COMMISSIONED BY THE CWM TAF COMMUNITY SAFETY PARTNERSHIP

Overview Report:

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 4.

Service	Acronym or name
Drug & Alcohol Single Point of Access.	DASPA
Cwm Taf Morgannwg	CTM
Cwm Taf Morgannwg University Health Board.	CTMUHB
Rhondda Cynon Taf.	RCT
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

Foreword by the Chair of the Review

George's mother shared with the Panel the following words,

"*My beautiful baby boy who has been tragically taken from us. We are heartbroken and absolutely devastated. Our lives have been ripped apart and destroyed and will never ever be the same again. George had a heart of gold and would help anyone before thinking of himself and always have time for anyone. He was a polite and well-mannered young man. He was a loving, doting brother to his sister, they were each other's world."*

The Panel wish to express their condolences to George's mother and sister and recognise how deeply they will miss him.

Jan Pickles OBE Chair and Author on behalf of the Panel

1 The circumstances that led to this review

This report of a domestic homicide review examines agency responses and support given to George a resident of the Cwm Taf area prior to the point of his death at his home in June 2022. 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 with whom he had been having a relationship 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 review will consider agencies' contact and involvement with George and Paula and look back at relevant events to understand the position George found himself in.

1.1Timescales

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. The DHR Panel was convened in January 2023 prior to the sentencing of Paula in late January 2023, The Chair attended the sentencing and was able to understand the significant evidence available to the Court in the Judges pre-sentence remarks.

1.2 Methodology (see also Appendix 1)

The purpose of this Domestic Homicide Review overview report is to

- Ensure that the review is conducted according to good practice, with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse including their dependent children.
- 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 policies and procedures as appropriate; prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

The Independent Management Reviews (IMRs) were prepared by members of senior staff from each organisation who had no direct involvement with George or Paula or who had held supervisory roles of the staff directly 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.

1.3 Terms of Reference (see Appendix 2)

The scope of the review covers the period from October 2018 until George'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 the 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. As 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 Paula had been convicted of a serious assault on a previous male partner in 2012. The Terms of Reference and scope was reviewed at all Panel meetings as a standing agenda item.

1.4 Confidentiality

The findings of this review are confidential; the Confidentiality Statement was reviewed at each Panel meeting. Information is available only to participating professionals and their line managers. To protect the identity of the victim the family were asked to choose pseudonyms.

1.5 Equality and Diversity

The Equality Act 2010 identifies these nine Protected Characteristics:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

George was thirty-nine years old at the time of his death he identified as white, Welsh, heterosexual, male and unmarried and to the families knowledge did not have children or a faith. Although was born with a disability following numerous operations, he did not regard himself as disabled. According to his family George's childhood experiences of prolonged periods in hospital had left him anxious about seeking help. George also struggled with low mood, anxiety and agoraphobia and linked substance misuse issues and these multiple issues compounded to create added barriers to him accessing support services. (see section 1.9 Research).

It was considered that George's sex was relevant to the review as the Panel learnt from his family that despite support provisions within the areas available to him as a male George would have been reluctant to seek advice or help.

Paula was aged 34 years old she identified as a white, Welsh, heterosexual, and female. Paula had previously been married and was the mother of two children but was at the time divorced Prior to the trial she offered a plea of guilty to the Manslaughter of George by way of diminished responsibility due to "severe alcohol dependence syndrome," which was accepted by the prosecution This was a diagnosis she received when assessed whilst remanded in custody following the offence. Although not understood by services at the time leading up to the offence, this dependence will have been an added barrier for professionals to identify and Paula to access the right services.

1.6 Involvement of George's family

Immediately following their appointment, the Chair contacted Victim's Support Homicide Team (VSHT) who were aware of George's family and had provided information and leaflets on the DHR process. The Chair met with George's mother and sister in January 2023 at Cardiff Central Police Station accompanied by the Family Liaison Officer (FLO) to outline the DHR process and to request their support for the Review. George's mother and sister consented to further contact with the VSHT, and the chair approached them on the family's behalf.

