Domestic Homicide Review

Overview Report

Report into the death of ‘Lesley’

Report produced by Andrew Twigger (Independent DHR Chair and Author)

Reference DHR 2016/1

First presented to Powys Community Safety Partnership on 26th January 2017

Re-presented on 10th January 2018

Contents

1 Introduction

1.1 This Domestic Homicide Review (DHR) was initiated following the tragic death of 'Lesley' on Sunday 10th April 2016. This was the first Domestic Homicide Review to be initiated by Powys Community Safety Partnership (CSP). It was carried out in accordance with the current Home Office Guidance (1.8.2013 onwards) and Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

1.2 The contents of this report have been anonymised. The names of persons and addresses have been changed. Where the fictitious names and addresses first appear in the report they are set in inverted commas. Thereafter they appear in plain text. The names of agencies and those that represent them have been retained.

2 Brief details of the Homicide

2.1 On the afternoon of Sunday 10th April 2016 Dyfed Powys Police received a call from 'Jean', the owner of 'Tyddyn' near Machynlleth, Powys. She informed Police that her husband 'David' had discovered the body of Lesley deceased lying on a settee in the upstairs of the property. Police and Ambulance attended the scene. Paramedics confirmed that Lesley had died.

2.2 Upon discovery, Lesley had blood on her face and marks around her neck consistent with strangulation. There did not appear to be any ligature in the immediate vicinity of her body. Lesley was fully clothed wearing a dressing gown over her pyjamas.

2.3 A later Post Mortem examination gave the cause of death for Lesley as blunt trauma (pressure) to face and neck.

2.4 A subsequent search of outbuildings at the location led to the discovery of the body of Lesley's recent partner 'Neil' who was found hanged from the beam of a barn. A rope had been used for this purpose.

2.5 Lesley and Neil occupied the top floor of the property which belongs to David and Jean who both lived on the ground floor with David's 97 year old father 'Albert'.

2.6 Accounts obtained from David and Jean indicated that Lesley was taken into Machynlleth at around 6pm on Saturday 9th April to meet friends. After visiting various pubs within the town centre, Lesley caught a taxi home for about 11.50pm. This was the last time she was seen alive.

3 Process

3.1 On 19th April 2016, having concluded their initial investigations, Dyfed-Powys Police informed the Chair of Powys CSP of the circumstances of Lesley's death. This prompted Powys CSP to consider whether the criteria for establishing a DHR were met. Those criteria are set out below:

> 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/she was related or with whom he/she was or had been in an intimate personal relationship, or
(b) A member of the same household as himself.

3.2 A telephone conference held on 26th April 2016 allowed for the initial sharing of information between agencies in Powys. At first view there was little known about either Lesley or Neil and there were proper considerations as to whether they were residents of Powys. However after initial investigation it was agreed that both were newly resident in the County.

3.3 On 3rd May 2016 an extraordinary meeting of Powys CSP, comprising representatives from core agencies, determined that the criteria for establishing a DHR, as set in the Statutory Guidance for the Conduct of Domestic Homicide Reviews (hereafter referred to as the 'Guidance'), were indeed met.

3.4 On 17th May 2016 Mr Andrew Twigger was appointed as the Independent Chair of the DHR panel and also as author of the Overview Report.

3.5 The Home Office was notified on the 17th May 2016.

4 Inquests

4.1 The Inquests into the deaths of both Lesley and Neil were opened and adjourned on 14th and 19th April 2016 respectively. A pre-Inquest Review was held on 23rd September 2016 to address matters raised by Lesley's family. The Inquests were resumed on 9th December 2016.

4.2 The Chair attended the Inquests and gave evidence in respect of the findings of the DHR to that point.

4.3 The Coroner recorded a verdict of unlawful killing in respect of Lesley by Neil and a verdict of suicide in respect of Neil. The evidence put before the Coroner is entirely consistent with the content of this report.

4.4 Both Lesley and Neil had alcohol present in their bodies at the time of post mortem examination. Lesley's reading was 151 milligrammes per decilitre, Neil's was 65 milligrammes per decilitre. The Coroner drew no inference from the readings. There was no indication of any other drug in either Lesley or Neil.

4.5 An audio file of the Inquests has been made available to the review.

5 Domestic Homicide Review Panel

5.1 As stated above, this was the first time that a DHR had been initiated in Powys. Therefore the panel was created on a bespoke basis for the purposes of this review. Section 27 of the Guidance was given due respect in that representatives from both statutory agencies (listed under S9 Domestic Violence, Crime and Victims Act 2004) and the voluntary sector were appointed to the panel. It was clear however that the panel would benefit from the involvement of a specialist in domestic violence

issues and to that end the Chief Executive of Welsh Women's Aid (WWA) was contacted and invited to join the panel.

5.2 The methodology of the review was in accordance with the Guidance in that those agencies invited to take part in the DHR were requested to complete a process known as an Individual Management Review (IMR).

5.3 The aim of an IMR is

a) to allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made,

b) to identify how those changes will be brought about,

c) to identify examples of good practice within agencies[1]

5.4 The IMR reports were received and analysed by the DHR Panel which then produced this Overview Report, bringing together and drawing overall conclusions from the information and analysis supplied in the IMRs, as well as from information commissioned from other relevant interests.

5.5 The purpose of a DHR is to consider the circumstances that led to the domestic violence death, to enable professionals to fully understand what occurred, and to identify where responses to the situation could have been improved. In doing so the lessons learned will be taken on board by the professionals and agencies involved in order to reduce the risk of such tragedies taking place in the future. The recommendations identified by the Review Panel are to be found at **Appendix A** to this report.

5.6 A DHR is not an inquiry into how the victim died or into who is culpable. That is a matter for coroners and criminal courts, respectively, to determine as appropriate.

5.7 Neither is a DHR part of any disciplinary inquiry or process. If information emerges in the course of a DHR indicating that disciplinary action should be initiated the established agency disciplinary procedures should be undertaken.

5.8 As specifically set out in Section 7 of the 'Guidance', the purpose of a DHR is:

a) 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;

b) to 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;

[1] Section 7 Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (1 August 2013 onwards)

c) to apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) to prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims, and their children, through improved intra and inter-agency working.

5.9 In March 2013 the definition of domestic violence and abuse was amended. It describes domestic violence and abuse as:

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

- Psychological
- Physical
- Sexual
- Financial
- Emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.[2]

6 Independent Review Chair and Author

6.1 Andrew Twigger is a retired Police Officer, having retired (August 2013) at the rank of Chief Inspector after 30 years' service in both the West Midlands and Dyfed Powys forces. Mr Twigger has experience in that role of leading on partnership issues in Powys. He has previously had line and departmental responsibility for Public Protection in the County, was a member of the Powys Domestic Abuse Forum, a Trustee of Powys Victim Support, and has chaired many multi-agency processes including Multi Agency Public Protection Arrangements (MAPPA). Mr Twigger was the chair of the joint Police and Powys Community Safety Partnership's Equalities group for several years. Mr Twigger is now employed by Powys County Council as an Emergency Planning Officer. Section 33 of the 'Guidance' requires that a Chair is not directly associated with any of the agencies involved in the review. This was properly considered by the Chair of Powys CSP prior to the appointment of the Independent Chair. Given the lack of involvement of Powys County Council with

[2] Para 14 Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (1 August 2013 onwards)

the deceased, and the nature of Mr Twigger's employment in an area of local authority business unconnected with the CSP, it was considered that Mr Twigger was sufficiently independent to carry out the role. Section 34 of the 'Guidance' sets out the requisite criteria for the skills and expertise required to perform the role. It was considered that these criteria were met. The Chair has fully explained his current and previous employments with Lesley's family.

6.2 The Home Office was contacted in respect of DHR Chair's Training events but there were no courses available. Instead Powys CSP was referred to courses available through Advocacy After Fatal Domestic Abuse (AAFDA). Given that this is the first DHR to be carried out in the County it was felt necessary to ensure that the County was represented and accordingly the Powys CSP Chair attended a two day DHR Chair's course in July 2016, the learning from which has been shared with the DHR Panel and Independent Chair. The Independent Chair has completed the Home Office on-line training packages.

