Domestic Homicide Review Report:

Sue
Date of Death: February 2021

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Review Completion Date: July 2023

Official Sensitive Government Security Classifications 2018

CONTENTS

Brief outline of circumstances resulting in the Review

This report of a domestic homicide review examines agency responses and support given to Sue a resident of Torfaen prior to the point of her death in February 2021. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

The authors like to express their condolences and thanks to the family for their invaluable contribution to the review. Due to the lack of contact Sue and Bob had with external agencies the review would have been flawed without the family's input.

In 2011 Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). A "domestic homicide review" is now required in circumstances where the death of a person aged 16 or over has, or appears to have, resulted from violence abuse or neglect by:

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself,

The purpose of a DHR is to:

a) 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) 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.
c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated, multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
e) Contribute to a better understanding of the nature of domestic violence and abuse; and
f) Highlight good practice.

Background to this Report

This DHR concerns a married couple. For the purposes of the report, they will be referred to as Sue (the wife and victim) and Bob (her husband). Sue was murdered by her husband Bob in February 2021. He has since been found guilty of murder and sentenced to 20 years in prison.

Sue and Bob are pseudonyms chosen by her family. Sue's death met the criteria for conducting a Domestic Homicide Review under Section 9 (3) (a) of the Domestic Violence, Crime and Victims Act 2004.

The review will consider agencies contact/involvement with Sue and Bob from February 2019 to February 2021 to identify any areas of possible concern and escalation.

Timescales
An Independent Chair and two authors were appointed in November 2021, and the Home Office duly informed.

Due to court process this review began with the first panel meeting held in April 2022 and was concluded in March 2023.

The review took longer to complete due to the restrictions and pressures of the pandemic and sickness.

Confidentiality
The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers. The pseudonyms used throughout the report were agreed with the family and used in the report to protect the identity of the individuals involved.

At the time of the incident Sue was 74 and Bob was 71 both were white British.

Terms of Reference
The purpose of this review was to –

- Determine whether decisions and actions in the case comply with the policy and procedures of Torfaen County Borough Council and the Domestic Homicide Review Statutory Guidance 2016.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Establish whether previous relevant information or history about the deceased and/or family members was known and considered in professionals' assessment, planning and decision-making in respect of the person, the family, and their circumstances. How that knowledge contributed to the outcome for the person.
- Review any barriers experienced by the family and/or friends in reporting abuse or concerns, including whether they knew how to report domestic abuse.
- Establish whether the actions identified to safeguard the person were robust, and appropriate for that person and their circumstances.

- Assess whether the actions were implemented effectively, monitored, and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.
- Identify the aspects of the actions that worked well and those that did not work well and why. Evaluate the degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes the person. Establish whether the protocol for professional disagreement was invoked.
- Review advice and learning for wider agencies and professionals in relation to identifying and reporting DA concerns, including estate agents and solicitors.
- Review communication to the public and non-specialist services about available specialist services related to domestic abuse or violence.

Methodology
Following a referral from Gwent Police, the initial decision to undertake a DHR was made in March 2021 by Torfaen Public Service Board (of which the statutory community safety partnership is a subgroup) in consultation with statutory partners and local specialists.

Family and others' Involvement
The Authors and DHR Panel members offer their deepest sympathy to all who have been affected by the death of Sue, and thank them, together with others who have contributed to the deliberations of the Review. The authors met with Sue's family at their home, as was their choice, and spoke about Sue's life.

Upon receipt of the referral the community partnership wrote to the family with contact details and the DHR leaflet. The family were supported by the Family Liaison Officer during this time and a support worker from Victim Support. During author visits with the family, they were supported by this support worker. The family chose not to meet the review panel but kept in contact with the support worker and were talked through the purpose of the review and the terms of reference.

Sue's two closest friends were approached and chose not to form part in this review; however, their views were shared by Sue's family.

Once the draft review was completed the authors with the support worker met the family at their home to explain the contents of the report, agree the pseudonyms and make any changes prior to this final report being submitted.

For note, Bob was written to in prison on different occasions by the author and asked if he would like to be involved in this review, but no response was received.

