COMMISSIONED BY THE CWM TAF COMMUNITY SAFETY PARTNERSHIP

Executive Summary

Domestic Homicide Review in respect of the death of 'George' in June 2022

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Contents

Glossary

The relationship between and Health and Social Care systems that the perpetrator ‘Paula’ engaged with are shown in diagrammatic form in Appendix 1.

Service	Acronym
Drug & Alcohol Single Point of Access	DASPA
Cwm Taf Morgannwg University Health Board.	CTMUHB
Rhondda Cynon Taf	RCT
Trivallis	Housing Provider
Local Primary mental Health Support Service	LPMHSS
A service which provides support to individuals affected by alcohol and drugs, and their friends and family.	Barod
Rhondda Cynon Taf Domestic Abuse Services.	RCT DAS
Multi Agency Risk Assessment Conference.	MARAC
Domestic Violence Protection Notice Domestic Violence Protection Order.	DVPN/DVPO

1 The Review Process

This summary outlines the process undertaken by the Cwm Taf Community Safety Partnership domestic homicide review panel in reviewing the homicide of ‘Geoge’ who was a resident in their area.

The following pseudonyms chosen by the victim’s family have been in used in this review for the victim and perpetrator to protect their identities and those of their family members: George as the victim’s pseudonym and Paula as the perpetrator's pseudonyms. George was thirty-nine years old at the time of his death he identified as a white, Welsh, heterosexual, male, unmarried with no children. Although was born with a disability following numerous operations, he did not regard himself as disabled.

Paula was aged thirty four years old she identified as a white, Welsh, heterosexual, female and the mother of two children from a previous relationship. Paula and George were in an intimate relationship at the time of his death they had known each other for approximately twenty years.

George’s death was due to an overwhelming infection caused by a stab wound which had pierced his colon some days before. In December 2022 Paula pleaded guilty at Cardiff Crown Court to Manslaughter by way of diminished responsibility due to "severe alcohol dependence syndrome” and was sentenced in January 2023 to 15 years and 9 months imprisonment. An Appeal against the length of sentence was heard in the Court of Appeal in June 2023 and was dismissed.

The process began with an initial meeting of the Community Safety Partnership on 20th June 2022 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with George and/or Paula prior to the point of death were contacted and asked to confirm whether they had involvement with them. Eight of the ten agencies contacted confirmed contact with the victim and/or perpetrator and Paula’s children and were asked to secure their files.

The DHR Panel was convened in January 2023 and approved the final draft following consultation with George’s family in November 2023.

2 Contributories to the Review

The following agencies were asked to provide Independent Management Reviews (IMRs) these were prepared by members of senior staff from each organisation who had no direct involvement with George or Paula or who had held direct supervisory roles of the staff involved with George or Paula. The IMRs prior to being shared with the Panel were authorised by a responsible officer in each organisation. The agencies' Independent Management Reviews were then integrated into an overarching chronology of events.

	Agency	Role	Author
1	Cwm Taf Morgannwg University Health Board.	Senior Nurse Community Mental Health Services	Tracey Larsen
2	Barod	Assistant Manager Cwm Taf and Bridgend	Eryl Gillard
3	Rhondda Cynon Taf County Borough Council	Head of Early Help,	Colette Limbrick
4	South Wales Police	Protecting Vulnerable Persons Manager,	Beth Aynsley
5	Rhondda Cynon Taf County Borough Council	Head of Community Safety and Community Housing,	Cheryl Emery
6	Rhondda Cynon Taf Domestic Abuse Services (formerly Rhondda Cynon Taf Women's Aid)	Development Manager, Domestic Abuse,	Emma Williams
7	Cwm Taf Morgannwg University Health Board.	Head of Safeguarding	Clare O'Keefe
8	Trivallis Housing Association	Service Manager,	Lianne Bulford
9*	Rhondda Cynon Taf County Borough Council*	Service Manager, Adult Safeguarding	Jackie Neale

* Due to limited contact a Helpful Report was accepted by the Panel

The Probation Service last contacts with George were in 2009 and with Paula in 2013 both out of scope for this Review and therefore an IMR was not requested.

3 The Review Panel Members

All Panel members were senior staff from each organisation they were independent in that although they represented their agency, they had no direct involvement with George or Paula or had held supervisory roles of the staff directly involved with George or Paula.

	Agency Representative	Role	Name
1	Jan Pickles (Chair)	Chair	Jan Pickles
2	South Wales Police	Independent Protecting Vulnerable Persons Manager	Beth Aynsley
3	Rhondda Cynon Taf County Borough Council	Head of Early Help,	Colette Limbrick
4	Rhondda Cynon Taf Domestic Abuse Services (formerly Rhondda Cynon Taf Women's Aid)	Development Manager, Domestic Abuse,	Emma Williams
5	Barod	Assistant Manager Cwm Taf and Bridgend	Eryl Gillard
6	Rhondda Cynon Taf County Borough Council	Service Manager, Adult Safeguarding	Jackie Neale
7	Safer Merthyr Tydfil	Regional Advisor, VAWDASV	Deb Evans
8	Cwm Taf Morgannwg University Health Board.	Mental Health, Senior Nurse, CMHT, Rhondda and Taff Ely	Tracey Larsen
9	Rhondda Cynon Taf County Borough Council	Head of Community Safety and Community Housing,	Cheryl Emery
10	National Probation Service	Head of Delivery Unit	Kate Fitzgerald Emma Richards

		Head of Cwm Taf Delivery Unit	
11	Trivallis	Service Manager,	Lianne Bulford
12	Cwm Taf Morgannwg University Health Board.	Head of Safeguarding	Clare O'Keefe Tracey Larson
13	Cwm Taf Morgannwg Safeguarding Board	Business Coordinator	Leah Morgan ,
14	Cwm Taf Morgannwg Safeguarding Board	Safeguarding Administrator	Hannah Lewis

The panel opened the review in January 2023 and met on nine occasions. Most of the Panel meetings were held virtually however the family met face to face with the Panel at a local (to them) domestic abuse service in September 2023. The Senior Investigating Officer of the case shared an outline of events learned in the investigation with the Panel.

The first draft was reviewed in July 2023, and the near final draft was shared with the family in October 2023 for their amendments. The chair then met with them and their advocate to discuss the review. Once the family were confident the review reflected their son and brother the review was completed in November 2023.