7 DHR Panel Membership

7.1 The DHR panel members were drawn largely from Powys CSP. All parties to the initial tele-conferences had agreed verbally to be part of the panel. Some of the panel members provided IMRs but given the lack of knowledge of the deceased these IMRs tended to address wider strategic issues around service delivery.

Andrew Twigger, Independent Chair

Fay Smith. Powys Community Safety Partnership Co-ordinator (also provided administrative support to the Chair, and to the Panel)

Duncan Kerr. Strategic Commissioning Manager (Violence against Women, Domestic Abuse and Sexual Violence), Powys County Council

Karen Arthur. Adult Safeguarding Lead Manager, Powys County Council

Pauline Galluccio. Head of Nursing, Adult and Children Safeguarding, Powys Teaching Health Board

Eleri Butler. Chief Executive Officer, Welsh Women's Aid

Sara Humphreys. County Manager, Hafan Cymru (a charitable housing association working primarily with people escaping domestic abuse across Wales. Also hosts Local Authority Independent Domestic Violence Advisors (IDVAs), providing advice, information and support to survivors of intimate partner violence)

Steve Davies. Detective Chief Inspector, Dyfed Powys Police. Force lead on Domestic Abuse and Senior Investigating Officer for the investigation.

Christine Harley. Head of Dyfed Powys Local Delivery Unit, National Probation Service Wales

8 Scope

8.1 The chronological scope of the investigation was limited to the period 1st September 2012 to 10th April 2016. Initial information from the police indicated that Neil and Lesley began their relationship in September or October 2012. At around that time Neil left his wife 'Louise' and began staying with Lesley at her home address in Rotherham. This is supported by sections of the chronology set out later in the report. The report also contains indications that, whilst Lesley's relationship with Neil had broken down in the weeks before the events of 10th April 2016, they were still physically residing under the same roof.

8.2 Notwithstanding the above, the review has included any relevant information pre-dating 1st September 2012 that was disclosed in the IMRs.

8.3 From an early stage it was known to the review that the Police were not looking for any third party in relation to the deaths of both Lesley and Neil. The police material formed the basis of their report to HM Coroner. The Chair of the DHR was allowed controlled access to that material to ensure that all relevant material had been shared between the two processes and that there was no conflict. This access also reduced the need for the witnesses to be contacted by the review ahead of the Inquests. This access allowed the Chair to progress the DHR report without compromising the Inquests.

8.4 Each agency or organisation that might have reasonably been expected to have had contact with either Lesley or Neil, was requested to undertake a comprehensive IMR of their involvement. Each of these IMRs was to be completed and produced in accordance with the Home Office Guidance.

8.5 The scope of the review also set out that family members were to be briefed on the process and offered the opportunity to contribute by means of an appropriate advocate.

8.6 For the majority of their relationship, Lesley and Neil were resident in the Rotherham area in the north of England. It was immediately clear to all that the review needed to cover agencies and organisations operating not only in Powys but also in the Rotherham area of England. To this end early contact was made with the Safer Rotherham Partnership to help to identify the relevant agencies and organisations in that area.

9 Terms of Reference

9.1 The terms of reference were set out as below:

- Identify which agencies/organisations had involvement with Lesley and Neil
- Review their responses to referrals and consider the appropriateness of any services provided
- Seek to identify which agencies/organisations (if any) were providers of relevant services but had no involvement with either Lesley or Neil
- Review the extent to which agencies/organisations worked together when responding to the needs and circumstances of both Lesley and Neil
- Consider potential gaps in service provision, alongside potential barriers to accessing services
- Consider the extent and adequacy of information sharing between local agencies in Powys and other areas
- All media enquiries will be dealt with via the Local Authorities Communications Team.

9.2 The terms of reference remained open to change.

10 Panel Meetings

10.1 The Panel first met on Tuesday 14th June 2016. The Chair gave an overview of the known history of both Lesley and Neil. That history is reflected later in this report. The terms of reference were amended slightly and the recipients of the IMRs agreed. The panel explored contact with persons outside of the IMR process, including family, friends, employers and colleagues. Those contacts are also detailed later in this report. The involvement of the SIO in the Panel ensured that there were no conflicts with the Inquest process and that the primacy of that process was not compromised.

10.2 The Panel next met on Friday 29th July 2016. At this time the majority of the IMRs had been received and the panel were able to scrutinise those that reported knowledge of Lesley or Neil and to discuss those IMRs that made recommendations in respect of service improvements. The panel recommended follow up enquiries in respect of one IMR. Three further agencies for IMRs were identified. The panel also recognised the difficulties in following up enquiries with Lesley's employers and recommended an approach to senior management instead. Approaches to Lesley's work colleagues and the owners of Tyddyn (as employers and landlords) were discussed but it was felt that this was inappropriate at that time given their possible involvement in the Inquests. Again the involvement of the SIO in the Panel was invaluable.

10.3 The third Panel meeting was held on 21st October 2016. The panel was able to further discuss the inclusion of some sensitive personal history. The panel debated the recommendations made by single agencies that were contained in the IMRs, and began to formulate these into the action plan contained at the end of the report. The panel was updated in respect of the scheduling of Inquests and of progress in consulting with family members.

10.4 There was a delay in completing the Overview Report brought about mainly by concerns raised by Lesley's family prior to the Inquests. Ordinarily the report should be completed within six months of the date of the decision to proceed. An extension of this timescale was agreed with Powys CSP given that the Inquests were postponed until December 2016. The Home Office was formally notified of the delay on 20th October 2016. The delay has proved beneficial in affording the family the opportunity for greater involvement in the DHR process than was initially believed likely.

10.5 The fourth Panel meeting was held on 5th January 2017. The panel received updates on the Inquests and details of contact with both families. The panel agreed a final version of the Overview report and concluded the wording of the initial recommendations.

10.6 The report was submitted to the Home Office for Quality Assurance in January 2017. Unfortunately the report was not considered by the Quality Assurance panel until July 2017 and the written response not sent out until September 2017. It was then necessary to instigate further IMRs with organisations and to form a new panel.

10.7 The fifth panel meeting was held on 24th November 2017. The revised panel considered the content of the Quality Assurance response, the updated IMRs and agreed a revised set of recommendations for inclusion in the action plan.

10.8 The revised version of the Overview Report was presented back to the Powys Community Safety Partnership on 10th January 2018.

10.9 The Home Office Quality Assurance panel finally approved the revised report in February 2018 and issued correspondence to that effect in March 2018.

10.10 Copies of correspondence are published online alongside this report.

11 Chronology of events

11.1 This chronology of events has been split into two parts.

Part 1, ‘England’, covers the lives of Lesley and Neil separately from birth until their move to Wales.

Part 2, ‘Wales’, details the move to Wales and the events that unfolded thereafter.

The events have been drawn from information provided by the families of Lesley and Neil, colleagues of Lesley and other significant witnesses. Such information has been given to the police investigation or to the DHR Chair directly. It is supplemented from official records received as part of the IMR process from contributing agencies.

The author has not sought to separate the chronologies in Part 2.

Readers are reminded that the report has been anonymised. The names of persons and addresses have been changed. Where the fictitious names and addresses first appear in the report they are set in inverted commas. Thereafter they appear in plain text. The names of agencies and those that represent them have been retained.

Furthermore the author has not sought to clarify all issues raised within this section. Some issues are dealt with later in the report.

11.2 Part 1: England

Lesley

Lesley was born in 1964, the 3rd of 4 sisters; ‘Elaine’ bn 1962, ‘Helen’ bn 1963 and ‘Elizabeth’ bn 1969. She had 2 further siblings, a half-sister ‘Charlotte’ bn 1979, and a half-brother ‘Derek’ bn 1981. She was 51 at the time of her death.

Her ethnicity is best described as white British (first language English).

Lesley married for the first time and moved to Bridlington where she had 4 children, ‘Jill’, ‘Ian’, ‘Colin’ and ‘Molly’.

Molly tragically passed away when aged just 3, a loss that is said to have affected Lesley deeply throughout her life.

Lesley was to become a proud grandmother, or Nana as she preferred to be known, to 7 grandchildren.

On 2nd August 2000 Lesley accepted the tenancy of ‘35 Archers Drive’, Rotherham. This was a property owned by Rotherham Metropolitan Borough Council (MBC).