Contributors to the Review/Agency Involvement
Agency information from the following agencies formed part of the review:

- Gwent Police

- Aneurin Bevan University Health Board
- Welsh Ambulance Service Trust
- Cyfannol Women's Aid
- Bron Afon Housing Association

All information and panel members were independent in that they had not been directly involved in the circumstances surrounding the death.

Review Panel Members

The review panel included representation from the above agencies, and local authority leads, including the Community Safety Partnership. All members were independent and had no previous contact with either party.

Name	Agency	Job Role
Mary Ryan	Independent Author – Newport City Council	Head of Adult and Community Services
Janice Dent	Independent Author – Newport City Council	Partnership and Policy Manager
Ann Hamlet	Independent Chair – Aneurin Bevan University Health Board	Head of Safeguarding (since retired)
Finn Madell	Independent Chair – Newport City Council	Head of Corporate Safeguarding
Kelly Beaumont	Cyfannol Women's Aid	Support Services Manager
Jane Rees	Welsh Ambulance Service Trust	Safeguarding Specialist
Howard Stanley	Aneurin Bevan University Health Trust	Head of Safeguarding
Neil Blyth	Gwent Police	Detective Inspector
Jodi Evans	Bron Afon Housing Association	Support Services Manager
Steve O'Connell	South Wales Fire and Rescue Service	Group manager for Torfaen and Blaenau Gwent
Lesley Groves	Torfaen County Borough Council	Housing Manager
Kate Williams	Torfaen County Borough Council	Group Manager (Community Safety)

The review panel met on the following dates:

7 April 2022
5 May 2022
14 June 2022

3 August 2022
20 September 2022
6 October 2022
17 January 2023
10 February 2023

The agenda for each meeting was appropriate; there was a good level of debate and appropriate challenge. Themes were identified and recorded as they emerged. The minutes and actions were promptly circulated with the latter being closely monitored.

Panel members were independent in that they had not been directly involved in the circumstances surrounding the death.

Authors of the Overview Report

Both Chairs/authors are employed by Newport City Council and had no connection with Torfaen's Public Services Board. They are therefore considered independent in their roles within this review.

Mary Ryan was the Head of Corporate Safeguarding, with an overview of Children, Adult and Education service and managed the regional Violence Against Women, Domestic Abuse and Sexual Violence Team for Gwent. Currently employed by Newport City Council as the Head of adult services.

Mary is qualified Social Work, CQSW, DIPSW, ASW, AMHP, MSc Advanced Social work practice. Mary has also completed the Home Office Domestic Homicide Training and completed Significant Incident Learning Programme (SiLP: University of Portsmouth).

Mary is an experienced reviewer and author of Adult and Child Learning reviews as well as Domestic Homicide Reviews.

Janice Dent was employed as the Regional Lead Advisor for Violence against Women, Domestic Abuse and Sexual Advisor, funded by Welsh Government and hosted Newport City Council.

Janice has completed the Home Office Domestic Homicide Training and completed Significant Incident Learning Programme (SiLP: University of Portsmouth). Janice was a member of the AADFA DHR Network and attended key webinars to ensure understanding of best practice at all stages of reviews.

Parallel Reviews

There was a thorough police investigation into the circumstances of Sue's death and subsequent court proceedings, which resulted in the conviction of Bob for her murder.

Information from the police investigation and court case has been used to inform elements of this review.

Equality and Diversity

Consideration to equality and diversity and the nine protected characteristics detailed in the Equality Act 2010 were considered in this review with age and disability being possible areas of focus for the learning points and action plan.

Dissemination

Following consideration by the family of this report it will be shared with panel member agencies, the Home Office, Torfaen Public Service Board. Once anonymised the findings of the report will be shared to support the learning identified in the action plan.

Background Information and Chronology

Sue had moved to the area with her first husband, the children's father, but they separated after living there for approximately 7 years. Sue stayed in the marital home and raised the children on her own. Although, due to divorce and subsequent financial difficulties, the house had to be sold and Sue and the children lived in privately rented houses around the area for a while.

Sue had known Bob and they had a short relationship a few years prior to them getting together permanently. When Bob got back in contact after a few years he offered to help her and the children, and they moved into his house. When Sue's mother became ill, she moved into their home so that Sue could care for her until she moved into a nursing home and shortly after passed away.

