Domestic Homicide Review
Executive Summary
DHR 01

Andrea

January 2016

Independent Author

Martyn Jones Bsc (Hons)

December 2017

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. The family declined the use of a pseudonym.

Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death on 30th January 2016 of Andrea Lewis, a 51year old, woman. Andrea was a single mother of two children who resided in the Neath Valley. Her boyfriend (known as P) was arrested and charged with her murder. P appeared before the Crown Court in October 2016, and was convicted of her manslaughter and sentenced to imprisonment.

The Perpetrator was 46 years of age at the time of the incident. He was a local man who also lived in the Neath area. The review identified that P had been involved in at least three other previous relationships where domestic violence was prevalent. P was identified as both a victim and perpetrator. P declined to be interviewed as part of the domestic homicide review process.

It had been established Andrea was unknown to statutory authorities until she entered, into a relationship with P.

During the early morning of the 30th January 2016 the emergency services were called to an address where P was residing with another male person. 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 another male 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 the other male person.

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

The Domestic Violence Crimes and Victims Act 2004 Section 9 (3), which was implemented with due guidance[1] on 13th April 2011 and later revised in December 2016 establishes the statutory basis for a Domestic Homicide Review.

Under this section a Domestic Homicide Review means a review of the circumstances in which the death of a person age 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 household as himself, held with a view to identifying the lessons to be learnt from the death

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*

In compliance with the Home Office Guidance,[2] on 17th February 2016, South Wales Police notified the circumstances of the death in writing to the Neath and Port Talbot Community Safety Partnership. The Board accordingly notified the Home Office of the circumstances of the incident and the intention to conduct a Domestic Homicide Review on 13th July 2016.

This is the first DHR to be conducted within the Neath and Port Talbot area.

The Domestic Homicide Review Panel

The review was carried out by a Domestic Homicide Review Panel made up of representatives of agencies who were involved in delivering services to the family of the victim. It included senior officers of agencies that were involved. The professional designations of the panel members were:

- Safeguarding Advisor to the Aneurin Bevan University Health Board.
- Manager, Neath and Port Talbot Housing.
- Domestic Abuse Co-ordinator Neath and Port Talbot Council.
- Manager, National Probation Service.
- Manager, Neath and Port Talbot Social Services.
- Peripatetic Consultant, Neath and Port Talbot Social Services.
- Public Protection Manager, South Wales Police
- Head of Operations, Hafan Cymru
- Manager, Welsh Centre for Action on Dependency and Addiction
- Manager, Western Bay Safeguarding Board.
- Business Support Officer, Western Bay Safeguarding Board

None of the panel members had any direct dealings with the Perpetrator or his family.

The Panel was chaired by an experienced Independent Chair and the Overview Report and this Executive Summary was compiled by an experienced Independent Author. Neither the Author nor Chair had any dealings with the Perpetrator or his family prior to being involved with this review.

Time Period

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

The review also considered any relevant information relating to agencies contact with the Victim and alleged Perpetrator outside the time frame as it impacts on the assessment in relation to this case.

Individual Management Reports

An Individual Management Reports (IMR) and a comprehensive chronology was received from the following organisations:

[2] Home Office Guidance page 8

- Abertawe Bro Morgannwg University Health Board
- Independent Domestic Violence Service
- South Wales Police
- Welsh Centre for Action on Dependency and Addiction
- Neath Port Talbot Social Services Department

Process of the Review

Home Office Guidance[3] requires that DHRs should be completed within six months of the date of the decision to proceed with the review.

The Criminal Trial took over twelve months to complete due to defence legal representations and the Crown Prosecution Service's decision to appeal against the sentence.

These extenuating circumstances contributed to the review being unable to be completed within the six-month time frame.

Family engagement and liaison was not completed until December 2017.

The Home Office was regularly updated and accepted the situation.

Terms of Reference for the Review

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;

- 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;

- 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 domestic violence victims and their children through improved intra and inter-agency working.

Family Involvement

Home Office Guidance[4] requires the family, friends and colleagues who have details or knowledge of Andrea or the Perpetrator to be given the opportunity to contribute to the review process. In this case, the Overview Author had regular contact with Andrea's mother. Visits to the family home included discussions with Andrea's sister and son. All, had

[3] Home Office Guidance 2013 page 15

[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Home Office 2011 Revised 2013 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*

significant comments to make and contributed considerably to the process. Their views were faithfully recorded and are included within the Overview Report. The family had the opportunity to review the report over a two-week period. They were also invited to meet panel members. This was declined although the family wish to place on record their appreciation of this invitation.

Confidentiality and Dissemination

The findings of this review 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.

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.

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

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

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

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

Summary of Key Events

Andrea was born in Wales in July 1964.

Andrea was initially employed at a large manufacturing company. Andrea had two children, a son being the eldest followed by a daughter some eleven years later. The father of the children did not reside within the family unit although is actively involved in supporting the two children.

The children currently live with their maternal grand-mother.

P had come to the notice of the Police on several occasions mainly for matters involving drunkenness, public disorder and as a victim in street based violence. These incidents invariably involved the misuse of alcohol.