In February 2001 she registered with a GP surgery in the Rotherham area. Records indicate that on in January 2002 she attended the surgery complaining of neck pain having been assaulted in the week previously. There is no record (from any source) as to who may have assaulted her or in what circumstances.

In September 2002 she notified the Housing Service that she had re-married and provided a copy marriage certificate.

From 2010 onwards it is understood that Lesley was working as a catering assistant.

In late 2012 Lesley met and began an intimate relationship with Neil.

Records indicate that Neil separated from his wife Louise and left his marital home in November 2012 (see chronology for Neil below). From that time on it is believed he began staying with Lesley.

On 6th March 2013 Lesley wrote and informed Rotherham MBC Housing that Neil had been staying with her 3 times a week and that as from 8th February 2013 he was there 'until he gets sorted'.

On 8th April 2013 Lesley contacted the Area Housing Office to inform them that Neil was officially a lodger.

On 25th April 2013 Lesley's medical records indicate she was signed off work with stress and was eventually made redundant. She disclosed to her GP that she was consuming excess alcohol. Lesley was seen regularly over the next 4 months and eventually saw the Practice alcohol worker but declined other counselling. Her stress eventually settled with medication and her drinking brought down to sensible levels. The condition is noted as relating to work only with no issues reported of a domestic nature.

From 2014 onwards there were periodic issues with rent payments and arrears and related action by Housing officers.

In 2014 Lesley secured employment with a care home in Rotherham where she remained until 2015.

On 24th November 2014 Lesley was last seen at the practice and referred to Rotherham NHS Foundation Trust for an unrelated matter.

On 16th December 2015 Lesley's keys to her tenancy were returned to Rotherham MBC. No formal tenancy termination process was undertaken. Subsequently the Area Housing Officer initiated the abandoned tenancy procedure and ascertained that Lesley had moved to Wales with no forwarding address known.

On 17th January 2016 the tenancy was officially ended. At the end of the tenancy there were outstanding rent arrears of several hundred pounds.

On 18th January 2016 Lesley transferred out of the GP surgery.

Neil

Neil was born in 1970. He was 45 at the time of his death.

His ethnicity is best described as white British (first language English).

Neil's mother's details are not known, he is survived by his father. Father and son had not seen each other apart from once in 22 years. Neil had 3 siblings; 'Sarah', 'Jane' and 'Rose' (deceased). Rose's funeral in August 2014 is believed to be the last time Neil spoke to his family.

Neil had one male child born in 1994 who was still an infant when Neil was sent to prison.

Neil has 14 previous convictions mainly for burglary and driving offences as a young man. His last conviction is of relevance to this report.

On 9th May 1996 Neil was convicted of manslaughter and robbery at Sheffield Crown Court. He was given a 10 year sentence. The circumstances of the offence are that he, and others, set out to commit a burglary of a former railway carriage occupied by an elderly male. During the course of that crime the male was tied to a chair and the safe, thought to contain a large sum of money, was stolen. Tragically the male died in the course of the crime, probably as a result of suffocation.

Whilst in prison Neil met his future wife Louise. She had been visiting a former partner in jail and had met Neil. She continued to visit him until he was released from prison on 21st February 2002. He then moved in to live with her at '18 Browns Lane', Rotherham.

Neil was managed by the National Probation Service. Records indicate this involvement ended on 27th September 2003. His sentence expired on 25th December 2005.

Neil registered with a GP practice in Rotherham in May 2002. His given address was 18 Browns Lane. There are few entries on the medical records. In 2003 he was issued with a sick note for 3 months for heroin addiction. A further sick note issued in April 2003 for 4 weeks was for depression. He was prescribed anti-depressants between May 2003 and May 2005. His last consultation in the surgery was in March 2012 when he had three appointments for a chest infection and further cholesterol and CVD risk assessments. He left the practice on 13th January 2016.

Louise and Neil were married. They never divorced. In her subsequent statement to police Louise summarised their relationship by stating that when they were together he did not drink excessively and there were no fights. They argued like any couple but he was never violent and never hit her. She added that during arguments he had a temper and she knew 'not to push him too far'.

Neil did not hold a council tenancy although he was a known occupant at both 18 Browns Lane (with Louise) and 35 Archers Drive (with Lesley).

In late 2012 he met and began an intimate relationship with Lesley.

On 11th November 2012 Louise contacted South Yorkshire Police to report that her husband 'had been really nasty for the last couple of days and had stayed out all night'. She reported that he had returned to the address and had threatened to smash the window with a hammer. She also alleged that he had punched her in the face. She stated that she suspected he was having an affair and had been smoking cannabis. She reported that 5 weeks earlier he had kicked a table over onto her foot and had caused an injury to her toe. The police record will show that she declined to pursue a complaint and that there was no visible injury. She is recorded as having ended the relationship and Neil had left the property. Police recorded a no crime

domestic incident (see paragraph 18.5 below for further detail) and graded the level of risk to her as medium.

It appears that Louise also contacted Rotherham MBC over the same incident because on 16th November 2012 the Housing Income Officer is recorded as contacting her by telephone. Records indicate that Louise was very upset as her partner had left her on 12th November 2012. Louise stated that police had been to her that week and that she had also received contact from a domestic violence officer.

On 14th January 2013 Louise contacted South Yorkshire Police to report damage to her car. The paintwork had been scratched and eggs thrown onto the roof. She suspected Neil had caused the damage. A crime report of criminal damage was recorded.

On 5th May 2013 she further contacted South Yorkshire Police when she received abusive texts from the phone of Neil's new partner (not named). Neil had used the phone to contact Louise requesting her to call him back. When she did not do so he sent her abusive text messages.

On 20th February 2014 information was received by Rotherham MBC that Neil was running a business from 35 Archers Drive and that there was scrap metal, wood and gas cylinders being kept at the property. The property was visited by Housing Officers with the case closed in April 2014 when the gardens were sufficiently cleared of the items.

11.3 **Part 2: Wales**

In late 2014 David and Jean purchased Tyddyn, a property near Machynlleth in Wales. They intended to move there with David's elderly father Albert. They began clearing items from an address in the Rotherham area in preparation for their move. It was at this time they met Neil in Rotherham. They became friends and David suggested Neil should come and work for him.

On 16th February 2015 Neil assisted David, Jean and Albert to move to Wales. From that point onwards Neil would travel to Wales and work for a few weeks before returning to Lesley in Rotherham.

David then invited Neil to move in and to renovate one of the outbuildings. This developed into Neil renovating the first floor of the property.

Lesley began to accompany Neil to Wales and by accounts 'fell in love with the area'. They decided to move there together. Lesley began to help care for Albert and received payment for doing so.

Neil carried out various manual labours around the property. The longer term plan was that Lesley would be able to care for David and Jean. In return, Lesley and Neil received cash payments and rent free accommodation.

In August 2015 Lesley visited Tyddyn in company with her sisters Elaine and Elizabeth. Comments are made that Lesley seemed very happy in Wales.

On or around 10th December 2015 Lesley moved to Tyddyn to live.

On 8th January 2016 Lesley registered herself and Neil with the local GP surgery in Machynlleth by phone. Both were subsequently sent a new patient registration letter on 10th March but neither made an appointment. Neither Lesley nor Neil were in receipt of prescribed medication from the GP surgery. An initial routine appointment for new patients was made for Lesley for 18th April but tragically events did not allow for her to attend.

On 18th January 2016 Lesley completed her first shift in her new job as a care assistant at a nearby care home in Machynlleth.

Relatives that had contact with Lesley during this time describe her as happy and had never seen the couple argue.

Lesley and Neil made one return trip to Rotherham when he was to be a witness in a civil case. The date of the court appearance was Tuesday 8th March 2016. They stayed for 3 nights with Lesley's friend 'Emily' and her partner 'Joe'. It was during this visit that Neil mistakenly formed a belief that Lesley had been unfaithful to him with Joe. This was denied by both Lesley and Joe but it marked the start of a deterioration in their relationship.

On 9th March 2016 they returned to Tyddyn, but from that point there are reports from Jean and David of arguing and raised voices. Jean will state that she never saw Neil aggressive towards Lesley but both were progressively drinking more heavily.