4 Author of the Overview Report

Jan Pickles was appointed as author of the DHR and author of this report in December 2022. She is a qualified and registered social worker with over forty years' experience of working with perpetrators and victims of Domestic Abuse, Coercive Control and Sexual Violence, both operationally and in a strategic capacity. In 2004, she received an OBE for services to victims of Domestic Abuse for the development of both the Multi Agency Risk Assessment Conference (MARAC) model and for development of the role of Independent Domestic Violence Advisers (IDVAs). In 2010, she was awarded the First Minister of Wales's Recognition Award for the establishment of services for victims of sexual violence. She has held roles as a Probation Officer, Social Worker, Social Work Manager at the NSPCC, Assistant Police and Crime Commissioner and as a Ministerial Adviser. She has served 17 years as an Independent Board member within the Welsh NHS and was a member of the inaugural National Independent Safeguarding Board for Wales for six years. She has completed the Home Office training for chairs and authors of Domestic Homicide Reviews.

Jan Pickles is not currently employed by any of the statutory agencies involved in the review (as identified in section 9 of the Act) and have had no previous involvement or contact with the family or any of the other parties involved in the events under review. Jan was employed as Deputy Police and Crime Commissioner for South Wales Police until February 2015 prior to that she had been an employee of the Probation Service. In 2022 Jan in an independent capacity chaired a Child Practice Review for Cwm Taf Regional Safeguarding Board.

5 The Terms of Reference

Home Office No: 202207210 0

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

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

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

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

Process of the Review

In compliance with Home Office Guidance, South Wales Police notified the circumstances of the death of George in writing to the Chair of the Cwm Taf (Community Safety Partnership on 20 June 2022.

The Chair of the Cwm Taf Community Safety Partnership advised the Home Office that the circumstances did meet the criteria for a Domestic Homicide Review and as such a review should be conducted under Home Office Guidance.

Timescales

Home Office Guidance requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review. However, in this case, a decision was made to delay the commencement of the Review pending the outcome of criminal proceedings. The proposed completion date is June 2023.

Domestic Homicide Review Panel

In accordance with the statutory guidance, a DHR Panel has been established to oversee the process of the review. The Panel consists of professionals with significant experience in Domestic Abuse issues. The Panel may seek independent advice as deemed necessary. The Panel will be supported by the Cwm Taf Morgannwg Safeguarding Board Business Unit.

The Panel will consider if there is a need to involve agencies and professionals from other Local Authorities and if so, identify which agencies and authorities will be requested to submit an Individual Management Review.

Independence

An independent Chair/Author has been appointed, Jan Pickles. The Chair/Author will prepare a redacted Overview report and an Executive Summary. The completed Overview Report and Action Plan will be presented to the Cwm Taf Community Safety Partnership and the Cwm Taf Morgannwg Safeguarding Board.

Once the Home Office has assessed the Overview Report it will be published on the Cwm Taf Morgannwg Safeguarding Board website.

Scope of the Review

The scope of the review will cover the period from October 2018 until the victim's death in June 2022 with summary reports for anything significant outside of this scope to be shared by agencies. The rationale for this timescale was to include the journey that led both victim and perpetrator to be in a relationship and to include previous relationships whereby both parties had been both victim and perpetrator, to enable agencies to possibly identify any significant opportunities there may have been to intervene. The victim and the perpetrator had extensive histories of being both perpetrators and victims of domestic abuse IMR authors were asked to review all details relating to domestic abuse in their records in a narrative format. This was especially important as there was a previous serious assault on another victim by the perpetrator in 2012. The scope will be reviewed at all future Panel meetings as a standing agenda item.

Individual Management Reviews

Individual Management Reviews will be required from, Rhondda Cynon Taf (RCT) Children Services, Cwm Taf Morgannwg Health Board including Primary Care Services, Local Authority Substance Misuse Services, Substance Misuse Service Barod, Probation Service, Domestic Abuse Services and South Wales Police.

The following factors will be considered by the Panel undertaking this Review:

It has been determined that the victim had contact with universal healthcare and substance misuse services just prior to the homicide. At no point was a disclosure of domestic abuse made during these contacts. The victim did not have any known contact with domestic abuse services. Therefore, the DHR will seek establish from family and friends of the deceased what they believe may have made a difference in this case. Particularly the DHR will seek to establish:

- What were the barriers that prevented either victim of perpetrator seeking help or advice from local services?
- What changes could local service make to enable advice and assistance being sought by victims or perpetrators or their families and friends?
- What more could be done in the local area to increase the use of services by victims of domestic abuse?

The review should address both the ‘generic issues’ set out in the Statutory Guidance, and the following specific issues identified in this particular case: The specific questions to be considered by the Panel in relation to this case are as follows:

a) What decisions could have been made and action taken by agencies to prevent the homicide?
b) How effective were agencies in identifying and responding to both need and risk?
c) Were there similar patterns of behaviour in their previous relationships known to services?
d) How effective were agencies in working together to prevent harm through domestic abuse in Cwm Taff?
e) How did the pattern of their substance misuse relate to the violence between the victim and the perpetrator in their relationship.
f) Were their signs of escalation in the violence and linked behaviour.
g) What were the disclosures of domestic abuse or violent behaviour, or intent known to your agency?
h) What appear to be the most important issues to address in identifying the learning from this specific homicide?
i) Are there ways of working effectively that could be passed on to other organisations or individuals?

j) Are there lessons to be learnt from this case relating to the way in which agencies work to safeguard victims and promote their welfare, or the way risks posed by perpetrators are identified, assessed, and managed? Where could practice be improved?
k) Are there implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?
l) How accessible were the services for the victim and the perpetrator?
m) What might be the barriers for agencies in working more effectively with adults with complex substance misuse and mental health issues?

Lessons Learned

The Review will consider any lessons learned from previous Domestic Homicide Reviews as well as appropriate and relevant research.

Media

All media interest at any time during this review process will be directed to and dealt with by the Chair of the Community Safety Partnership.

Parallel Enquiries

There were no parallel enquires.

Arrangements for Review

These Terms of Reference will be considered a standing item on Panel Meetings agendas and will be constantly reviewed and amended according as necessary.