The family shared that approximately 10 years ago they noted that their mother's relationship with Bob had started to change, and they noticed that the relationship was not as happy. Bob's circumstances had changed when he retired early and then him losing his driving licence following a medical incident, although he could have reapplied after a year Bob chose not to. Bob's behaviour is said to have changed around this time, and he rarely left the house. It was reported that Bob became more frugal with his money at this time and expected Sue to continue working and contribute to all financial expenses, even though he had no financial pressures.

Sue sought legal advice as she was concerned for her housing security, as the house was in Bob's name. Sue had reassured family that she was looking to leave the relationship but that she didn't want to leave her home and start again. Family explained that Sue had struggled with finances when her children were younger but had always worked hard and provided for her children.

Not long afterwards, in 2012, Sue and Bob married, and Bob changed his will to leave half of the house to Sue. Family described a lavish wedding and remembered Sue as being 'over the moon'.

Approximately 5 years later Sue returned to the solicitor for further advice. At this time Sue described a strained relationship with regular arguments about money and smoking. Bob was a chain smoker and insisted on smoking in the house. After the legal appointment Sue was unhappy to return to Bob and went to stay with a friend for a couple of days. Bob sought Sue out and persuaded her to try again and return home with him, he agreed to build an extension to the house something that he knew Sue had wanted to do for some time.

A short while after Sue's return home the arguments and unhappiness within the relationship returned, so they started to live separately in the same house. Sue was so unhappy she returned to the solicitor approximately 2 years ago and started divorce proceedings.

During this period family refer to Sue as feeling low and spending more time with them at the weekends etc. Sue spent many hours driving around with her daughter looking for alternative accommodation. Sue did not want to start over again building a new home and life for herself, but felt she had no choice due to the poor relationship she had with Bob.

When the lockdown occurred during the initial phase of the Covid Pandemic, it meant that her usual escapes to family and out and about in the community were no longer a viable option.

On the morning of Sue's murder, she was in her own bed upstairs, Bob entered her bedroom and murdered her by stabbing her repeatedly while she was in bed.

After murdering Sue, Bob called the police to tell them he'd stabbed his wife and that they should also arrange an ambulance.

Following an investigation and court proceedings, Bob was convicted of murder in March 2022 and sentenced to 20 years in prison.

Overview

As part of this DHR the authors met with Sue's family, and accessed all relevant professional agency, both statutory non-statutory, and timeline information for a forensic examination of the records relating to contact with Sue and Bob.

There is only one contact from 2014 from a domestic abuse service that Sue attended a drop-in service but no records of the content of any discussions or evidence of follow up are available due to the time limits of paper record storage.

Records from the Health Board and Ambulance Trust do not specify any enquires in relation to domestic abuse but focused on Sue and Bob's physical needs.

From August 2020, it is clear from housing association support records that Bob's concerns over the possibility of Sue claiming against the property were escalating, looking for alternative accommodation and expressing threats towards her.

Reflections of Sue by her family

Sue's family described her as a loving, 'young at heart', well liked, and family-oriented person, who nobody had a bad word to say about. Sue had worked hard throughout her life, and they remember this particularly from when they were children and Sue was a single parent. Sue's children describe growing up in a loving atmosphere, where Sue worked hard to provide for them financially.

Sue had a close relationship with her family, with her children and their wider families and cared for her own mother for the last few years of her life.

Sue always made friends in her workplaces and the communities she lived in and established a long-lasting good circle of friends through her love of dancing.

Reflections of Bob by Sue's family.

Sue's family described Bob as an old-fashioned man. When Sue first moved in with Bob, Sue's daughter lived with them and remembered the earlier years of Bob being 'great with them' recalling spending a lot of time together going out as a family and being very close and happy.

Sue had met Bob at a dance when the children were young but split up after a while before getting back together after a few years and were together for over 30 years.

Bob had been married twice previously and has a son with his first wife. After each marriage Bob told Sue and her family that he had lost out financially and wouldn't lose out again to Sue. This appeared to be a theme throughout their marriage with Sue and her family having to contribute financially throughout for every purchase within and outside of the home. This included petrol money for days out and half payments for new carpets etc. in the house.