The first recorded incident involving P was in November 1995 where he appeared before the local Magistrates Court having been charged with causing criminal damage during a domestic dispute with his then partner. P was found not guilty.

Between 1995 and 213, P was involved in a catalogue of domestic incidents with partners which required Police intervention and in some cases appearances at the Magistrates Court. These incidents again involved the misuse of alcohol. On one occasion P was bound over by the Magistrates Court to keep the Peace.

Some of these incidents were violent in nature. On one occasion, armed Police Officers were deployed to secure the arrest of P after an appropriate risk assessment process was undertaken.

In May 2011, P sustained a stab wound during a domestic dispute. His then partner was charged with Grievous Bodily Harm. The female assailant appeared before the Crown Court and received a suspended prison sentence.

The first recorded incident between Andrea and P was in April 2013. This was in relation to a domestic dispute that had been reported to the Police. The incident had occurred at Andrea's home address. The Police were called, they subsequently escorted P off the property and conveyed him to another address.

There then followed a series of reported domestic related incidents where on one occasion Andrea was found injured on the road outside her home address. Andrea was conveyed to hospital and after receiving initial treatment she 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 by both Andrea and P was evident in the, majority of these incidents.

Family members recall that Andrea would often mask facial injuries and provide explanations that the injuries had been sustained as, a result, of, a fall. Andrea did not disclose to the Police that she had ever been assaulted by P.

Both Andrea and P were risk assessed as "High" and Police watch markers were placed on Andrea's home address.

During this relationship 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 2016 Andrea ends her relationship with P. Andrea's family are aware that P had moved out from Andrea's home and that she had changed the locks at her home address. That Christmas Andrea accompanied both her mother, daughter and sister on a family Turkey and Tinsel short holiday.

During the early morning of 30th January 2016, incident occurred at an address owned by a friend of P where Andrea was found by the emergency services in an unresponsive state. Andrea died at the scene. Andrea was found to have sustained multiple injuries consistent with a pro-longed assault.

P was arrested, charged and later convicted of manslaughter where at the Crown Court he received a custodial sentence.

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”

Analysis and Recommendations

The Review Panel has identified that Andrea had experienced significant episodes of abuse that for a variety of reasons were not pursued to any form of eventual judicial outcome. Andrea was a repeat victim of domestic abuse and categorised rightly as “High Risk.”

It is of note that P was also categorised as a victim “High Risk”.

There is information available to evidence support from professional services who could offer specialist bespoke support. What is clear is that Andrea was fiercely independent, reluctant to accept support and constantly reminded her family that she was ok.

Local policies and procedures appear to have been complied with in the risk assessment of Andrea as a vulnerable person. Whilst this appears acceptable in terms of statutory responsibility, the issue remains as to why Andrea chose not to cooperate more fully with support agencies.

The family have a strong view that Andrea’s independence was a significant contributory factor to her being un-co-operative. Although Andrea disclosed to medical professionals whilst a hospital patient in November 2015 that her relationship with P was deteriorating and the domestic abuse was escalating, for some reason Andrea did not co-operate with the Police to take this matter further.

The family holiday the month before her death illustrates a situation where Andrea had ended her relationship with P and had informed her closest relatives that she had moved on with her life. Safety

P is identified as a serial offender in domestic violence with at least four other partners being identified. One ex-partner actively participated in this review and outlined a catalogue of incidents where P was violent and abusive. Coercive control being at the heart of this behaviour.

The author of this report has formally written to P, with an invitation for him to contribute to the review, but to date no response has been received. The review therefore has not had the opportunity to investigate P medical background especially in relation to the misuse of alcohol.

The review panel identified the following 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.

The panel identified the significance of the strategic role that Western Bay Safeguarding Board has, to play but local accountability lies with Neath Port Talbot.

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 was in progress.

Recommendation Three

The independent chair of this domestic homicide review submits a request to the Home Office for further clarification of paragraphs 99 and 100 of the recent 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.

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.

The panel identified this recommendation in relation to local policy and practice especially in terms of the provision of both primary and secondary health care.

Conclusions

Significantly Andrea had, no involvement with any agencies identified in this review until she entered, into a relationship with P. There were no prior concerns regarding her alcohol consumption.

Andrea's family specifically asked the review panel to look at the following:

Did Andrea receive support?

The review identified numerous instances where support was both offered and put in place. An 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. Family members report Andrea to be happy and relieved that she had beaten cancer and terminated her relationship with P.

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

The review identified that P had at least three other partners that were involved in incidents of domestic abuse. One of the ex-partners actively engaged with the review, the other two although written to decided not to co-operate. P had a long history of domestic violence, he was a serial offender and well known to authorities. Disappointingly there was no evidence to suggest that P was brought into the criminal justice system for this offending, where perhaps this offending behaviour could have been addressed by way of a bespoke rehabilitative support programme. Appearances at the Magistrates Court were for relatively minor offending linked to alcohol misuse.

P was also identified as a victim of domestic abuse.

The misuse of alcohol was a significant factor in respect of all incidents identified within the time frame.

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

Martyn Jones

Independent / Chair and Author

December 2017

List of Recommendations

The following recommendations are made:

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