6 Summary chronology

6.1 George lived in the Cwm Taf area of South Wales; he died at his home from an overwhelming infection caused by a stab wound to his abdomen in mid-June 2022. Paula, his partner of 16 months had stabbed George with a bladed instrument some days earlier at her flat four miles away. After the stabbing George, then injured, had returned to his own home where he died alone sometime later. His body was discovered by police officers contacted by a friend, concerned that he had not seen George for some days. Paula was arrested the next day on suspicion of the murder of George. She was subsequently charged and found guilty of his manslaughter at Cardiff Crown Court in December 2022 by way of diminished responsibility due to "severe alcohol dependence syndrome" and was sentenced in January 2023 to 15 years and 9 months imprisonment. An Appeal against the length of sentence was heard in the Court of Appeal in June 2023 and was dismissed.

6.2 It is known and has been reinforced by George's family in the course of this enquiry that George had suffered multiple traumas including serious and long term disability early on in his life and that his family believe he had never really recovered from these traumas and difficulties. Police records indicate that George had significant relationships with two women prior to that with Paula between the period of 2009 and 2015, and that there were more than eighty notifications regarding George by South Wales Police, mostly involving incidents of domestic abuse against these two women. These incidents included allegations of stalking, harassment, physical violence, and breach of bail conditions that forbade his contacting them. Not all these occurrences indicate proven incidents of domestic abuse, but there were four referrals to MARAC because of police attendance at incidents, which is an indication of the level of concerns around them. Of significance and undoubtably traumatic to George, particularly in the light of his own earlier experiences, was the death by suicide of one of his ex-partners in 2011.

6.3 Paula also had a known history of being both a perpetrator and a victim of domestic abuse, including serving seven weeks in custody in 2013 for assaulting her then partner using a glass, this incident was assessed as 'high risk' and had been referred to MARAC. Soon after Paula's release from prison she had breached a Restraining Order by attempting to contact the victim. In March 2019, before her relationship with George began, Paula had lost the custody of her two children due to her abusive behaviour towards her partner. She had after this returned to her parents' home to live. Paula had for most of her adult life experienced mental health and related substance misuse problems and had at various times sought help from local services. Paula was able with the help of her GP and local substance misuse and mental health services to achieve a six month period of abstinence from drugs and alcohol

from July to December 2020. Paula relapsed into severe alcohol misuse (resulting in a hospital admission) shortly after being told that a previous partner of whom she was extremely fearful was soon to be released from prison. It is seen as significant by the Panel that although Paula was working with the CDAT at the time and they had been informed of this issue; they took no action to ensure her safety and did not attend the MARAC convened in response to this threat to her. Paula later successfully recovered from this relapse, and in February 2021 entered the local Women's Refuge, where she stayed until being rehoused in May within the local area. It was whilst she was at the Refuge that it was first known that she was in a relationship with George.

6.4 Records indicate that George had limited contact with any community based services apart from his GP, but that he was seen by the Community Mental Health Team (CMHT) in March 2017, (outside of the scope of the review but significant). This contact was in relation to the impact on George of his earlier experiences of trauma, the deaths of his father, fiancée, and best friend combined with the effects of George's substance misuse and poor mental health (namely agoraphobia and anxiety) on his current familial relationships and functioning. Records indicate that George was seen by an Occupational Therapist who at that contact advised him to access local substance misuse services. He did not seek a referral to that service He was not felt to have needed secondary mental health services.

6.5 Records from local substance misuse and alcohol services show that George had previously sought help to control his alcohol use between 2014 and 2018 which he described as linked to his low mood and anxiety. The service's records refer to difficulties in terms of his relationships with his partners and their children from previous relationships. In 2018 records indicate that George disclosed to his GP that he had a long-standing depression. Records show that he was not consistently compliant with the medication regime provided by the GP and that he would use alcohol to self-medicate so that he could cope with his feelings of anxiety and depression. George did not follow up referrals that had been made on his behalf by his GP to local services.

6.6 The first date at which agencies knew that George and Paula were in a relationship was in March 2021, when Paula was reported missing from the Refuge she had entered in February 2021, and George was named to South Wales Police as a possible partner of hers. Paula had been referred and entered the Refuge soon after being informed of the imminent release of an ex-partner of whom she was extremely fearful due to his previous violent and abusive behaviour to her.

6.7 George and Paula had known each other as friends for more than fifteen years before becoming involved in a sexual relationship sometime in February 2021. During the period under review South Wales Police responded to twenty-four incidents within the course of George and Paula's relationship, eleven of which relate to domestic incidents involving George and Paula together. Of these, eight described violent behaviour under the influence of alcohol. George was identified as a victim on two occasions, and Paula as a victim in the remaining six incidents. The first incident of domestic abuse reported to the Police involving both Paula and George was at the end of August 2021. George alleged that Paula had punched him. Police attended and George stated he did not wish to take any further action. A DASH was completed, and he was assessed as 'standard' risk, despite their history as individuals who had been in several abusive relationships either as a victim or perpetrator and had been at times before assessed either at or of 'High Risk.' This risk assessment was not amended at review. The last police call out being a month before George's death in May 2022 when George alleged Paula had threatened him with a knife. This was the first incident in which the possession of a knife had been alleged by either party.

6.8 In Oct 2021 Paula made a 999-call alleging that George has physically assaulted her after a night of drinking alcohol. Police officers responded and a DASH was completed, and Paula was assessed as at Medium Risk (using DASH). George was arrested and bailed. The attending police officers established that Paula was pregnant, and this information was shared with CTMUHB and Children's Services. The case was reviewed two days later by the Charging Officer and the decision to take 'No Further Action' was made. George's family stated that he was desperate to be a father, and they believed that this was the reason he stayed with Paula, despite the arguments and violence. However, Police records indicate that the pregnancy was terminated in late October 2021. Further incidents occurred in January and February 2022 in which Paula contacted emergency services in relation to George's violent and abusive behaviour to her. In mid-February 2022 Police Officers attended at George's home after a call from Paula and found her semi-conscious and experiencing seizures having consumed a bottle of vodka with bruising and scratches on her face and body- a number of them believed to be old. George stated as explanation that Paula had recently been assaulted by a neighbour. She was taken to Hospital and placed in an induced coma in Intensive Care in a 'Stable but Critical Condition and was being sedated whist on a ventilator.' When well enough Paula refused to make a complaint or seek support in relation to the assault. Due to the seriousness of the assault, information was shared with Children's services and CTMUHB.