Lesley's sister Elaine and her husband 'Adrian' visited Lesley at Tyddyn (date not clear). Neil was reported to be drinking lots of vodka during their visit. During that visit Lesley disclosed Neil's criminal history to her sister. Elaine asked if Neil had ever hit her to which Lesley replied 'No' but did state that he had grabbed her. Elaine also asked her if she was safe. Lesley said that she was and that she wasn't frightened of Neil. During the visit Adrian reports that Neil had said to him 'I just can't get it out of my system. I could throttle her'.

At work during this time Lesley confided to some extent in a colleague 'Maureen'. She described her partner as a bully but did not say that he was violent or had hit her. Maureen got the impression that Neil was nasty and that Lesley was sad. Maureen advised Lesley not to tolerate it and to move out. Lesley replied that she was too scared to move out and would put a brave face on it and deal with it. Maureen offered for Lesley to stay with her but Lesley had laughed and didn't take it seriously. Maureen felt that Lesley trusted her not to say anything and so she never told anyone, trying instead to be a good listener.

On 17th March 2016 Lesley's Facebook page contained the post 'As from today I'm single, anybody want me, I'm waiting'. It is believed that this was posted by Neil.

Just prior to Easter 2016 Lesley made a trip to Leeds to see her daughter Jill and her grandchildren. They then all returned to Tyddyn for the Easter period. During that

visit Lesley informed her daughter that she and Neil had separated. Whilst in Wales Jill reports that she overheard Neil make drunken remarks about harming Lesley.

On 27th March 2016, (Easter Sunday), Lesley informed a co-worker Rebecca that she and Neil had broken up.

On 7th April 2016 Rebecca and Lesley were together in work. During their conversation Lesley disclosed to Rebecca that Neil had accused her of giving him a 'dose'. The report presumes this to mean a sexually transmitted disease but notes that there is no medical evidence to support such a claim. Rebecca suggested that Lesley should speak to the home manager about staying in the care home flat to get away from him.

On 8th April 2016 David's daughter 'Jennifer' visited her father and step-mother at Tyddyn. Her relationship with her step-mother was strained and there was apparently a difficult atmosphere at the property. David is understood to have had enough of the various tensions and spoke to both Neil and Lesley asking them both to leave.

On the evening of 9th April 2016 Lesley met up with Maureen in Machynlleth. During the course of the evening Lesley commented to Maureen that Neil could be violent towards her but no more was said. Maureen tried to pursue the line of conversation but Lesley declined to talk about it further. It was clear to Maureen that Lesley felt tied to Tyddyn because of her work with Albert but she also mentioned looking at a flat in Machynlleth. Significantly Lesley said that she did not want to go back. Maureen assumed this to mean Tyddyn rather than Rotherham and asked why. Lesley said she wasn't sure but Maureen felt it was because she knew that Neil would have been drinking.

Sometime after 11.30pm Lesley was taken back to Tyddyn by taxi. The taxi driver mentioned that he had previously driven her partner to which she replied that they were no longer together.

On the morning of 10th April 2016 Jennifer left to return to Rotherham. She was heard to call to Neil and offer him a lift back to Rotherham. There was no reply and she left.

David and Jean left to visit friends. When they returned in the afternoon, and with no sign of Lesley or Neil, David went upstairs to check and discovered Lesley's body. The police were then called.

12 Individual Management Reviews (IMRs)

12.1 IMRs were split into 2 groups for the purpose of the Review;

Group 1: Agencies delivering services in Rotherham or England

Group 2: Agencies delivering services in Powys or Wales

Group 1: Agencies delivering services in Rotherham or England

Agency	Role	Date IMR received	In brief
Rotherham Rise (formerly Rotherham Women's Refuge)	Provider of support services for adults and children who have been affected by domestic violence and abuse.	18.8.2016	Parties unknown
National Domestic Violence Helpline	24 hour national domestic abuse telephone service	18.8.2016	Parties unknown
Rotherham Metropolitan Borough Council	Adult Care and Housing	22.7.2016	Tenancy records for Lesley and Louise. Records re Neil.
Rotherham Metropolitan Borough Council	Neighbourhood and Adult Services/Domestic Abuse Services	4.7.2016	Parties unknown
Greenside Surgery, Rotherham	GP Practice	5.7.2016	Background re Lesley's medical history
Rotherham, Doncaster and South Humber NHS	Provider of Primary Care (Shared Care) Alcohol Service	14.7.2016	Details of Lesley's referral for service
Rotherham NHS Foundation Trust	Operates Rotherham General Hospital	4.7.2016	Details of Lesley's GP referral
Parkgate Medical Centre, Rotherham	GP practice	4.7.2016	Background re Neil's medical history
Lifeline	UK led organisation involved with drug abuse, alcohol	23.6.2016	Parties unknown

	abuse, drug addiction and related disorders		
Yorkshire Ambulance Service	Provider of 24-hour emergency and healthcare services	8.7.2016	Parties unknown
National Probation Service	Statutory criminal justice service	12.7.2016	Historical re Neil
South Yorkshire Police	Police service covering Rotherham, Doncaster, Barnsley and Sheffield	13.7.2016 (updated 3.8.2016)	Historical data re Louise and Neil. No record re Lesley

Group 2: Agencies delivering services in Powys or Wales

Agency	Role	Date IMR received	Comment
CALAN	CALAN provides a range of immediate and long term support options for individuals and families experiencing domestic violence and abuse. (South of County)	12.7.2016	Parties unknown
Hafan Cymru	Hafan Cymru is a charitable housing association that works primarily with people escaping domestic abuse across Wales. Also hosts Local Authority Independent Domestic Violence Advisors (IDVAs), providing advice, information and support to survivors of intimate partner violence	14.6.2016	Parties unknown
Montgomery Family Crisis	Supports men, women and children experiencing or affected by domestic abuse in North Powys	6.6.2016	Parties unknown

New Pathways	Supporting those who have experienced trauma, particularly from rape or sexual abuse	2.6.2016	Parties unknown
Radnorshire Women's Aid	Support to women and their children experiencing domestic abuse. (Mid-Powys)	20.6.2016	Parties unknown
West Wales Domestic Abuse Services	Ceredigion DV service provider	11.8.2016	Parties unknown
Welsh Women's Aid	National umbrella organisation representing local Women's Aid Groups situated throughout Wales. Manage the 24 hour Live Fear Free Helpline	13.7.2016	Parties unknown
Powys County Council	Adult Safeguarding	14.6.2016	Parties unknown
Powys County Council	Housing	3.6.2016	Parties unknown
Powys County Council	Housing Benefit	29.6.2016	Parties unknown
Powys County Council	Planning	29.6.2016	Parties unknown
Powys County Council	Refuse & Recycling	5.8.2016	Parties unknown
Powys County Council	Strategic Commissioning (Violence against Women, Domestic Abuse and Sexual Violence)	7.8.2016	Parties unknown
Powys teaching Health Board	Provider of Community Healthcare services in Powys delivered through a network of Hospitals, Health Centres and Clinics	27.6.2016	Parties registered for GP services but not seen.
Kaleidoscope	Provider of drug and alcohol services to adults	16.6.2016	Parties unknown
Welsh Ambulance Service Trust	Provider of emergency and patient transport	8.7.2016	Nil contact prior to 10.4.2016

	services for the NHS in Wales		
National Probation Service (Wales)	Statutory criminal justice service	4.7.2016	Parties unknown
Dyfed-Powys Police	Police service covering Carmarthenshire, Pembrokeshire, Ceredigion and Powys	5.7.2016	Nil contact prior to events of 10.4.2016

13 Analysis of IMRs

13.1 The analysis of the IMRs, and other correspondence received from the various agencies, has been grouped according to function. Within each function the service provision for both Rotherham and Powys have been considered separately. IMRs were received from public services in Wales impacted by recent relevant legislation. For clarity this legislation is explained below.

13.2 The Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAWDASV) came into effect in Wales on 1 April 2016. The legislation aims to improve the public sector response, in Wales, to domestic abuse and sexual violence. Amongst other things it seeks to:

> Improve arrangements to promote awareness of, and prevent, protect and support victims of gender-based violence, domestic abuse and sexual violence, and
>
> Improve consistency, quality and join-up of service provision in Wales.