Whereas Sue's family describe their mother as outgoing and sociable, they describe Bob as a bit of a loner who stayed outside smoking when he attended any social events and saying what he thought without consideration of feelings leading to falling out with individual and joint friends.

After losing his driving licence due to ill health, Bob mainly stayed at home and was reluctant to spend any money on taxis to go out anywhere.

Other insights

During the trial, Judge Michael Fitton QC, upon sentencing Bob said.

"I see you as a profoundly self-centred, bitter, and unpleasant man. You are bitter and angry at life and took out your anger on Sue on the day you killed her. You told a family friend that you felt you could stab her. When she said, 'where would that get you?' you responded, 'I don't care'. I don't think you care about anyone other than yourself".

Analysis and themes

It is important to note this section is completed with the benefit of hindsight and having access to information from different sources and is not written in a way to suggest blame or to guarantee a different outcome but to support learning and aims to prevent similar circumstances happening in the future.

Theme 1 – Coercion and Control

The overarching theme identified during the review was that of coercion and control, which has informed the learning points from this review.

Coercion and controlling behaviour fall within Section 76 of the Serious Crime Act 2015. It applies to controlling or coercive behaviour in an intimate or family relationship. For the purposes of this offence, behaviour must be engaged in 'repeatedly' or 'continuously'. Another, separate, element of the offence is that it must have a 'serious effect' on someone and one way of proving this is that it causes someone to fear, on at least two occasions, that violence will be used against them. There is no specific requirement in the Act that the activity should be of the same nature. The prosecution should be able to show that there was intent to control or coerce someone. (https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship)

When the authors met with members of the family and heard from others who gave examples of what can be construed as coercive and controlling behaviour by Bob. It is on reflection that the family can view the relationship as coercive in nature, but at the time did not see it as an abusive relationship in the sense of abuse by physical violence.

The controlling nature of the relationship by Bob centred around finances and tapping into Sue's sense of security and pride of her home. Having worked all her life, he was aware it would be a trigger for Sue as a push and pull factor in how he controlled her. Some family members were aware of the tension in the relationship regarding Bob's sexual demands on Sue and how she would not want to participate but felt she had no choice. Another element of how Bob controlled Sue was with isolation from her family and friends. Previously they had enjoyed an active social life

with dancing central to it. When Bob no longer wanted to participate, he expected Sue to stop and be content to stay in with him.

Throughout their relationship, family describe finances always being a key issue for Bob, but these became more prominent after his retirement. Bob had been heard to say he'd 'been stung twice before and wasn't going to let it happen a third time' (2 divorces), prior to their marriage he is said to have asked Sue to sign a pre-nuptial agreement not to claim anything against the house, but she agreed to a verbal agreement instead. The house and bills were all in Bob's name and he frequently told Sue he had 'put a roof over your head and that he had saved her and your kids' and that 'this is my house if you want to go then go'.

After losing his driving licence, Bob would be reluctant to spend money on taxis, so the couple's social life was severely limited. Sue was described as outgoing and loved dancing and spending time with friends, but on occasions when Bob went with her, he would isolate himself by smoking outside the venues, and say things that upset others leading to an awkward atmosphere and both staying in more.

Family reported their relationship had been affected by Bob's behaviour. Previously, Sue and Bob were close to Sue's extended family and her grandchildren would stay with them, but more recently family reported a strained atmosphere and that Bob had stopped coming downstairs to say hello when they visited resulting in the family visiting less. Sue had expressed to her family she felt Bob had become jealous of her relationship with her grandchildren.

Although a very sensitive issue, Sue shared with friends and family that Bob used to make her do things sexually she didn't want to do, but was threatened by Bob repeatedly stating, 'no sex, no marriage' and that he blamed her for his difficulties in that area, including that of erectile disfunction, after his heart attack.

Sue cited the reason for contacting the solicitor to begin divorce proceedings as she couldn't take anymore, and that Bob was threatening her all the time leading to her feeling on edge a lot of the time. The solicitor recommended Sue stay in the marital home during the proceedings but that she should leave and move out if she felt physically threatened at any time. However, Sue had told the solicitor, family, and the police that she wasn't fearful of him.