Following that initial contact George's mother and sister agreed to meet with the chair in April 2023 at their family home. They were generous enough to share their memories of George growing up and describe him as a loving son and brother who had faced considerable traumatic events in his late twenties following the death of his then girlfriend, father, and best friend. The family agreed to a referral to Advocacy After Fatal Domestic Abuse (AAFDA) and this was made immediately. The Terms of Reference were discussed with George's family and shared in full for them to add to. They agreed to choose the pseudonym for him to be used in this Review. All of the Panel meetings had been arranged virtually, however as the family were not online, they met with the Panel at a face-to-face meeting at a local Women's centre in September 2023. At this meeting George's mother and sister described him as a loving and hardworking man they shared that they believe George was subject to Coercive and Controlling Behaviour (CCB) by Paula. Prior to the submission the Review was shared with the family for their amendments and the Chair met with them at their home in October 2023.

The family had to face a daunting wait for the release of George's body and his funeral was delayed until mid-May 2023 some eleven months after his death.

The DHR panel agreed a communications strategy that sought to keep the family informed throughout the review and worked with both the Family Liaison Officer, AAFDA and Victims Support Homicide Team to do so. The Chair/ author has tried to be sensitive to their wishes, their need for privacy and support.

1.7 Involvement of employers

At the time of George's death, he was not in formal employment, on leaving school George had undertaken an apprenticeship as a motor mechanic and worked in garages for many years. His mother and sister describe him as a hard worker always in employment working in factories and shops until he met Paula, his last job was setting up stages for different events. Paula completed an apprenticeship in painting and decorating and then a further qualification to teach this subject at a local Further Education College. Following her earlier prison sentence in 2013 her contract with the College was terminated and since then she had worked in a local café and as a delivery driver. As neither George nor Paula had been in formal employment in the period in scope the Panel agreed it would not attempt to contact their previous employers.

1.8 Involvement of the Perpetrator

In April 2023 following a discussion with George's family they understood that the Chair would seek the views of the perpetrator as to what if any preventative measures and services could have been put in place. The Probation Service agreed to arrange a hand delivery of a letter in the prison to Paula seeking an interview to ensure she could give informed consent to an interview. This

letter was sent in May 2023 and initially it was considered she was not able to make the decision to meet. However, following her request the Chair interviewed her in HMP in June 2023 at that time the Probation Service assessed Paula as having the capacity to consent to an interview.

1.9 Research

In this case both parties presented to agencies as victims and perpetrators at various times. The identification of bidirectional violence and the management of cross allegations is complex for agencies especially in the heat of the moment during of a Police Officer immediate response when both parties are distressed or impacted by substances, as in this case, However, there were opportunities for this to discussed by agencies at the three MARACs held during the scope of this DHR. Gendered models of abuse are often embedded in services as demonstrated by research by Hine et al published in April 2022[1].They note:

"*Gendered models of abuse describe intimate partner violence (IPV) as unilaterally perpetrated by dominant, aggressive men toward vulnerable women. This unidirectional conceptualization has contributed to a "domestic violence stereotype" which, alongside broader attitudes regarding gender, influences attitudes toward "non-typical" victim and perpetrator groups (e.g., male victims, female perpetrators, those within same-sex relationships), and has significant outcomes for help-seeking decision-making, as well as responses from service providers and the criminal justice system. While prevalence data and research suggest bidirectional violence is in fact the most common pattern, there is still little known about how the stereotypes and attitudes described above manifest in scenarios where both parties occupy "victim" and "perpetrator" labels."*

Attempts have been made to understand the concept gender symmetry in domestic abuse published in 2016 Holmes et al [2] explored previous experiences of abuse.

"This study investigates the prevalence and predictors of IPV perpetration in a sample of 227 women in battered women's shelters. Participants were asked to complete a number of measures assessing demographics, Diagnostic and Statistical Manual of Mental Disorders…….traumatic life events, and perpetration and victimization of IPV. Although the vast majority of women in this sample (93%) report perpetrating some form of IPV, few women endorsed violence that was not mutual (5.3%). Furthermore, for every type of IPV assessed, women were victimized significantly more than they perpetrated. Results also indicate that women's perpetration of IPV, and predictors of such perpetration, varied across type, severity, and measurement of violence. However, most IPV outcome variables were predicted by women's experience of victimization. Taken as a whole, these results support the assertion that context matters when examining the relative rates of perpetration as well as its predictors."