13.3 The Act applies to relevant authorities in Wales and these are Local Authorities, Local Health Boards, NHS Trusts and Fire & Rescue Authorities.

13.4 The National Training Framework (NTF), issued under Section 15 of the Act is statutory. It is designed to ensure that all public service professionals in Wales are able to recognise the signs of domestic violence and know how to signpost people for help. The NTF is split into six groups based on role and responsibilities to ensure that the more likely a person is to encounter someone experiencing such abuse, the more training that person has access to and therefore the more able that person is to help.

13.5 Group 1 is the widest audience as all employees of the relevant authority must undertake the training. Whilst the training is statutory to relevant authorities it is likely to be promoted to all who work in the VAWDASV arena including the specialist providers and the police. The training for Group 1 comprises a 45 minute e-learning package.

13.6 Groups 2 and 3 are known as ‘Ask and Act’. Training for these groups will build on the knowledge gained from the e-learning. The groups will include those in a public facing role coming into regular contact with the general public (eg housing officer) and in a role where the experience of their client group of these forms of violence and abuse complicates and impacts on the nature of the clients engagement with the service offered in that role (eg social worker). The training is designed to equip the person to ask, where they spot a client is showing signs of VAWDASV, and then act to ensure the client gets help.

13.7 Group 4 comprises specialist professionals (eg Independent Sexual Violence Advisors and refuge workers). Group 5 comprises senior service managers whilst Group 6 is formed of public service leaders.

13.8 Relevant authorities (for the purpose of this report Powys County Council and Powys Teaching Health Board) will be expected to produce a training plan by the

end of March 2017. Progress by the authority is required by law to be reported annually.

14 Domestic Violence Support Agencies

14.1 A full list of all relevant agencies offering support to women suffering domestic abuse or violence in both Rotherham and Powys was compiled with the assistance of the respective CSP Co-ordinators. The national organisations were also identified as they maintain the national 24 hour help lines. The responses of each agency is set out below but in short none of the organisations had knowledge of either Lesley or Neil.

14.2 Delivery of Domestic Violence support services in Rotherham is provided by Rotherham Rise (formerly Rotherham Women's Refuge). Rotherham Rise confirm that they have had no dealings with Lesley.

14.3 The National Domestic Violence Helpline jointly provided by Women's Aid and Refuge for callers in England was contacted. There is no record of any contact by Lesley.

14.4 In respect of domestic abuse and sexual violence service provision in Rotherham there are no recommendations in this report.

14.5 Delivery of Domestic Violence support services in Powys is primarily through three providers operating on a geographical basis. CALAN in South Powys, Radnorshire Women's Aid in Central Powys and Montgomery Family Crisis in North Powys. Those providers confirm that they have had no dealings with Lesley. Further agencies operating within Powys, namely Hafan Cymru and New Pathways, were also contacted and again those agencies confirm no knowledge of Lesley. Given the geographical location of Tyddyn another specialist provider in neighbouring Ceredigion, West Wales Domestic Abuse Services, was contacted. This provider also confirmed no knowledge of Lesley.

14.6 WWA observes that Powys is well-served by the provision of local domestic abuse services. This provision is augmented by the presence of a specialist provider in Ceredigion whose services may be considered more accessible to residents of Machynlleth. The county is also served by the Wales Live Fear Free Helpline, providing free 24 hour confidential information and support for anyone experiencing domestic abuse or other forms of violence against women.

14.7 The WWA report identifies that there is always scope for better communication about domestic abuse and the help available across communities and workplaces. This is also the case in Powys where it is suggested by WWA that further work to promote the Live Fear Free helpline was required. The WWA report made a number of suggestions for extending the reach of communication in respect of domestic violence. The Panel accepted that there was an ongoing requirement to promote assistance to victims of domestic violence including the helpline. It agreed that **Recommendation 1** of this report should focus on the promotion of the Live Fear Free helpline across the County.

14.8 The response by WWA suggested that employers across the County could be seen as a key group through which communication with victims might be improved. By increasing the number of employers who introduce domestic abuse workplace policies, and by those employers providing associated training for staff, WWA argued that more people would be supported to contact specialist service providers.

This issue was considered by the Panel and the key discussion points are outlined in Section 21 Colleagues & Employers below.

14.9 Welsh Women's Aid is currently working, in partnership with Women's Aid and relevant local authorities, to deliver the Ask Me pilot scheme in 3 areas of the UK. One of those pilot areas is Powys where two rural communities have been selected for the pilot. The Ask Me scheme aims to create safe spaces in the local community where women experiencing domestic abuse might already visit. These might include local businesses and other community settings where women would know they can safely tell someone about their experiences. Trained members of those local businesses and/or community centres taking part in the scheme will know how to sensitively question and respond to disclosures of domestic abuse and where to signpost the women for further help. Premises involved in the scheme will display a sign that shows they are participating in the programme and are a safe place to tell someone about the abuse. The local authority is playing a key role in supporting this project.

14.10 The impact of rurality in an area such as Powys was highlighted in the WWA report. It identifies that survivors of domestic abuse in rural areas might not want to access local services and should therefore have the choice of being supported by a service in a neighbouring county. Whilst the panel recognised the impacts of rurality on many aspects of life in Powys it did not find a proven link between Lesley's death and the availability of services. The panel did recognise the value of the Ask Me scheme within a rural setting. **Recommendation 2** of this report supports the delivery and evaluation of the Ask Me pilot scheme.

14.11 The WWA report also highlighted the position of landlords as a group through which communication with victims might be improved. Section 22 Private Landlords below refers.

14.12 The circumstances of this case highlight an escalation from examples of coercion and control to homicide within a very short time scale. The panel agreed with comments from the Home Office Quality Assurance panel that a specific recommendation in respect of coercive and controlling behaviour was therefore merited. The panel's view was that this was an area for further publicity and awareness raising both amongst professionals and the wider community. **Recommendation 3** of this report requires specific highlighting of coercion and control during publicity and awareness training.

15 Local Authorities

15.1 The panel sought to identify any relevant engagement of local authority services in both Rotherham and Powys.

15.2 Rotherham MBC was requested to check records for Lesley, Neil and Louise. The records recovered are exclusively from the Housing and Neighbourhood Services service area.

15.3 All three persons were known to Rotherham MBC and the pertinent remarks are reflected in the chronologies above. In summary Lesley was known to Rotherham MBC as a tenant at 35 Archers Drive, Rotherham between 2000 and 2016. Louise was known as a tenant of 18 Browns Lane, Rotherham until 13th January 2014. Neil did not hold a tenancy but was a known occupant at 18 Browns Lane (with Louise) and thereafter 35 Archers Drive (with Lesley).

15.4 In relation to the report made by Louise to Rotherham MBC on 16th November 2012 it was recognised, with hindsight, that the Housing Support Officer could have made further enquiries of her with regard to the domestic violence unit contact from police. Appropriate advice and support could then have been offered to her such as a referral for support services or an assessment of her home for possible target hardening measures. There is no record of such a conversation in the authority's files. It is noted that Louise remained at the property for a further fourteen months before the tenancy ended and there are no records in Rotherham MBC files of any further incidents.

15.5 Rotherham MBC report that since 2012, Housing staff, as part of a Council wide awareness raising and training programme, have received training on safeguarding. Housing staff have also received training on domestic violence and referral processes. The Rotherham MBC report adds that staff should be reminded of the need for appropriate professional curiosity and pursuing qualified lines of enquiry with customers, in relation to information received from customers which may raise safeguarding issues.

15.6 Consequently Rotherham MBC has committed to issue all Housing staff with appropriate guidance by August 2016. The panel has received confirmation that this has been carried out and does not consider that any further recommendation is required.

15.7 It is recognised that prior to the arrival of Neil at 35 Archers Drive there had been no record of housing rental arrears. Rotherham MBC reports housing arrears beyond that point and whilst there may be various reasons for such arrears, the potential for financial abuse has to be considered. Lesley's close family were asked by the author to comment specifically on this issue but have provided no further insight. There is no evidence of financial abuse but the local authority were contacted to ascertain what procedures are in place to screen for such abuse.

