Domestic Homicide Review Report:

Executive Summary

Adult A

Born: 17th May 1992

Died: 4th May 2014

Tony Blockley
Director: Johnston and Blockley Ltd

Date: February 2016

This executive summary outlines the circumstances of the death of Adult A on 4th May 2014 and the subsequent statutory Domestic Homicide Review undertaken by One Newport Local Service Board (LSB). Adult B, her boyfriend, had murdered adult A. Following his conviction Adult B was sentenced to 20 years imprisonment. He must serve at least 16½ years before he is eligible for parole.

The Domestic Homicide Review Panel would like to extend its sincere condolences to Adult A's family and offer continued support to them all.

Adult A and Adult B had only been in a relationship for around three months when she was killed. When she was young Adult A was diagnosed with attention deficit hyperactivity disorder and some years later she was also diagnosed with autistic spectrum disorder. Adult B was a single, long-term unemployed man; mutual friends had introduced them.

After an evening in a local pub, there was an argument between them. They both went back to Adult B's home, where Adult A ran straight upstairs and locked herself in the bathroom. Adult B persuaded her to open the door at which point he killed her. During the trial the judge said that the attack was "*a sustained and brutal assault upon your defenceless 21 year old girlfriend."*

Following agreed protocols, Gwent Police notified One Newport Local Service Board (LSB) of the circumstances of Adult A's death. On 3rd March 2015, the One Newport Local Service Board (LSB) determined that Adult A's death appeared to fall within the criteria of the Multi-Agency Statutory Guidance for the conduct of domestic homicide reviews' issued under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004) because she had been killed by a person with whom she had been in a personal relationship with.

The following agencies were asked to provide chronological accounts of their contact with Adult A and with Adult B for the preceding 12 months to ascertain patterns of behavior relating to Adult A and/or Adult B:

- Gwent Police

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

2. Key issues arising from the review

Within the short time Adult A and Adult B had been together, there were no reported incidents of domestic abuse, the only suggestion had been that she had been strangled at one point in the relationship, but she minimised this incident and did not want any action taking.

When the health visitor was made aware of the incident by Adult A's family a vulnerable adult referral was made, which was recognised as good practice. There is no doubt that Adult A was a vulnerable adult. She was also the victim of domestic violence and whilst this was recognised within the context of being a vulnerable adult, it was not considered as a specific issue, hence no specialised risk assessment process took place although there was a vulnerable adult referral completed, which is not a referral specifically focusing on domestic violence. If the focus had been on domestic violence then it is likely that a DASH risk assessment would have been considered and a possible MARAC referral made.

Within a month of this information coming to light and the vulnerable adult referral being made, Adult B murdered her.

Following the review it became apparent that Adult B had a previous abusive relationship in which he had strangled that partner, which was never reported to any authorities or agencies.

3. Conclusions from the review

The incident in which Adult A died was not a one-off. Adult B had tried to strangle her a month before her death and 3 ½ years previously; Adult B had been involved in a similar incident but with a different partner. Adult A was a vulnerable adult and whilst she had some capacity, she clearly had difficulties recognising the impact of Adult

B's behaviour. She was fully supported by her family who did their upmost to ensure she had a safe and fulfilled life.

Even though it was not a one-off incident, nothing has come to light during this review to suggest the death of Adult A could have been predicted or prevented.

4. Recommendations from the Review

National (Wales)

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

One Newport Local Service Board

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

Individual agency

- To engage with partners and agencies to ensure information sharing arrangements are clear and appropriate to domestic violence and abuse.
- To review and deliver training to all staff involved with vulnerable adults, raising awareness of domestic violence and abuse and what action to take.
- To have a clear process in place for staff to escalate safeguarding concerns if they feel another agency has not taken the appropriate action.
- Introduce a policy that ensures that all cases with a domestic violence aspect is shared or notified directly to the police.
- Clarity should be improved across adult services that in all cases, whether capacity is assumed or otherwise, the level of engagement, intervention and

possible outcomes the adult expects from the process is made explicit. Such detail should then be clearly noted within case notes and revisited at each stage of future intervention. Compliance and co-operation should not be seen as the only measure.

- It is paramount that records are correct; agencies should ensure that their records are accurate and contain all available information.
- Examine the role and communication with third sector specialists in domestic violence, especially in relation to adults with any learning disability and developing service provision in support of persons with learning disabilities.