The authors note that while family were able to describe incidents, they are minded that the review will consider information in the knowledge that Sue was murdered. As such actions can be seen to indicate a behaviour that may not be reasonably expected to be recognised in isolation. None the less there were examples given that suggest that a greater awareness of this behaviour is needed within communities if the risks are to be recognised and understood. For example, Sue had been watching a Coronation Street storyline where one of the women was in an abusive relationship, and Sue said she felt like that woman but that she didn't want to leave her home and start again.

In research published in 2018 Dr Monckton Smith reviewed domestic violence killings in the UK which showed an 8-stage timeline of events before a homicide takes place. Coercive and controlling behaviour is a known risk factor in Domestic Homicides. The authors are minded that they have been considering the information they receive with this knowledge.

The Crown Prosecution provides in their guidance the following examples of coercive and controlling behaviour, but is not limited to:

- Stopping or changing the way someone socialises
- Physical or mental health deterioration
- A change in routine at home including those associated with mealtimes or household chores
- Putting in place measures at home to safeguard themselves.

Theme 2 – Missed Opportunities for intervention and support.

In research published in 2018 Dr Monckton Smith identified eight steps in almost all of the 372 UK domestic violence killings she studied, referred to as the 'homicide timeline'.

Dr Monckton Smith identifies these as:

- A pre-relationship history of stalking or abuse by the perpetrator
- The romance developing quickly into a serious relationship
- The relationship becoming dominated by coercive control
- A trigger to threaten the perpetrator's control – for example, the relationship ends, or the perpetrator gets into financial difficulty
- Escalation – an increase in the intensity or frequency of the partner's control tactics, such as by stalking or threatening suicide
- The perpetrator has a change in thinking – choosing to move on, either through revenge or by homicide
- Planning – the perpetrator might buy weapons or seek opportunities to get the victim alone
- Homicide – the perpetrator kills his or her partner, and possibly hurts others such as the victim's children

Through the lens of hindsight and knowledge that Bob went on to kill Sue we can see evidence of many, if not all the above.

Escalation and the reporting of this is a key learning point identified in this review. The clarity of the timeline from involved agencies, and through speaking to Sue's family, provides evidence of the escalation of concerns, coercive control, and threats. Bob had made threats towards Sue to a housing association, which were reported to the Police, and expressed these to an estate agent with Police visiting the house and spoke to a neighbour. The mechanism for all agencies reporting

concerns to the police as intelligence may support the identification of escalation and support safety planning and prevention.

Within the timeline, in hindsight there were missed opportunities for additional questions to be asked of Sue using the Ask and Act principles in Wales.

In February 2019, WAST clinicians reported Sue appearing very anxious and frightened and avoiding eye contact. At this visit Bob made the decision for Sue not to attend hospital with him. However, this could have been an opportunity for clinicians to speak to Sue separately to ask further questions and consider her views and medical needs in relation to being transported to hospital with Bob.

Timeline records show incidences of low mood and relationship stresses but no records of these being followed up within Ask and Act processes with Sue or Bob separately.

As the timeline progresses there is some evidence of a worsening relationship however this may not have been clear to practitioners at the time. It is not clear if professionals were focussed on Bob's poor physical health needs at the time besides one record that Bob was asked about any relationship issues by a health practitioner. But no record of this being followed up with Sue, however this would be usual practice.

Theme 3 – Community awareness

The role of the wider community in addressing and preventing domestic abuse is documented throughout this review. Supporting families, neighbours, and non-specialist services to recognise but more importantly how they can help is a key learning point identified by Sue's family, agencies involved and the authors.

We know that Bob spoke to a neighbour about feeling like he wanted to 'kill' Sue which in hindsight if this had been reported to the police along with other threats this might have led to a higher recognition of risk by the Police.

Bystander awareness campaigns and training will be a key element of the action plan for this review.

Theme 4 – Limited Professional Curiosity

Through analysis of the timeline and agency management information there are situations in which professional curiosity and actions may have been affected by conscious and/or unconscious biases by practitioners.