In the Cwm Taf Morgannwg (CTM) area significant work had been undertaken to provide services for male victims of domestic abuse. From the latest SafeLives MARAC data (2022-23) South

[1] Hine B, Noku L, Bates EA, Jayes K. But, Who Is the Victim Here? Exploring Judgments Toward Hypothetical Bidirectional Domestic Violence Scenarios. J Interpers Violence. 2022 Apr;37(7-8):NP5495-NP5516. doi: 10.1177/0886260520917508. Epub 2020 May 12. PMID: 32394785; PMCID: PMC8980443.

[2] Holmes SC, Johnson NL, Rojas-Ashe EE, Ceroni TL, Fedele KM, Johnson DM. Prevalence and Predictors of Bidirectional Violence in Survivors of Intimate Partner Violence Residing at Shelters. J Interpers Violence. 2019 Aug;34(16):3492-3515. doi: 10.1177/0886260516670183. Epub 2016 Sep 27. PMID: 27655866; PMCID: PMC5501762.

Wales is identified as having the second highest percentage of male victims heard at MARAC 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 reflect the 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. CTM however is not complacent recognising that there will be male victims who do not see themselves as victims and this DHR will recommend that this campaign is informed by the University of Bristol research (explored in 8.5) is further resourced.

2 The Review Process

2.1 Panel membership

	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 Head of Cwm Taf Delivery Unit	Kate Fitzgerald Emma Richards
11	Trivallis Housing Association	Service Manager,	Lianne Bulford
12	Cwm Taf Morgannwg University Health Board.	Head of Safeguarding	Claire O'Keefe – Attended one meeting.

			Tracey Larson
13	Cwm Taf Morgannwg Safeguarding Board	Business Coordinator	Leah Morgan ,
14	Cwm Taf Morgannwg Safeguarding Board	Safeguarding Administrator	Hannah Lewis

2.2 Agencies that provided an Individual Management Review

	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	Claire O'Keefe – Attended one meeting
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.

2.3 Review Panel Meetings

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 with the Panel face to face 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.

2.4 Author of the Review

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.

2.5 Parallel Reviews

The Police IMR stated that the Coroner had agreed not to resume matters, therefore there was no inquest in this case following the criminal proceedings. The Panel was not informed of any other single agency Reviews or other parallel processes.

2.6 Dissemination

The Panel agreed following approval by the Home Office Quality Assurance Panel that the Review would be placed on the Cwm Taf Morgannwg Safeguarding Board website and a 7-minute briefing would be prepared for dissemination to all agencies. The Review would be submitted to the Wales Repository to aid academic research. A copy of the finalised Review would be shared with the family and HM Prison Service and the perpetrator. Copies will be shared with Welsh Government to be integrated into the repository of reviews and reported on to the Ministerial Board under the

Single Unified Safeguarding arrangements, the Office of the Police and Crime Commissioner and the UK Domestic Abuse Commissioner.

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3 Background Information

3.1 George lived in the Cwm Taf area; he died at his home in mid-June 2022 from an overwhelming infection caused by a stab wound. Paula, his partner of 16 months, had stabbed George with a bladed instrument some days earlier at her flat four miles away. The weapon was never found. The medical examination showed that the stabbing had pierced his colon, leading to the infection from which he died a few days later. George's mother and sister stated that having spent a lot of his childhood in and out of hospital for his foot, he did not like hospitals, and this may account for him not having contacted the Emergency Services. During the Police investigation it became apparent that after the assault, Paula had left the house to buy pain relief medication for George's 'upset' stomach. There was evidence that the wound was dressed at her flat with gauze that was already in the house. It was noted by the Senior Investigating Officer that at the scene of the stabbing there was evidence of a bleed but not a large amount of blood.

3.2 After the stabbing George, then injured, had returned to his own home where he died alone sometime later. The date of his death is not known. There is no evidence that he felt able to seek treatment at this time, and from his online history seen by the Police he believed he had a severe stomach upset and had not connected those symptoms to the stab wound. A friend of George's concerned for his welfare as he had seen him unresponsive through the kitchen window of his flat, had alerted South Wales Police (SWP) of his concerns, and Officers then attended the property and found his body in the house six days after the stabbing. Paula was arrested the next day on suspicion of the murder of George. At that point, Paula claimed she did not know about George's injury, or how it could have happened, and that alcohol had affected her memory. She was, following investigations subsequently charged with his Murder and later offered a plea of guilty to the Manslaughter of George which was accepted by the prosecution. George was aged thirty-nine years old at the time of his death.