6.9 In March 2022 there were two calls made to the Police by Paula and George. The first, a 999 call from George at Paula's new property (Paula had in May

2021 been rehoused from the Refuge to this address) alleging that she had hit him causing his mouth to bleed. Officers attended, a DASH was completed, and George was assessed as 'High Risk,' a MARAC referral made, and information shared with CTMUHB, Children Services and 'Operation Encompass'[1] to inform the schools at which Paula's children attended. The case was discussed at MARAC, in which the relationship was described as 'turbulent' with the presence of significant alcohol misuse as a risk factor. George was reported to have stated that he was willing to support further action against Paula and that he "had had enough of her and her abuse towards me." Contact was made with George by the IDVA offering him support which he declined, stating he was 'ok'. Paula was arrested and bailed until early May 2022 with conditions not to contact George. The case was later withdrawn after George declined to support it. The second call to the Police later that month came from Paula alleging George's theft of her computer stick from her. Later the police were notified of Paula being found unconscious on a stranger's living room floor. The occupant of the house had discovered her in the morning and had then contacted the Police. It emerged that the man had forgotten to lock the front door to his house when he went to bed, and coincidentally Paula had in a drunken stupor presumably found the door would open, walked in, and fell asleep on the floor. This incident whilst not indicating any intended direct threat to anyone does suggest that Paula's behaviour was often out of control.

6.10 In early April 2022, Paula was found with bleeding wounds on the street near her home. Paula told the Police Officer attending that she had been assaulted by George at her flat. This placed her in breach of her bail conditions by her allowing George into her flat. George was arrested and denied harming her, the advice from the CPS to seize the blood stained clothing was followed by the attending police officers but they were not sent for analysis. A week later the investigation was closed as Paula was not willing to support the prosecution. Paula refused a DASH or a referral to any agency, but as she had children, Children's Services and the CTMUHB were informed. A DVPO/DVPN was considered but rejected after considering the nature of the assaults, and that both George and Paula lived in separate properties, some miles apart and warning flags were in place.

[1] Operation Encompass is a police and education early information safeguarding partnership enabling schools to offer immediate support to children experiencing domestic abuse. Operation Encompass ensures that there is a simple telephone call or notification to a school's trained Designated Safeguarding Lead /Officer (known as key Adult) prior to the start of the next school day after an incident of police attended domestic abuse where there are children related to either of the adult parties involved. https://www.operationencompass.org/

6.11 Later in April 2022 Police responded to a 999 call by Paula alleging that George had ‘ripped the pipes out of her flat’ and thrown her out of bed and injured her. The attending officers noted she was heavily intoxicated and had numerous injuries, and that some of them were old. Paula became irate with officers and insisted they leave and refused to support a prosecution or make a statement. Officers were unable to complete a DASH with Paula and the incident was graded as ‘High Risk’ and referrals were made to MARAC, and the assessor later noted the escalation in incidents between Paula and George. Following this incident Paula was contacted in early May 2022 by the ‘Oasis Centre’ but declined support. The case was heard at MARAC twelve days later in May 2022 with one action being recorded for ‘target hardening’ measures to be put in place at Paula’s flat. It was not specified what this involved, though the referral was not actioned by RCT DAS. In any event given that the couple remained in a relationship such measures would have been of limited use had they been carried out.

6.12 In May 2022, a month before his death, George rang 999 stating that Paula was at his property in breach of her Bail Conditions. On attending, police officers found the couple to be heavily intoxicated. Paula alleged that George had assaulted her which had been witnessed by her mother on ‘facetime.’ Her mother when interviewed described George and Paula’s relationship as ‘toxic’ ‘and stated someone could get seriously hurt,’ and that she had on the call witnessed “George grab Paula around the throat with his hand.” Both parties were arrested, Paula for breach of her bail conditions and an application was made to remand her in custody due to the likelihood of her non-compliance with any bail conditions set to protect George. This application was not granted. . George when interviewed, denied Paula’s version of the event stating that when he had told Paula he was ringing the police she took a knife from the kitchen and threatened him with it, and had ‘gone mad.*’* All agencies were informed including Adult Services. Paula moved into her mother’s address and a Critical Warning Marker was placed on the address. This was the first incident in which it was alleged a knife had been used as a threat. At the next MARAC in late May 2022, the Housing Association responsible for Paula’s tenancy stated she was now living at her home and Adult Services stated that there ‘were no care and support needs’. Five attempts had been made to contact Paula before the MARAC by the IDVA with no success. The IDVA then informed ‘Trivallis’ of this and asked if they would pass on to Paula the IDVA’s number.

6.13 The last contact the police had in connection with either George or Paula was a telephone call to them mid-June 2022 by a friend concerned for George’s welfare as he had not seen him for some time. Police officers attended, forced entry on receiving no reply and found George’s body. The presence of a stab wound triggered a murder investigation, which later

identified that the stabbing had happened at Paulas' flat, and that George had then returned to his own flat, where he had subsequently died. Evidence indicated that some rudimentary 'First Aid' had been attempted whilst he was at Paula's flat. It was noted that George, although most likely being able to, had not made a 999 call in relation to his injury. The investigation team believe that he most probably did not consider the wound to have been the cause of his feeling unwell, mistakenly thinking instead that his symptoms were due to a 'stomach upset' for which he attempted to self-medicate.

6.14 In reflecting on this relationship George's sister stated that as George had previously been involved in a violent relationship "they knew what to look out for" and they agreed to screenshot everything they had received. They believe he made attempts to move from his property to be nearer their home, the Review Panel however could not find any records of an application to move or swap properties on agency records. His mother and sister also believed that Paula prevented George from working. As George was working 'unofficially' and was not an employee of a company or organisation, the review has been unable to confirm this.

7 Key issues arising from the review.

7.1 George's death was in large part due to his relationship with Paula at a point in her life in which her life circumstances, surrounded as she had been by violence and abuse, both as a perpetrator and a victim left her immersed in a world of destructive and violent relationships, emotional and physical instability, and insecurity. These factors were further amplified by Paula's chronic substance use and linked poor mental health. Many of these features were also endured by George who had himself experienced significant trauma in his early life. Both had been victim and perpetrator of domestic abuse and had experienced failed and poor relationships with other partners, marred by violence and abuse. It seems that violence, physical and emotional abuse, and substance use had become a normal and expected part of life for George and Paula.

