Violence (Wales Act 2015) sets out an action plan to conduct a review of high risk victim management which includes the MARAC process and will include the following,

Key elements to the success of MARAC should be defined, these include agency roles and responsibilities to act as conduits for exchange and implementation of MARAC action for the agency they represent.

Agencies should ensure consistent, appropriate representatives at MARAC with designated authority for decision making.

Agencies to work collaboratively around the design of a MARAC referral form for it to be more qualitative than quantitative.

Recommendation Three

The chair of the DHR submits a request to the Home Office for further clarification of paragraphs 99 and 100 of the home Office Guidance for the conduct of Domestic Homicide Reviews December 2016. This is regarding the term ‘The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest’ and for the Home Office to produce a sample template letter that could be used nationally informing the perpetrators that their medical information relevant to the review is to be disclosed as well as advising health agencies of this process irrespective that permission has not been obtained from the perpetrator.

This is critical to those perpetrators who have been convicted and are serving substantial prison sentences.

Recommendation 4

In response to the legislation Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, Neath Port Talbot County Council and Abertawe Bro Morgannwg University Health Board roles out its training programme in accordance with the National Training Framework, including 'Ask & Act'.

This will equip all staff to respond appropriately to all victims of Domestic Abuse.

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