15.8 Rotherham MBC reports that all housing officers have been trained within the last two/three years (ie 2015 onwards). This training encompassed domestic abuse and safeguarding issues, including financial abuse. The authority states it is

committed to refreshing that training and has agreed to look again at the content of the training, in the light of this report, in particular for those involved in financial transactions. The Rotherham MBC Housing department use the DASH[3] risk checklist as an assessment tool for domestic abuse which touches upon financial issues. Rotherham MBC believes that a sudden rise in debt in a tenancy, tied to a new arrival in the household would trigger a DASH assessment.

15.9 Powys County Council had no record of either party within any section. Records of all departments likely to have personal contact with the occupiers of Tyddyn, such as planning, refuse collection, housing and housing benefits, have been checked. Departments such as Adult Safeguarding, likely to have contact with Lesley or Neil, have also been checked.

15.10 Whilst there is no record of any contact with either Lesley or Neil, Powys County Council is a relevant authority under VAWDASV. Consequently Powys County Council is required by statute to deliver appropriate training to all Council staff. Those staff who are more likely to come into contact with people affected by domestic violence, such as housing officers, will receive additional enhanced training.

15.11 Given the possible link between financial abuse and debt it is also considered appropriate that local authority staff concerned with debt collection will also receive enhanced training. The training is required to be delivered by March 2018. **Recommendation 4** of this report supports enhanced VAWDASV training for all Housing and debt collection officers within the local Authority.

15.12 The panel considered it an anomaly that staff employed directly by a relevant authority (such as the local authority) were required to be trained in VAWDASV, whilst staff employed by a third party commissioned to deliver the same service on behalf of the authority were not. This issue is considered further under Section 21 Colleagues and Employers below.

[3] Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification Assessment and Management Model

16 Medical services

16.1 The Panel sought to track the medical histories of both Lesley and Neil to identify any indication of domestic abuse or sexual violence.

16.2 A report was received from Lesley's previous GP practice in Rotherham indicating records held since 2001. This was considered to be a sufficient period for the purpose of the review and exceeded the review's timescales. There are no indications in the report of any domestic abuse. The medical history shows two referrals and these have both been investigated. Neither gives any indication of domestic abuse. The report from Rotherham Doncaster and South Humber NHS Foundation Trust reports that Lesley's reported issues were entirely work related and that the worker discussed both alcohol use and lifestyle. The report from Rotherham NHS Foundation trust specifically states that that there are no indications within the records of problems within her relationship. Additionally Neil was known to that service.

16.3 A report was received from Neil's previous GP practice in Rotherham indicating records held since 2002. Again this was considered to be a sufficient period for the purpose of the review and again exceeded the review's timescales. There are no indications in the report that might suggest him to be the perpetrator of domestic violence.

16.4 Neither party was known to the Yorkshire Ambulance Service.

16.5 There are no recommendations for service improvement for medical services in the Rotherham area.

16.6 Both Lesley and Neil had left their respective GP practices and had re-registered with the GP surgery in Machynlleth. Neither had visited the surgery and neither was in receipt of prescribed medication from the surgery. The new patient registration forms were populated with the very basic detail such as names, dates of birth and addresses. There was no information relating to medical history, medication, treatment or lifestyle. It is not clear whether these were completed by surgery staff over the phone or sent out to Lesley and returned by her. There was therefore no opportunity, in line with current legislation and guidance, to ask her privately in person to discuss matters such as her relationship with Neil.

16.7 Neither party was known to the Welsh Ambulance Service prior to the events of 10th April 2016.

16.8 As previously stated in Section 13 above, VAWDASV applies to Health Boards in Wales. Powys Teaching Health Board recognises that it has statutory obligations in respect of training to comply with the Act.

16.9 There are no recommendations for service improvement for medical services in Powys.

17 Probation Service

17.1 Neil was previously known to South Yorkshire Probation Service but this involvement ended in September 2003. He was not known to National Probation Service Wales.

17.2 There are no recommendations in respect of the National Probation Service.

18 Police

18.1 Two Police forces are identified as being relevant to the report. South Yorkshire Police, covering the Rotherham, Doncaster, Barnsley and Sheffield areas, and Dyfed-Powys Police, covering Powys and the Dyfed counties of Carmarthenshire, Ceredigion and Pembrokeshire.

18.2 South Yorkshire Police had knowledge of all three parties: Louise, Neil and Lesley. Their involvement was limited to the reports from Louise that accompanied the breakdown of the marriage as listed in the chronology above. The first of those reports indicates a level of domestic violence at the hands of Neil. The matter was recorded, the complaint of assault was not pursued and the level of risk to Louise was assessed as medium. This grading is explained below.

18.3 Since March 2009, all domestic cases recorded by Police are subjected to a DASH risk assessment process. It is relevant at this point to clarify the DASH levels of risk: Standard, Medium and High.

> Standard: Current evidence does not indicate likelihood of causing serious harm.
>
> Medium: There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.
>
> High: There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

18.4 Louise is recorded as having been referred to both domestic abuse and victim support services and also as having been given appropriate safeguarding advice. Accordingly South Yorkshire Police did not identify any recommendations for service improvement.

18.5 South Yorkshire Police were requested to further clarify the recording of a no crime incident following the events of 11.11.2012 as reported by Louise (see Chronology above). Having re-visited the electronic incident log and the crime recording system it is recorded that the complainant, Louise, refused to divulge any information regarding her being assaulted. She did not display any outward sign of injuries and consequently the attending officers recorded it as a no crime incident. South Yorkshire Police state that this was in accordance with policies at the time. They go on to explain that policies and procedures have been updated and amended

since that date in line with Home Office guidelines. There is now in place an audit and governance unit who review crime reports and amend any that that do not comply with crime reporting guidelines.

18.6 Whilst recognising that there were no further reported incidences of domestic violence towards Louise, the panel questioned whether consideration was given to any notification to Neil's new partner, Lesley. The processes by which this might occur are explored below:

18.7 Multi-agency risk assessment conferences (MARACs) were in place across UK police forces by 2006. This model of intervention follows a process of risk assessment in all reported cases of domestic abuse to identify those at the highest risk of domestic violence to enable a specialist multi-agency response. The Review Chair has held further conversations with South Yorkshire Police on this matter. The incident grading of medium would not have triggered a referral to the MARAC process at the time. It is of note that South Yorkshire have amended their criteria to allow for consideration of individual circumstances on a more flexible basis. Domestic abuse investigations may, following assessment, be identified as either: VOLUME or PRIORITY or SERIOUS AND COMPLEX[4]. Therefore a series of events, each at Medium or Standard risk, may now trigger a referral under VOLUME. The single event nature reported by Louise would not meet this revised criteria. SERIOUS AND COMPLEX are generally those cases classed as High risk. The review enquired whether the nature of Neil's previous conviction for manslaughter might in itself, or in conjunction with other factors, have been a trigger such investigation. The force considered this question but took the view that, given the facts of the case, the conviction would not have influenced the referral mechanism.

18.8 The Domestic Violence Disclosure Scheme (Clare's Law) was introduced nationwide in March 2014. South Yorkshire Police was not one of the original four pilot forces but introduced the scheme in line with national direction. The scheme gives members of the public a 'right to ask' Police where they have a concern that their partner may pose a risk to them or where they are concerned that the partner of a member of their family or a friend may pose a risk to that individual. Where an application is made under the scheme, Police and partner agencies carry out checks and if they show that the partner has a record of abusive offences, or there is other information to indicate that there may be a risk from the partner, the Police will consider sharing this information. It is recognised that both Louise and Lesley had knowledge of Neil's criminal past.

18.9 MAPPA stands for Multi-Agency Public Protection Arrangements. It is the process through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.

18.10 MAPPA was being introduced into South Yorkshire Police in 2002/3, which approximately coincides with Neil's release from prison in 2002. The probation

[4] South Yorkshire Police – Recording, Investigation and Management of Domestic Abuse

service ended their involvement with him in September 2003. Neil was not subject of MAPPA in South Yorkshire.

18.11 South Yorkshire Police were asked to provide further clarification as to why Neil was not subject of MAPPA. Their reply confirms that Neil was sentenced and released prior to the introduction of MAPPA and any associated filter meetings in that area. He could have been subjected to MAPPA at the time of his release from prison in 2002 but this would have ended after his conditional release expired on 25.12.2005. As he did not commit further offences there was no reason to reconsider that position.