7.2 One of the key issues arising in this review is the failure of both parties to be successfully engaged with local community mental health and substance misuse services despite their evident high and long term need. Both suffered from pre-existing substance misuse and mental health issues, both seeming interlinked, yet local services were unable to engage in any effective way with either of them. Connected to this is the apparent centrality of the respective GP's role in linking them with local community resources, and how, particularly in the case of George this was not sufficient to secure his engagement in them. There was a long term pattern in both cases of drug, alcohol and mental health problems being borne by both George and Paula and their families until a crisis erupted of some type at which point, they saw their GP who then referred them to local services to which they did not respond, usually not attending, or if attending then not keeping follow up appointments. It is significant that on the one occasion that George did attend an appointment with the CMHT complaining of anxiety and depression in 2017, he was redirected to substance misuse services, which he did not attend. It seems that there was on most occasions an unbridgeable step between referral by the GP to community services and take up of that service offer.

7.3 Effective information sharing within and between agencies does not appear to have been routinely achieved in this case, particularly in relation to Paula. Paula was admitted to the area Accident and Emergency Unit in January 2021 with acute blood poisoning due to relapse into alcohol use, the community Drug and Alcohol Team with whom she was working were not informed of this, nor in February 2022 when she was admitted to the local Hospital and was found to be 'covered in bruises' was any action taken or information shared despite its suspicious presentation, and earlier information By SWP of her being a victim of 'stalking'. This may have been because on questioning Paula

denied the injuries as being linked to abuse. The Alcohol Liaison Nurse involved accepted this at face value and took no further action.

7.4 The Refuge at which Paula stayed did not appear to share information with other services concerning her relationship with George. The Panel are not aware of the reason for this and would flag it as a potential area to review. That said the Refuge appeared to provide a much needed safe space that enabled Paula to establish her own secure accommodation following move on. It would seem however that this opportunity was marred by the poor coordination of services after she left the Refuge that had successfully supported Paula prior to her moving there. The Panel would note that COVID pandemic contact restrictions were in place when Paula left the Refuge, but through a combination of administrative error and worker absence Paula was not seen at the critical moment of her leaving the refuge, until she herself made contact sometime later.

7.5 Paula's' GP notes indicate that through 2019 and 2020 she had been experiencing feelings of depression and anxiety caused by a range of issues in her life, especially her losing the custody of her children and the conflict with the children's father over that. Paula's alcohol use appears to have swung from periods of attempts to abstain to periods of heavy use. Paula's GP's notes record in July 2020 that she was 'trying' to reduce her alcohol use, and a referral was made to the Local Primary Mental Health Support Service (LPMHSS) by the GP. That referral resulted in a successful and "sustained period of engagement with the Community Drug and Alcohol Team" (CDAT) between this date and December 2020, and that "Paula as a result (was) prescribed medication to help with alcohol cravings, she was focused on the custody (of the children) case, and she is making clear plans to move forward with her life and seek out meaningful employment." (CTMUHB IMR) Paula was to remain alcohol free for six months and cooperated with the services she was referred to in this time. This contact seemed to end when she moved into the Refuge. It is not clear why- whether planned or due to the change in the local authority area involved in the move to the Refuge.

7.6 A key learning point from this review is how important it is that practical and emotional support is provided that is easily accessed and proactive when a person leaves residential care. For several reasons described above Paula received very little move on support despite being accommodated in a new and unfamiliar area and with support workers she had not met before and had no contact with for some time. It is not known if this support, had it been provided would have materially affected the history of George and Paula's relationship. The gap in contact at this stage appears to the Panel to have

been a critical factor in Paula's relapse into heavy alcohol use and is an important lesson to draw from this case.

7.7 Finally, the MARAC although convened on four occasions in response to the incidents described above were unable to develop and deliver effective safety plans for either George or Paula. The reasons for this are not clear to the Panel. It would observe however that none of the services which were involved on a non-statutory basis – community mental health and substance misuse teams, the Refuge and local housing officers had representatives present at any of the MARAC's convened. This is a matter that should be reviewed. Linked to this, the Panel would also not that the bulk of actions from the MARAC were related to 'target hardening' and 'information sharing'. There were few actions that were specified or measurable. The Panel would note that both George and Paula were hard to engage as victims and perpetrators and that over the span of their relationship they were demanding in terms of time and resources and generally uncooperative and unresponsive to interventions offered. Such 'reluctant' service users will be an expected part of the users of such services. The Panel feels there was little evidence of a shared and considered strategy to manage them.

8 Conclusions

8.1 The Panel do not know whether any interventions would have succeeded in preventing George's death at the hands of Paula. It was an impulsive act without, as was established in court the intent to kill. There was no evidence of planning and no motive beyond presumably the expression of either anger or fear. The lifestyles and history of both George and Paula made them both a threat to and vulnerable from others, interlaced as both lives were by substance misuse, poor mental health and a culture in which violence and the threat of it seem to have been an almost normal part of life. And yet George and Paula both came from families' that were reported to be stable and loving, and for large parts both had a good education followed by apprenticeships and were qualified and able to hold down jobs. Both George and Paula had had periods of recovery from significant substance abuse, Paula's in recent times, George himself had exhibited his strength of character from his childhood onwards in living with and overcoming a lifelong physical disability and linked poor physical health.

8.2 The Panel believe that the evidence indicates that the Community Mental Health Service and CDAT found it difficult to establish and maintain contact and importantly any working relationship with George and to a lesser degree with Paula as adults. This despite referrals being made and evident need as seen by primary care services. Neither George nor Paula usually responded to referrals made or appointments offered and were clearly reluctant to use these services. George remained in this state throughout his adult life, seeing his GP with mental health and alcohol related concerns but he did not feel able to follow up and attend appointments offered by community mental health and substance misuse services. Paula also was reluctant to seek help and had a similar pattern to George but did demonstrate that she was at times open to help and for a period when she was the Refuge particularly worked well with both CDAT and domestic abuse services. This reluctance was most likely due to the difficult issues in her life that she was experiencing, her resolve to stop drinking in July 2020 coincided with and was probably linked to Paula's determination to regain unsupervised contact of her two children which she had just lost, and her significant relapse in late December 2020 (when she was hospitalised) was likely due to the return to the local area of the abusive ex-partner and of whom she was extremely fearful, and her new relationship with George who like Paula also drank heavily and was prone to violence. Despite these clear links between Paula's alcohol use and mental health and the difficult events in her life she was trying to manage, there is no evidence of joint working between statutory and voluntary community health or welfare services to anticipate and prepare for events that could have been anticipated, such as Paula's leaving the Refuge and establishing a new home away from her family, losing the custody of and unsupervised contact with her children,

and managing the stress of a relationship that was mutually destructive. This situation appears to have been compounded by what appears to be the complete lack of engagement by community and hospital-based health services, mental health services and substance misuse services with the MARAC and the MASH in relation to this case, crucially depriving it of valuable intelligence and insight.