3.3 Both George and Paula were well known to services as both victims and perpetrators of domestic abuse. Both had been involved in domestic abuse incidents with previous partners in which the Police were called. They had known each other as friends for more than fifteen years before becoming involved in a sexual relationship in February 2021. During that relationship the Police were called on twenty-four occasions, 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.

4 Chronology integrated as requested same content.

4.1 George's mother and sister have provided much of the detail of George's early life within this report. They describe him as an energetic child who had experienced a difficult childhood due to illness and disability, being born with a 'club foot' but who had despite that, due to his fortitude remained positive and had been able to participate in sports, dancing, and worked hard at school. They describe him as a child as an accomplished ballroom dancer and football player, gaining awards and recognition.

4.2 George's mother stated that she and her husband had created a close and caring family and that both he and George's sister felt valued and loved. However, George, aged twenty-seven (circa 2010) experienced three traumatic events the effects of which his family believe stayed with him for the rest of his life. Firstly, his fiancé killed herself by hanging and George discovered her body. Only weeks after this George's father sadly aged only 53 years old died from lung disease, followed soon after by the sudden death of his closest friend, whom he had known since his childhood. George's mother and sister believe that he never recovered from these three bereavements. George soon after these events moved from the Rhondda valley to the Taf-Ely area. This was against their wishes as although it was only eight miles in distance as they did not drive it meant they saw much less of him.

4.3 George's mother and sister described George as a 'bright and able man' who after undergoing an apprenticeship in motor mechanics always worked as a mechanic until around 2021 when he met Paula. His mother and sister had concerns about Paula as they too had known her for many years; they described her as 'controlling' George. Paula had been the girlfriend of one of George's friends some years earlier. They described a sense of their having 'lost' George when he started his relationship with Paula.

4.4 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 as a result of Police attendances at incidents which is an indication of the level of concerns around them. Of significance and undoubtably traumatic to George, was the death by suicide of one of his ex-partners in 2011. This was likely to have been an extremely disturbing and re-triggering event for George, although we do not know the nature of his relationship with this person at the time of her death. This was for George the second known significant person in his life to have died by suicide.

4.5 Records provided by Adult Services state that George had been discussed at MARAC four times in 2009 and 2015 in relation to domestic abuse. These MARACs are out of scope of this

review. Primary Mental Health Services describe George as being 'little known' to their services. There were occasions as described above when he had sought help in response to low mood, anxiety and agoraphobia and linked substance misuse issues. George had no significant contact with services however, and so one can only surmise that the symptoms persisted and George self-managed them or that they eased. However, George's reluctance to seek medical help was noted by his family and was an ongoing concern for them.

4.6 Records indicate that George had limited contact with mental health services, 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 familial relationships and functioning. Records indicate that George was seen by an Occupational Therapist at that contact and was advised to access local substance misuse services. He was not felt to have needed secondary mental health services. The notes state "Assessment feedback - NFA for CMHT as it was recommended that his needs can be met by addiction services which he is in agreement with. Information given to patient for referral to DASPA."

4.7 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 then partners and their children from previous relationships. In 2018 records indicate that George disclosed to his GP that he had a long-standing depression. The GP records note that he was reluctant to take the medication and suggest that he would use alcohol to self-medicate so that he could cope with his feelings of anxiety and depression.

4.8 The Panel acknowledge there is extensive background information relating to Paula in this Review, however, to understand George's death at her hands, one has to understand how it was that Paula had arrived at a state mentally and physically to act in such a manner. George and Paula's sexual relationship began 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 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. Violence, physical and emotional abuse, and substance use had become a normal and everyday part of life for George and Paula.