18.12 Where persons subject of MAPPA move from one Police force area to another there is a duty on the host area to communicate such information. Accordingly, even if South Yorkshire Police had known of Neil moving to Wales in 2015, this information would not have been communicated. There was therefore no failure to communicate between the two forces.

18.13 Dyfed-Powys Police had had no contact with any of the parties until the events of 10th April 2016. Jean was known on police systems following her reporting of minor theft and unconnected anti-social matters.

18.14 Dyfed-Powys Police is not a relevant authority under VAWDASV.

18.15 Consequently in respect of both police services there are currently no recommendations included in this Review.

19 Family

19.1 The Panel wishes to express its condolences to the family of Lesley on their sad loss. The Chair has spoken in person to members of Lesley's family at the Inquest and on a subsequent visit to share the original overview report with them. The Chair has maintained regular contact with the family.

19.2 The Chair has also spoken with Neil's father and has conveyed the condolences of the panel on the loss of his son.

19.3 The panel sought in the first instance to identify key members of both families through the Family Liaison Officer (FLO) appointed by Dyfed-Powys Police and the police investigation team.

19.4 The FLO had referred Lesley's death to Victim Support through the normal reporting channels for Wales. Given the location of family members, across the North East of England, the case was duly referred on and a team leader within Victim Support's Homicide Service in that area was appointed as the central point of contact. Three Homicide Service workers were appointed to deal with family members on a geographical basis. The panel sought the assistance of the Homicide Service to act as advocates in its dealings with Lesley's family.

19.5 Following their initial contacts with Lesley's family the Homicide Service suggested that the Chair write to family members to introduce the DHR process.

Letters were sent to identified family members together with the relevant Home Office Information Leaflet.

19.6 On 12th July 2016 the Chair made telephone contact with Lesley's sister, Elaine, to introduce the DHR process and to offer face to face contact with her family. Having consulted with family members a message was passed back to the Chair through the Homicide Service that the family did not, at that time, wish to engage with the review. It was clear from the brief telephone contact with the Chair that the family did not recognise that Lesley had been subject to a pattern of domestic abuse or violence that would have been reported to agencies. Accordingly it was felt at the time that this would be too painful a process for little outcome. Lesley's family were engaged with the Inquest process and would be in Wales for that purpose. The panel supported continuing efforts to engage with them.

19.7 The Chair attended the Pre-Inquest Review on 23rd September 2016 and at that time was able to introduce himself and the DHR process to the family members present in person. This contact was repeated on 9th December 2016 following the conclusion of the Inquests at which time the family agreed to receive pre-publication sight of the draft overview report.

19.8 Whilst the report has drawn heavily on information contained within statements made to the Police, it is also aware of comments expressed by family members to the press that reflect well on Lesley, her love of her family and her motivation for moving to Wales. The following comments are drawn from an interview with Lesley's daughter that appeared in a newspaper article in the days following Lesley's death:

"She was a wonderful person. She was a Nana, not a grandma, she always preferred to be Nana. She was an amazing friend, an amazing mum and an amazing Nana. She loved all her seven grandkids more than anything else".

"She wanted a change of scenery, there was nothing left for her in Rotherham. She wanted to start a new life but now it's over".

19.9 Following the conclusion of the Inquests, the Chair made contact with Neil's father. Whilst he had not seen Neil for some time he did state that Neil was not a violent man. He did not believe there had been any violence exhibited by Neil to either Louise or Lesley prior to the tragic events that unfolded in 2016.

19.10 On 12th January 2017 the Chair met with Lesley's close family to discuss the report and recommendations. There were no amendments to the report following that meeting. The family expressed the view that the initial timeframe for the report of six months had made it difficult for them to engage in the first instance. At the time that contact was first made in respect of the DHR the family were still trying to come to terms with the fact that Lesley had died. They were however grateful for the continued contact and the opportunity to be involved.

19.11 The Chair has maintained regular contact with Lesley's family via their preferred method of contact.

20 Friends

20.1 Lesley's closest friend was identified by the police enquiry as Emily. It was with Emily that Lesley and Neil stayed for the trip to Rotherham in March 2016. Both Emily and her partner have contributed statements to the police investigation and these form part of the file sent to HM Coroner. Emily states that to her knowledge Neil was 'possessive and controlling'. A letter was sent to her together with the relevant Home Office Information Leaflet. No response has been received in respect of that letter.

21 Colleagues and Employers

21.1 Initially, the only colleagues identified by the panel were those who had provided statements to the Police. The relevant parts of their statements are reflected in the above chronology. Again given their involvement in the Inquest process they were not spoken to by the Chair. Their evidence, clearly described at the Inquests, reflected an escalation of disclosures by Lesley in the days immediately preceding her death that coincided with the breakdown of her relationship with Neil. Their accounts recalled offers of help to Lesley which, for whatever reasons, were not taken up. It is significant to note that none of the accounts from colleagues described any visible marks or injuries to Lesley.

21.2 One further colleague was spoken to by the Chair at the Inquests. She confirmed that Lesley was employed directly by the care home rather than through an agency but added nothing further to the known facts of the case.

21.3 Three of Lesley's previous employers were identified for the purpose of the review, two of whom have been contacted.

21.4 Lesley was casually employed at Tyddyn to look after Albert. Given that the owners of Tyddyn were central witnesses in the Inquest process no contact was made with them prior to the Inquests. The Chair attended the Inquests and listened to the evidence they were able to give. The key elements of their accounts to the Police are contained in the above chronology (see also para 22.3 below re landlords).

21.5 Lesley was also formally employed at a local care home in Machynlleth. The home is owned by Powys County Council but operated by a company contracted by them. The manager of the care home had provided a statement to the police in which she stated that she was picking up third hand within the workplace that Lesley's relationship with Neil was on and off. Telephone contact was made with the manager to explain the purpose of the DHR and a letter was sent to her, together with the relevant Home Office Information Leaflet. No response was received in respect of that letter.

21.6 Given that this particular care home forms part of a larger nationwide organisation of similar care homes, the panel considered the lack of response and suggested that a follow up was made at a senior level to identify whether, as an employer, the organisation had in place policies that would enable staff experiencing

domestic abuse in the future to access support from the workplace. This enquiry was subsequently addressed by letter from a company Director.

21.7 In that response it was confirmed that Lesley commenced her work at the care home in January 2016 and had completed 41 shifts, receiving in the process approximately 40 hours of training. She was a bank staff member, which means she wasn't in the home on a regular basis. The Director described Lesley as well-liked by the team and that she was known for her cheerful, happy nature. Staff have been shocked by her death and wish to convey that she is very much missed at the care home.

21.8 The response states that throughout her time in the home neither her colleagues nor her manager saw any signs of domestic abuse.

21.9 The response also indicates that policies and procedures are in place to provide a safe, supportive environment for staff in the workplace. There was no reference in the response to specific domestic abuse training.

21.10 The Chair has since spoken in person to two longstanding staff members from the care home who have indicated to him that there has been no specific domestic violence training provided to them.

21.11 The IMR response by WWA highlighted that the few disclosures that Lesley did make in the weeks before her death were predominantly to work colleagues. The Home Office DHR Information leaflet for employers and colleagues indicates that 12 per cent of those who experience intimate partner violence tell someone at work (Roe, 2009)[5]. The panel accepted WWA's suggestion that if employers introduced domestic abuse workplace policies, and provided associated training for staff, more people would be supported to contact specialist service providers.

21.12 It was noted by the Panel that the Local Authority (Powys County Council) had previously publicly announced its intention to resume the operation of its owned care homes (including the home at which Lesley was employed) through the development of a Local Authority Trading Company (LATC) to manage the homes on the council's behalf. This decision had been expected in May 2017 when current contracts expired. A two year extension to that contract has since been announced. Therefore the Local Authority will continue to commission services through its contracts with private companies for beds at care homes, with additional beds periodically purchased under spot contracts. This is of significance in that staff at that care home and others across the County, if they were to be transferred back into the employment of the Local Authority under a LATC, would be required to be trained in accordance with the terms of VAWDASV.