8.3 The Panel have found that the MARAC and the MASH, both designed to join up services, information sharing processes and develop a common strategy to reduce risk of harm to identified victims did not appear to be able to do this in this case. An example of this was when Paula presented in hospital with alcohol poisoning in December 2021, clearly vulnerable and with bruising all over her body and yet no referral was made to the MASH or the MARAC, nor was there any enquiry or referral made into domestic abuse services either within or outside of the hospital to discuss what should have been at the least the evidence of suspicious injuries by those working with Paula in hospital. It seems that Paula's and her mother's denials of abuse were taken at face value. There also appeared to be a lack of information sharing throughout services, none within any health provider knew of Paula's relationship with George, although staff at the Refuge did in the spring of 2021, nor of Paula's fear of her ex-partner and his return to the area at this time also. Yet the MARAC agencies were aware of both these threats. Had services involved in Paulas' discharge from the Refuge known of these risks would their discharge plans have been any different? One must draw the conclusion that the lack of representation at the MARAC from agencies involved in the care of both George and Paula had an impact on both the timing and management of Paula's move to her own property in the spring of 2021.

8.4 In relation to the above, the Panel conclude that in this case the MARAC was not able to move beyond an information sharing body to one which was able to actively manage the risks presented by both Paula and George, as both perpetrators and victims, despite the MARAC being aware of the likelihood and seriousness of the risks they posed both to each other and the public. From the evidence of the three MARACs convened concerning both George and Paula the only strategy employed was to share information and to 'target harden.' There is no evidence of more active strategies being considered to address the cycle of violence, abuse and threat, poor mental health, and substance misuse where agencies could have worked together to engage and distract one or both of them. There were very real threats facing both George and Paula, for instance the presence of her abusive ex-partner in the community presumably released on licence and subject to supervision by the Probation Service, the endemic issue of substance misuse, poor mental and physical health affecting both parties which required a joined up approach

which the MARAC could have but did not deliver due in large part to the lack of involvement of those key agencies involved in the care of Paula.

8.5 The ability of agencies within the various health bodies both community and inpatient to effectively assess and manage risk was poor. This is evidenced by the inaction of the ALN in responding to Paula's presentation at A&E and later in the ward with bruising on her body. There was no specialist assessment nor referral either to community or internal resources, nor evidence of even advice offered. There is no evidence of a DASH or equivalent tool being completed, nor of an inquisitive approach as to the possible evidence of domestic abuse in Paula's life when she presented, despite observation of her bruising. This mirrors what seems to have been a lack of curiosity by BAROD workers in seeking reasons for Paula's relapses from abstinence or controlled drinking and dropping out of treatment which happened several times. Since this tragedy, a Health IDVA is now co-located in A & E and works across the Out Of Hours service following an embedded process in which a referral is made to the Health IDVA to pick-up cases the following working day.

8.6 In RCT male victims of domestic abuse that were assessed as standard and medium risk were offered a service from the Oasis Centre who received the PPN's from the Police. The male victims were then contacted and offered support as demonstrated following the offer to George following the March 2022 domestic abuse incident and Police referral. The Oasis Centre will now offer the option of a referral to a specialist male worker at RCT DAS. The skills required to engage male victims of domestic abuse are different and this addition to service offered recognises the reluctance of men to seek help and address this barrier.

8.7 Finally, the Panel recognise that George would probably have been reluctant and appearing difficult to engage in contact with services. That he resisted contact with state services is clear from the history available to the Panel. George's life seems to have been affected by the impact of lifelong disability and trauma experienced from childhood onwards. The Panel can only speculate as to the impact of those events on him and his ability to navigate his way safely and securely through his life. George would have been eligible for Information, Advice and Assistance and a well-being assessment under the Social Services and Well-Being (Wales) Act 2014, but he did not seek this and was not referred by any agency. He was assessed by an Occupational Therapist from the Community Mental Health Team in 2017 prior to his relationship with Paula. There are specialist mental health social workers in this integrated multi-disciplinary team, but he was assessed as not requiring secondary care level mental health services and was signposted to Substance Misuse services, where there are also specialist social workers, which he did not follow up on. George did not access any services other than his GP and

then on rare occasions. Equally, Paula would likewise have been entitled to an assessment under the same Act, from a specialist substance misuse social worker, but she was not referred for this by any of the agencies she was involved with and did not seek this out herself.

8.8 Penetrating Abdominal Injuries

The Panel discussed the public understanding of the implications of penetrating abdominal injuries as George an able an intelligent individual did not seek medical care for the wound. After being wounded he searched the internet for health advice but sadly did not know the true severity of the injury and the ongoing implications for his life.

The BMJ describes ‘Stomach, small bowel, and colorectal injuries occur more frequently following penetrating abdominal trauma than following blunt trauma. The small bowel is the organ most injured by penetrating abdominal trauma.’

The Panel considered the need for some public facing information for those more at risk of this type of injury.

8.9 Support for parents separated from their children.

Paula’s motivation to seek help was her desire to have greater contact with her children, however this was not enough for her to remain engaged with services. RCT Children’s services recognises the significance of an attuned response to information sharing and responses to the needs of parents who are separated from their children. At present there are insufficient specialist services for these adults.

9 Lessons to be learned.

9.1 That poor communication and information exchange limits the effectiveness of all services in working with service users and their families experiencing abuse. The effectiveness of the health services, both in-patient and community based to protect victims, and their families was marred by poor information sharing both within their own organisations and with external agencies.

9.2 Secondly this case has made clear that the community services available to George and Paula in the area, the GP, Community Drug and Alcohol and Mental Health Teams were not able to engage or develop a means of reaching out to either of them effectively, despite both having longstanding problems with mental health and substance misuse. There was a repeated pattern of GP referral to community services that were never opted into – particularly in relation to George. This gap between visit to GP and contact with secondary services must be reconsidered, for both public and personal health reasons.