4.9 Prior to being in a relationship with George, Paula had been in contact with local agencies from 2014 onwards with varying degrees of intensity through this time. Although out of scope of this DHR Paula is described as being in contact with agencies including the then commissioned Treatment and Education Drug Service (TEDS) between 2014 and 2018 in relation to her problematic drinking. These contacts were reported to have been brief and were not ongoing but that she had sought help in relation to her use of substances and her poor mental health and had

described a “wish to control drinking and seek help in relation to anxiety and low mood.” There is reference to previous convictions for assault on a partner and difficulties with contact with her children due to her use of alcohol. Related to this, the children’s father had successfully applied for and gained residence of the children following a formal assessment by Children’s Services and the Court making a Residence Order in favour of the children’s father in March 2019 following his application for custody of them. Paula was to have supervised access only to her children. The SWP IMR records that the father’s application for formal custody rights had been prompted by Paula ‘kicking off’ in front of the children during contact. Contact arrangements it seems continued to be a source of conflict between Paula and her children’s father.

4.10 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 their father over that. Paula’s alcohol use appears to have swung from periods of attempts to abstain to periods of heavy use. GP 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.” (Health IMR) Paula was to remain alcohol free for six months and cooperated with the services she was referred to in this time.

4.11 However in mid-December 2020, CDAT reported information from ‘Patient Safety’ that Paula had reported that she was being stalked by her ex-partner ‘since she had ended the relationship a month ago, and that he had been following her and displaying controlling behaviour and was sat in car at the end of her road’. There is no reference to any action taken in response to this disclosure other than CDAT documenting that Paula confirmed the incident at an appointment with them on Christmas eve 2020. The Health IMR states in relation to this that “There was no documentation by CDAT of the outcome of the MARAC or record of the CDAT keyworker being invited into MARAC.” Indicating a critical misunderstanding of how the MARAC model operates whereby agencies are not invited in but are expected to be part of the multiagency management of high-risk domestic abuse cases and not await an invite to participate in that.

4.12 In mid-January 2021, CDAT records that concerns were raised by ‘family’ about Paula having relapsed into drinking alcohol and was admitted into hospital as an emergency. The IMR from Health states that “There was no communication around A& E admission and discharge relayed to CDAT by A&E nor evidence of referral from A&E for review by the Mental Health Liaison Team prior to discharge as would be usual practice. CDAT keyworker attempted telephone contact but with no answer. CDAT keyworker found Paula had been admitted to A&E following PV bleed and vomiting of dark fluid. Notes detailed relapse for 5 days after 6 months of abstinence. Discharged from A and E after investigations with advice.”

4.13 A further telephone appointment took place with the CDAT Health Care Support Worker (HCSW) in early February 2021, by which point Paula appeared to have recovered from her relapse. She was reported to have restarted her anti-craving medication and was working with peer mentoring and the Oasis Centre.

4.14 Paula confirmed when interviewed that linked to this relapse was a notification to her from SWP in December 2020 of the imminent release of an abusive ex-partner of whom she was reported to be 'terrified of' due to his stalking and harassment of her. This was seen at the time as legitimate threat by SWP. This notification elicited no response from CDAT, despite 'Patient Safety' reinforcing the information a week later, and the risk it posed to Paula and to her recovery from her use of alcohol. CDAT did not made any arrangements to see her in a safe place. It does not appear either that a representative from CDAT attended the MARAC which discussed this matter In January 2021, despite their active involvement with her and knowledge of the risks she faced, and her current situation and state. The help she was receiving in relation to her substance misuse did not seem able to keep pace with these worrying developments, BAROD in December 2020 referring her to the 'Peer Mentoring Service', presumably although not stated a step down in the level of support being offered to her by that service, just at the time that her fear of abuse and risk was increasing.

4.15 Coincidentally and critically at this time there was a period of absence from work by Paula's keyworker at CDAT. A phone appointment was held in mid-January 2021 with the team HCSW in which Paula "admitted she had not taken her anti-craving medication for the last five days as had forgotten to pick them up and was planning to restart this week". According to the Health IMR Paula was "drinking small amounts daily at this point." This IMR also notes there was no record of any exploration as to the background and circumstances of the relapse. This was a significant omission as it may have provided an insight into the background of abuse and threat Paula was living with. This is recognised within the IMR and noted that this contact was with a duty worker and not Paula's key worker which may have been conducted with a more inquisitive approach, and also was not a face-to-face conversation, again limiting the opportunity for further exploration.