21.13 In Section 15 Local Authorities above, the panel noted the anomaly that staff employed directly by a relevant authority (such as Powys County Council) were required to be trained in VAWDASV, whilst staff employed by a third party

[5] Domestic Homicide Review Information Leaflet for Employers and Colleagues

commissioned to deliver the same service on behalf of the relevant authority were not.

21.14 The panel agreed with WWA's view that it would be ideal if all employers developed domestic abuse awareness, policies and training. It was recognised however that such an aim could only be achieved through legislation and even then only achieved with extensive monitoring. It was recognised that the Welsh Government was leading the way on this issue but even so had only introduced legislation that covered those functions that were devolved, including Health, Local Authorities and Fire. The Welsh VAWDASV legislation does not extend to non-devolved functions nor to the private sector. As a result the panel did not make an initial recommendation in respect of employers.

21.15 Following initial Home Office Quality Assurance processes it was suggested that a recommendation 'broadened to embrace all employers in the region' be further considered. This suggestion was accordingly taken back to panel for consideration.

Recommendation 5 states that Powys County Council will encourage all employers in the area to have relevant domestic abuse policies and training.

21.16 The panel also discussed the influence that the Local Authority could bring to bear on the range of organisations and employers through which it commissioned services to develop domestic abuse policies. In particular the panel wished to encourage all organisations contracted by the Council for the provision of care services on its behalf, to offer training to their staff that accords with the requirements on relevant authorities of the National Training Framework under VAWDASV.

Recommendation 6 seeks to encourage all organisations contracted by Powys County Council for the provision of care services on their behalf to offer staff training that accords with VAWDA&SV.

21.17 Lesley's previous employer, in Rotherham, was also a care home but this time a smaller independent company. Telephone contact was made with the manager and a letter was sent to him, together with the relevant Home Office Information Leaflet. No response has been received in respect of that letter.

21.18 It is understood that prior to her work as a care assistant Lesley was employed in the catering industry. The review is sighted on comments regarding difficulties with her previous employers and has not sought any correspondence from that quarter.

22 Private landlords

22.1 This section was included in response to the suggestion from WWA to extend the reach of communication about domestic violence to private landlords. Whilst the panel supported the general need to extend communication it wished to consider whether there was a vehicle through which this might specifically be achieved for private landlords.

22.2 Since 23 November 2015, Part 1 of the Housing (Wales) Act 2014 requires private landlords operating in Wales to become registered. Landlords meeting the definition under the Act were given one year to comply with this new obligation.

22.3 As previously stated, the owners of Tyddyn were not spoken to by the review. The status of Lesley and Neil's tenancy of the upper floor at Tyddyn was however confirmed during their evidence to the Inquests. Their tenancy was on a casual basis forming part of the overall benefit to them for the work that they did there, including Lesley's caring for Albert.

22.4 The review has confirmed with the operators of the registration scheme, Rent Smart Wales, that the owners of Tyddyn would not have been defined as private landlords under such an arrangement, and would not therefore have been required to register as such. The current registration scheme does not therefore represent a potential means of communicating with women in a similar housing position to Lesley.

23 Conclusion

23.1 There are two episodes of known domestic violence documented in the report.

23.2 The first of these occurred during the breakdown of Louise's relationship with Neil in Rotherham in 2012. Whilst Louise states that Neil was never violent towards her, she did report that in the weeks before their separation he had kicked a table over onto her foot, threatened to break a window with a hammer and punched her.

23.3 The report concludes that agencies in Rotherham either had no knowledge of the parties involved or that they reacted appropriately to the report. The one issue of staff training identified has since been addressed.

23.4 The second known incident resulted in the death of Lesley following the breakdown of her relationship with Neil. There is no other evidence of physical violence against Lesley except for the injuries sustained on Sunday 10th April 2016 that are documented in the post mortem examination.

23.5 The report has found no indication that agencies in Powys had knowledge of either party other than from the initial registration process with their local GP surgery.

23.6 What has become clearer from the various accounts given to the police and the Inquests is that both Lesley and Louise used language that indicated the existence of coercive and controlling behaviour by Neil.

23.7 This is corroborated by Lesley's closest friend who was aware that Neil could be 'possessive and controlling'.

23.8 Louise describes in her statement to police that Neil 'had a temper' and that she knew 'not to push him too far'. As their marriage broke down there is evidence that the physical risk of domestic violence to her increased.

23.9 In the early part of their relationship Lesley and Neil appeared, from the outside at least, to be happy. As the relationship deteriorated it became clearer in Lesley's disclosures that her partner could be 'a bully' and that he had grabbed her. It is tragically evident that the risk of domestic violence to her during the break up of her relationship increased to the point where she was killed. It was not until the hours before her death that she first described her partner as violent and exhibited a fear of him.

23.10 From discussions with Lesley's family it is clear that prior to her death, they did not consider her as a victim of domestic abuse.

23.11 The accounts from colleagues is that when they did try to engage with Lesley on the subject of domestic abuse their attempts were unsuccessful.

23.12 There is no evidence that Lesley contacted domestic abuse agencies or any other party for help.

23.13 The new definition of domestic abuse was introduced in 2013 to include coercion and control. It is clear from the circumstances of this case is that domestic

abuse can exist in the form of coercion or control and escalate suddenly and directly to an act of homicide.

23.14 It is also clear that the significance of coercive and controlling behaviour may not yet be widely appreciated in society. It is clear to the panel that both public and professional awareness of domestic abuse needs to increase in general but especially in respect of coercion and control.

23.15 The Review has however found no clear trail of evidence that might have led agencies and organisations, in Rotherham or Powys, to act differently.

23.16 The report concludes that the risk of such incidents occurring in the future are best reduced by increasing public awareness of domestic abuse and domestic abuse services, by ensuring that suitable information and assistance is widely available in the community and through the training of professionals and others to recognise the many signs of abuse and to offer appropriate support.

23.17 The recommendations made in this report are without exception aimed at the delivery of increased levels of awareness not only across agencies in Powys, but also to the wider communities of Powys where Lesley had chosen to make her new home.

Powys Community Safety Partnership Domestic Homicide Review 2016.1 Action Plan

	Recommendation	Scope of recommendation ie local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date & Outcome
	What is the over-arching recommendation?	*Should this recommendation be enacted at a local or regional level?*	*How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation ?*	*Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved.*	*When should this recommendation be completed by?*	*When is the recommendation actually completed? What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?*
1	Promote public awareness of domestic violence issues and services across Powys and in particular the Live Fear Free Helpline.	Local (Countywide)	Relevant VAWDASV agencies and Police to produce a delivery plan for extending communication and promoting the helpline.	Commissioning Manager (Violence Against Women, Domestic Abuse and Sexual Violence)		To be agreed	
2	To support and evaluate the community based 'Ask Me' pilot scheme in selected	Local (Pilot area)	As per the scope and terms of reference of the pilot scheme. Pilot area chosen for Powys is rural in nature.	Welsh Women's Aid Powys County Council Powys Teaching Health Board		To be agreed	

	communities in Powys.						
3	All publicity campaigns in Powys will specifically highlight issues of coercion and control	Local (Countywide)	During publicity campaigns, training etc the issues of coercion and control are specifically highlighted.	Commissioning Manager (Violence Against Women, Domestic Abuse and Sexual Violence)		To be agreed	
4	Housing Officers and those concerned with debt collection within Powys County Council receive enhanced VAWDASV training.	Local (Countywide)	Powys County Council will include Housing Officers and those concerned with debt collection in Level 2 'Ask & Act' training cohort to ensure signs of financial abuse are recognised.	Powys County Council		March 2018 (VAWDASV)	
5	Powys County Council will encourage all employers in the area to have relevant domestic abuse policies and training.	Local (Countywide)	Powys County Council will encourage all employers in the County to have in place domestic abuse awareness training and policies for all employees. The authority will assist with policies and course content.	Powys CSP			
6	Powys County Council will encourage all organisations	Local (Countywide)	Support to providers on implementing this is provided by PCC	Powys County Council	Activity to commence once	To be agreed	

	contracted by the Council for the provision of care services on their behalf, to offer training to their staff that accords with the requirements on relevant authorities of the National Training Framework under VAWDASV.				report accepted at HO. DK to confirm route to achieving this eg does it require Cabinet approval		

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4th January 2018