9.3 The lack of Adult Service's involvement with two people with such evident high need and risk to self and others is also one that must be considered, again in the interests of the public good as well as the personal good of those involved. Linked to this information sharing based on the PPN's was not effective in this case and did not bring services in that should in the Panel's view have been involved- Adult Services particularly. Additionally, The Panel would suggest that that the lack of engagement of reluctant service users with community services offered must be reframed as a problem for all, and a common approach to address the issue be sought.

9.4 This case has shown that the MARAC was not able to move from an information gathering and sharing forum into one that was able to discuss and agree realistic and practical plans to manage the risks of harm posed to themselves and others in this case. There was no evidence of services being directed to act and then be held to account within the MARAC process. The Panel feel the role of chair is key in this looking to the future. Linked to this the Panel believe the effectiveness of the MARAC was hampered by the absence of the key players in this case, mental health and health services in particular and that the emotional, personal and financial cost of these services not cooperating in information exchange and risk management planning should in the Panel's view be considered unbearably high.

9.5 From the latest SafeLives MARAC data (2022-23)[2] South Wales is identified as having the second highest percentage of male victims heard at MARAC

[2] https://safelives.org.uk/node/2315

across England and Wales, at 11.3% of the total MARAC referrals in the area. This suggests that agencies recognise that men are also victims of domestic abuse and refer to MARAC. This may well be a reflection of the relatively long-term availability of services for male victims in the area with the Dyn service being developed by Welsh Government as an All Wales service from 2007 and the recent CTM campaign to target male victims. The Panel considered how male victims of domestic abuse such as George know how and where to seek help, we understand it is inextricably linked with men's wider help seeking behaviour. The British Medical Journal in June 2019 published research by Bristol University[3] which reviewed twelve studies which were published between 2006 and 2017 on this issue. They grouped nine themes described over two phases (a) barriers to help-seeking, which were primarily; fear of disclosure, challenge to masculinity, commitment to relationship, diminished confidence/despondency, and invisibility/perception of services; and (b) experiences of interventions and support: initial contact, confidentiality, appropriate professional approaches, and inappropriate professional approaches. Many of the issues identified in the research applied to George. This thematic analysis confirms previously identified barriers to men seeking help and provides new insight into barriers and aids to successful professional advocacy and service provision with recommendations for practice. The study summarised thus, "It would seem that services need to be inclusive, to cater to diverse client groups, to involve ongoing support and to be widely advertised. In addition, specialised training is required to address the specific needs of men and to foster greater levels of trust."

[3] https://bmjopen.bmj.com/content/9/6/e021960

Help-seeking by male victims of domestic violence and abuse (DVA): a systematic review and qualitative evidence synthesis

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10 Recommendations from the Review

1. The current training offer of 'Ask and Act' in Cwm Taf Morgannwg (CTM) University Health Board for the identification and management of risk related to domestic abuse be reviewed to ensure staff are confident and competent to respond. This to be achieved by:

    I. Frontline staff are asked to evidence their use of the 'Ask and Act' training in supervision.
    II. The CTM University Health Board gain assurance that the 'Ask and Act' training is effective.
    III. The CTM University Health Board gain assurance that the 'IRIS' model is being applied.

2. Building on the Welsh Government Good Practice guidance for Violence Against Women, Domestic Abuse, Sexual Violence and Substance Misuse. 2018[4], the services that deliver mental health and substance use services in the community work with conjunction with safeguarding and domestic abuse services to co-produce a dual diagnosis care pathway with service users who are or have experienced domestic abuse. This care pathway to enable these services to deliver a (solution focused) brief intervention to encourage and motivate service users opt into treatment and support.

3. The VAWDASV Board
    I. Monitor the attendance and contribution of all partner agencies to the MARAC.
    II. Dip sample MARAC minutes to establish the level of involvement of all representatives in offering actions, and conversely to determine whether the level of 'directed' actions are reducing, in line with good practice guidelines and the recent training.
    III. Review with all agencies the purpose and status of PPNs, their role in information sharing, risk assessment and management.
    IV. From this process create clear guidelines for all agencies to outline what is expected of them within the legal framework.
    V. Establish a task and finish group to provide guidance on the management of cross allegations in domestic abuse cases now referred to as bi-directional violence, using this case as an example of how complex domestic abuse cases should be managed. Safelives in

[4] https://www.gov.wales/sites/default/files/publications/2019-02/good-practice-framework-for-violence-against-women-domestic-abuse-sexual-violence-and-substance-misuse.pdf

September 2023 has produced useful guidelines on this issue which will act as a useful starting point for local discussions and guidance. [5]

VI. Provide information for frontline staff to aid service users to process information received through a Clare Law Disclosure. This may mean the Police notify relevant agencies engaged with the individual that a Clare Law Disclosure has been made.

4. RCT Children's Services early help provision, identify a champion for parents who are separated from their children, who will lead on the development of an information source for staff about those services that might meet need in this area. This role will have close links with Choices[6] and Magu to maintain the information source.

5. Improving awareness of services for male victims
   I. A previous CMT wide campaign that targeted male victims of domestic abuse be refreshed with information on Coercive and Controlling Behaviour highlighted and repeated focusing on the range and accessibility of services available to male victims in light of the Bristol University research referred to in 8.5[7].
   II. The development of the recent Home Office Prosperity Funded service for male victims in RCT is based on this research.

6. The Vulnerability Knowledge and Practice Programme (VKPP) are to undertake a review of the volume of cases going to MARAC. As this case resulted in repeated MARAC referrals, we recommend the learning from this case inform their review of the MARAC processes across the South Wales Force area scheduled for the 2023/2024 work programme. (This review had been earlier agreed as SWP have the second highest rate of referrals into MARAC in the UK.)

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[5] https://soundcloud.com/domestic-abuse-podcast/counter-allegations-podcast

[6] 1. (Choice is a CTMUHB reproductive support programme for vulnerable women, especially those who have been separated from their children. The Magu Project delivers an integrated care pathway for pregnant women and their families across early intervention and edge of care services, that focuses on building skills and resilience and reducing risk. A single agreed early intervention approach will deliver the opportunity to prevent children entering care at birth as well as provide consistency and continuity for families whose care requires step to statutory intervention.)