In hindsight, agencies felt the presented fragility of Bob, and the perceived unfazed responses by Sue reduced the recognition and understanding of risk by practitioners. An example of this is when officers visited the couple after the report of threats to kill by Bob had been reported and although they had the option to arrest Bob on threats

to kill based on their assessment of Bob and Sue, they felt the risk of harm was minimal.

Good Practice Identified

Ongoing support was provided to Bob by a housing association support worker and concerns escalated internally and reported to police when Bob stated he wanted to stab his wife to the housing worker.

Police visited Sue following this report to share their concerns and a safety plan was discussed. A skeleton DASH was completed at the time, but Sue did not give consent for this to be fully completed or shared.

There is evidence of regular contact with the GP in relation to mental health concerns (depression and anxiety) with associated assessment and treatment. Counselling was also provided to Bob and Sue, individually and separately, although this concentrated on physical and emotional aspects of Bob's heart attack and impact within their relationship.

Conclusion

By conducting this review and speaking to Sue's family and other agencies it has become clear from the information shared that Sue had experienced coercive and controlling behaviour for many years. It is not possible to say whether she recognised this, although she had sought legal support and raised some concerns with family members.

Coercive and controlling behaviour is challenging in many ways; victims may not recognise that this is happening to them. If the relationship is regarded as loving and the behaviour seen as originating from a point of love, they may not see that it is restricting or limiting their life.

To effect change, there needs to be a greater public awareness of how coercive and controlling behaviour and domestic abuse in a wider form can present. More importantly this needs to be presented with information about what families, neighbours and other people involved can do as there is a risk that telling someone to leave may put them at greater danger.

The messages around the COVID-19 pandemic also had an impact on this situation. National messages about those at risk of harm from domestic abuse were able to leave their home, these focused on physical risk more than psychological and relied upon people recognising they are a victim of domestic abuse. Although it is hoped there won't be a need for these messages to be used again, should a similar crisis occur care will need to be taken to ensure fuller understanding from Government departments.

Learning and any lessons to be learnt

Coercive control continues to be an area where increased awareness amongst community members and professionals would be beneficial. In hindsight, there are indications of the coercive control Bob used with Sue, financially, psychologically, and sexually.

In addition to being able to recognise coercive control it is important to ensure referral pathways are clear. In one example Sue had reflected her own situation mirroring a domestic abuse storyline on a soap but there was no evidence she or her family knew how and where to access support or the range of safeguarding measures available including property markers and protective orders.

The Welsh Government VAWDASV National Training Framework is supporting awareness raising amongst relevant authority staff, but it is important this learning is further disseminated among communities and other agencies, including but not limited to housing associations and estate agents.

There were concerns raised by Bob and Sue to different agencies during the timeline period with no obvious referral to specialist support. There is a potential for unconscious bias with older couples. An example of this is the decision not to arrest appearing to have been influenced by Bob's fragility and Sue's unfazed reaction to the comments made by Bob.

Gwent Police report a lack of professional curiosity when speaking to Sue following the report by the housing association although this is in the context of very little Domestic abuse history reported to the Police. Intelligence reports from other agencies on comments and threats made, along with the escalation of these may have triggered further exploration of the domestic abuse history with Sue, her family, friends, and neighbours and may have provided a more detailed picture of the risk involved, and additional safeguarding procedures implemented including options of Police bail with conditions or the issuing of a Domestic Violence Protection Order and/or an urgent response marker applied to the address.

Even though there is evidence of good practice by their attending and speaking to Sue and Bob separately, they didn't fully explore with neighbours or family to fully understand the history and the risk with no record of Sue being asked for her consent to speak to family members about the nature of the threats made by Bob.

The importance of utilising opportunities to implement Ask and Ask processes and reporting concerns by all relevant agencies was identified through conducting this review.

The family are clear if they had been informed of the threat to stab Sue by Bob, they would have intervened and removed her from the home. We need to consider how this can be addressed by practitioners and with respect to Sue's confidentiality.

Recognising the coercive control that Bob had over Sue and not prioritising herself or the potential risk she faced requires intervention and sensitivity to enable victims to seek assistance when they are most vulnerable.