4.16 In terms of the role of health agencies at this time in responding to the risk posed by the presence of domestic abuse, the IMR from Health itself acknowledges that there was "no reference (from) CDAT of the known numerous and serious occurrences of domestic abuse involving Paula." Although notified by the Police in December 2020 of the risk to Paula of being a victim of stalking, this information was not shared within the other services within health working with Paula, nor were bespoke measures considered to allow her to safely access services."

4.17 In mid-January 2021, SWP were called to attend the home of Paula's father as Paula was reported to be behaving in a threatening manner. Her father reported that Paula had drunk a bottle of vodka, and had started another, and had 'urinated on the floor.' Paula was then admitted to A&E with symptoms of severe vomiting and possible internal bleeding because of a relapse into substance use following a period of abstinence. The Panel understand that the Public Protection

Notice (PPN) was shared with Adult Services and directed to Adult Social Care's Substance Misuse Social Work Team. The Panel have been assured that because of the PPN, Paula would have been considered both in terms of her care and support needs and her engagement with substance misuse teams by Adult Services, and at the weekly Joint Allocation Panel (a multi-agency allocation Panel involving CDAT, Barod & the Social Work Team). Paula was discharged from hospital some days after admission following examination and treatment. It is noted that there was no liaison between A&E and CDAT who were still involved with Paula. Paula was at this time still an active case with CDAT, though contact had at this time been disrupted due to the absence of her key worker. Contact was soon resumed by telephone and Paula disclosed her relapse into alcohol use and non-compliance with her anti-craving medication. The IMR from CDAT acknowledges that the level of service provided at this time to Paula was not as good at it should have been, particularly the lack of face-to-face contact with Paula following her relapse as the UK was back in a Covid national lockdown in January 2021.

4.18 Despite these setbacks, and possible resumption of alcohol use (there is no further mention of her collecting anti-craving medication) Paula moved to a Women's Aid Refuge in Pontypridd in early February 2021. Records indicate that she was engaged with support in relation to her anxiety, alcohol use and poor concentration whilst at the Refuge. Paula has described the support she received by both staff and the other women in the Refuge to the author as 'very helpful.' From this point of stability Paula secured a tenancy near Pontypridd in May 2021. Paula had been reported to be working well with CDAT whilst at the Refuge. However, records indicate that Paula felt unable to continue her contact with support services once she had left the Refuge and had been rehoused. Paulas' rehousing to another area meant a change in support worker and a different team within the CDAT service.

4.19 George's mother and sister believe the relationship with Paula began in the spring of 2021. The first known date of George and Paula being in a relationship by agencies was in March 2021, when Paula was reported missing from the Refuge, she had entered in February2021, and George was named to the Police as a possible partner. Paula had been referred and entered the Refuge following abuse by a previous partner who had been convicted of stalking her and had been released from prison a month earlier in February 2021. In April 2021, when Paula made an online (with the information provided over the phone due to Covid) 'Claires law 'application regarding George's previous history of domestic abuse, she said 'to protect' herself in future. She stated they had been together for eight weeks and that the relationship was in her view 'healthy.' She informed the Police that they had known each other for ten years and had several mutual friends, including Paula's ex-partner. Police records note that following the Clare's Law disclosure Paula appeared shocked by the 'volume of calls and violence recorded' relating to George's previous history. She told the Police Officer at that time that she planned to end the relationship because of the information they had shared.

4.20 As stated above Paula began her relationship with George sometime whilst at the Refuge. Refuge Staff knew of Paula being in a relationship and was given his name by another resident

when Paula was reported as missing from the refuge in March 2021. The Police IMR shows that Refuge staff had contacted the SWP with concerns that they had not seen Paula for several days. The IMR from SWP note that Paula's absence coincided with the release of her ex-partner of whom she was afraid and added "It was also noted that Paula appeared to have a new boyfriend, George, Paula returned to the Refuge the next day in the early hours." There is no record of any action or interview being held with her by staff at the Refuge concerning her absence from the Refuge, a new partner, or her wellbeing.