[7] https://www.gov.wales/sites/default/files/publications/2019-02/good-practice-framework-for-violence-against-women-domestic-abuse-sexual-violence-and-substance-misuse.pdf

7. This case is referred to Public Health Wales and the VKPP for them to assess the benefits of an awareness raising campaign to be targeted at known high risk groups of the risks of and action needed in cases of suffering penetrating abdominal injuries, primarily knife and gunshot wounds of whom most victims are males and victims of violent crime[8]. We know that George in this case did not link his symptoms that is feeling unwell etc to be linked to his injury as there was little blood loss, the wound appeared small and the injury to be minor.

[8] https://bestpractice.bmj.com/topics/en-gb/1187

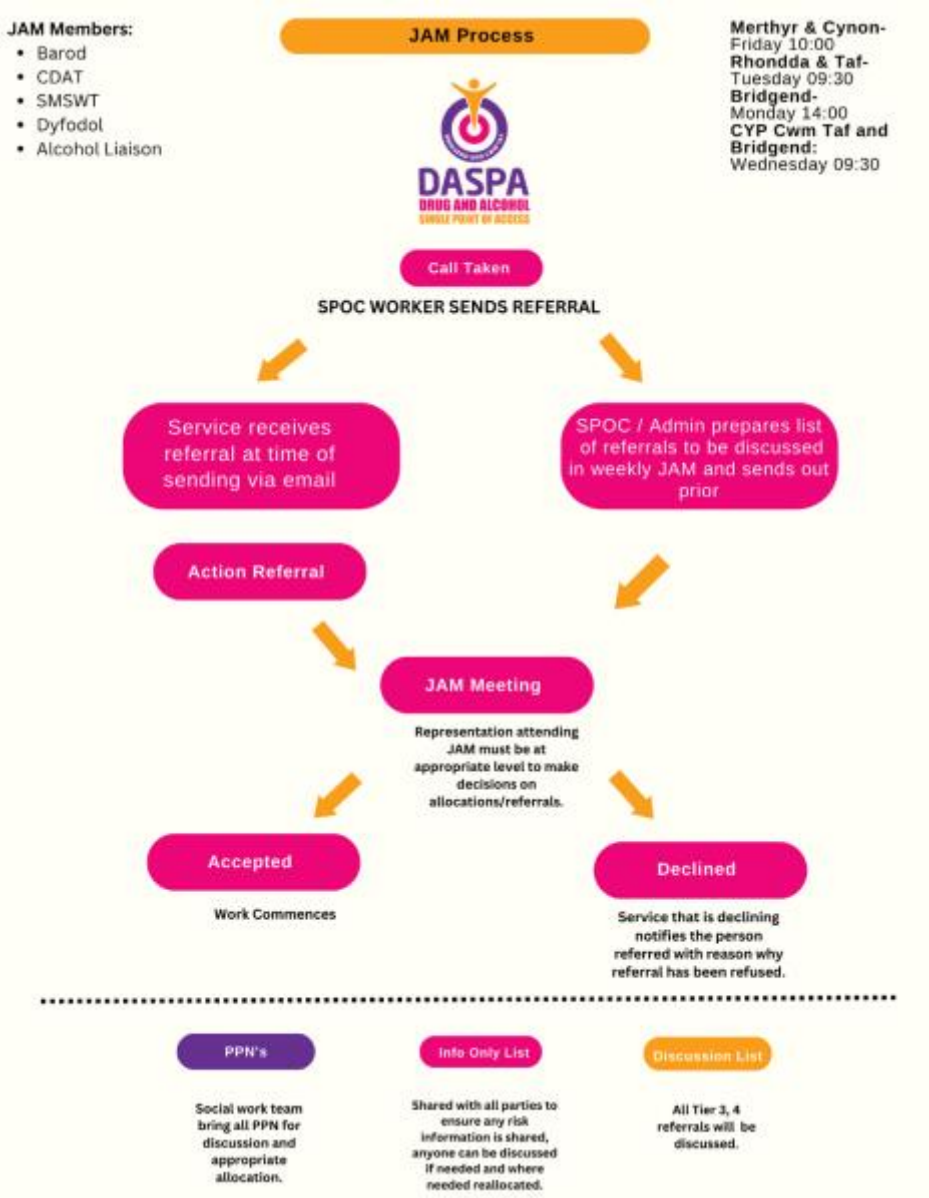
Appendix 1 The CWM TAF (Integrated Substance Misuse Service) multi-agency discussion forum to be known as Joint Allocation Meeting (JAM).

Aims and Objectives

The overall aim of the Cwm Taf Integrated Substance Misuse Service (ISMS) Discussion Forum is to function as a formal mechanism for multi-agency/ multi-disciplinary discussion of clients receiving treatment for substance use within the Cwm Taf APB. This forum will be known as the Joint Allocation Meeting or JAM.

The objectives of the meeting are:

- Provide an opportunity for discussion and subsequent appropriate allocation of new referrals.
- Provide an opportunity for discussion of existing clients where there are concerns about risk or questions around management so that the existing treatment agency can receive advice regarding future treatment planning.
- Provide an opportunity to review the placement of clients within services when needs alter and effect efficient transfer.
- Provide an opportunity for transition planning for young people transferring to adult services.
- Share general information in relation to risk e.g., new trends in use, clinical governance concerns, safeguarding concerns.
- Share information on service development.


JAM Members:
• Barod
• CDAT
• SMSWT
• Dyfodol
• Alcohol Liaison
JAM Process
DASPA
DRUG AND ALCOHOL
Merthyr & Cynon-
Friday 10:00
Rhondda & Taf-
Tuesday 09:30
Bridgend-
Monday 14:00
CYP Cwm Taf and
Bridgend:
Wednesday 09:30
Call Taken
SPOC WORKER SENDS REFERRAL
Service receives referral at time of sending via email
SPOC / Admin prepares list of referrals to be discussed in weekly JAM and sends out prior
Action Referral
JAM Meeting
Representation attending JAM must be at appropriate level to make decisions on allocations/referrals.
Accepted
Work Commences
Declined
Service that is declining notifies the person referred with reason why referral has been refused.
PPN's
Social work team bring all PPN for discussion and appropriate allocation.
Info Only List
Shared with all parties to ensure any risk information is shared, anyone can be discussed if needed and where needed reallocated.
Discussion List
All Tier 3, 4 referrals will be discussed.