During the review process, panel members identified a possible gap in support for people in privately owned homes as opposed to those living in accommodation provided by social landlords. For example, it was highlighted that within social housing organisations there are designated safeguarding teams and domestic abuse liaison officers who would approach both parties separately. They also have positive links to be able to refer into the Multi Agency Risk Assessment Conference (MARAC).

Early learning and improvements already made

Raising awareness of the abuse of older people especially domestic abuse is a priority of the Older Person's Commissioner for Wales. Further information can be found here.

Locally additional community-based training and resources have been developed and disseminated including training for the hair and beauty sector, Ask and Act training and IRISi roll out in local GPs.

Gwent Police have developed a 2-year learning plan to ensure all frontline officers receive Domestic Abuse Matters training.

South Wales Fire and Rescue Service train all members of staff at a minimum of Ask and Act Group 2 and have a dedicated IDVA as part of the service.

Welsh Ambulance Service Trust (WAST) require all staff to complete mandatory Group 1 training in domestic abuse and sexual violence and all front-line staff are required to complete Group 2 training. Training is refreshed every 3 years.

WAST have also developed a digital referral pathway to the Live Fear Free service via an electronic reporting device, Docworks system. This was introduced in November 2021 for all frontline staff who are supplied with iPads. Clinical staff who are office based also follow the same pathway however referrals are by telephone. Referrals can be made with the Victims consent.

Although South Wales Fire and Rescue Service (SWFRS) were not involved with the couple, as a statutory partners SWFRS are wholeheartedly committed to the safety and wellbeing of all community members, especially those who are most vulnerable and at risk from harm. SWFRS accept the key learnings from this case and will review how they can be implemented within our service. SWFRS are currently reviewing safeguarding training at all levels. Key areas that will be included in this training following the review are the significance and signs of coercive control, importance of professional curiosity and disclosure/non-disclosure recording.

Guidance for practitioners in relation to Coercion and Control has been developed and shared through the Regional Safeguarding Board and VAWDASV Partnership.

In line with the work of the Older Person's Commissioner additional funding was provided to a specific older person's project with Cyfannol Women's Aid and a specialist IDVA.

Recommendations

The following recommendations are based upon information provided by Sue's family, and relevant agencies through information submitted as part of management reports and through discussions during panel meetings.

Recommendation 1
Information and campaigns aimed at community members on domestic abuse at any age and in different circumstances, and especially in relation to coercive control need to be reinforced both on a national and local level. There are some positive examples detailed above but is recommended the awareness raising and bystander type campaigns are regularly repeated in a way that doesn't lead to them not being impactful.

Recommendation 2
Public Services Board/VAWDASV Partnership to consider sharing this report and recommendations with the Wales VAWDASV National Advisors, and to ask if the National Training Framework could be expanded to include additional agencies including solicitors and estate agents who are likely to encounter citizens during stressful and emotional times.

Recommendation 3
The local commissioning of older persons specialist staff and the work of the Older Person's commissioner on abuse of older adults to be promoted to aid recognition of domestic abuse within older relationships and referral routes for support. With family consent this report and findings could be utilised as a case study for learning.

Recommendation 4
Ask and Act training to be considered for wider staff within agencies, including NHS employed counselling staff and control centre staff within WAST and Gwent Police with a focus on domestic abuse within all relationships including older adults.

Recommendation 5
Region to consider further training on recognition and referral for those displaying and/or expressing abuse behaviour including mapping of services that support behavioural change and recognition of risk to partners. With consent, this report and recommendations could be utilised to raise awareness of the need to engage with potential perpetrators, with a focus on older and perceived frail adults.

Recommendation 6

Gwent Police are piloting the Domestic Abuse Risk Assessment (DARA) tool alongside the DASH risk assessment due to highlighted concerns in some of the key questions which may result in a lower risk score for older adults (as an example in relation to pregnancy). The region and or Welsh Government VAWDASV team may wish to consider a task and finish group to share learning and good practice.

Recommendation 7

Report and recommendations to be shared with the Gwent VAWDASV and Safeguarding Boards to consider the support available to those who own their own homes, like, and in line with the support available via dedicated safeguarding and domestic abuse practitioners within registered housing associations. This is particularly a concern where couples are assessed as standard to medium risk and therefore not supported via MARAC.