4.21 Paula's application for rehousing was submitted within ten days of her arriving at Refuge and was accepted. Refuge staff supported Paula to obtain the property, at the time there were no available supported housing spaces available. It appears she moved suddenly when offered the new tenancy, there is no evidence of any plans or preparation having been made to enable Paula's transition from the Refuge to her new property On the day of the move in late May 2021 she was assisted by the refuge team to settle into the property and taken on by the floating support scheme which provides tenancy support to integrate a person into their property e.g. help with utilities, bills, security and safety etc. This support was offered between then and the end of September 2021 and during this period she was offered twenty-five appointments, keeping fourteen with her support worker. After Paula missed eleven appointments, her case was closed. Other support services such as BAROD were not informed that Paula was living independently as Paula did not consent to information being shared.

4.22 At this point Paula had a known history of perpetrating 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. Despite this history there did not appear to have been any consideration of sharing information relating to Paula's' history of being a High-Risk perpetrator with George via a Clare's Law application.

4.23 CDAT records state that at the end of May 2021 when she was last seen and was reported to be "stable" and drinking "small amounts" of alcohol. Paula stated she had left the Refuge and moved to her new address. Paula had whilst at the Refuge seen a CDAT worker in Pontypridd, to help with the transition to a new area and worker. Records state that Paula's mental health was discussed, and referral agreed to LPMHSS. There is no record of this referral being made, although Paula remained under the care of CDAT at this time, as noted by the IMR from Health. In addition, there is no evidence of any discussion between LPMHSS, nor the Refuge to support the referral. Paula's GP made a referral to LPMHSS on Paula's behalf in early July 2021, stating that the Refuge had suggested referral to LPMHSS and citing 'anxiety' as a problem. Paula did not attend the appointment offered and was discharged. The IMR states that several appointments were sent by CDAT to Paula and followed up by phone call between May and July 2021, with no response, and Paula was discharged in July 2021 from their service, and Paula's anti-craving medication stopped. CDAT acknowledge that two appointment letters had been sent to Paula after

she left the Refuge, but to the wrong address. Two follow-up letters sent to the correct address, but Paula felt unable to engage with the service.

4.24. South Wales Police responded to twenty-four incidents within the period of this review, eleven of which relate to domestic incidents involving George and Paula together. Of these, eight described violent behaviour under the influence of alcohol, and in these eight incidents, George was identified as a victim on two occasions, and Paula as a victim in the remaining six incidents.

4.25 The first incident of domestic abuse reported to the Police involving both Paula and George was at the end of August 2021. By this time Paula no longer had the supervision of her two children. Their father had been granted a Residence Order which granted Paula supervised contact only with her children. Paula had, prior to her relationship with George been in several other abusive relationships and had been both a victim and perpetrator in these. Whilst in the Refuge she is reported to have been receiving help from a local mental health service, with which she cooperated, and had additionally secured on leaving the Refuge a new tenancy in the Pontypridd area. This incident involving George and Paula occurred outside of George's flat in which 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 assessed either at or of 'High Risk.' This risk assessment was not amended at review. The Panel believe that given their previous history of abuse the review should have elevated the risk to medium. In addition, there was no consideration given to a Clare's Law disclosure for George in relation to Paula's record as a domestic abuse perpetrator in 2013. A Domestic Violence Protection Notice (DVPN) was not considered for George, as a DVPN requires there to be reasonable grounds for believing that the suspect has been violent or has threatened violence towards an associated person, which there was no evidence of. Paula also had not been violent to a partner for eight years.

4.26 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. George was arrested and bailed. The attending Police Officers established that Paula was pregnant, and this information was shared with health and children's services, and Paula was encouraged to seek help from the 'Live Fear Free' Helpline. A Police Sergeant reviewed the case two days later 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 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 similar 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. The Officers attending noted that she had a bruised eye and bruising and scratches on her body. George provided an explanation for this, stating that Paula had recently

been assaulted by a neighbour. Due to a projected ambulance wait of more than three hours the attending officers took Paula to hospital where she was placed in an induced coma in Intensive Care and was said to be 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 Health.

4.27 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 Health, Children Services and 'Operation Encompass'[3] to inform the schools which Paula's children attended. The case was later discussed at MARAC in early March 2022, 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' but agreed to a safety pack being sent to him. Paula was arrested and bailed until early May 2022 with conditions not to contact George or go into his home area. George had been assessed as being at 'High Risk' of Domestic Violence from Paula and a 'Medium Risk' towards Paula. At the first court hearing in mid-May 2022, the Court IDVA attempted to contact George without any response from him. Four days later in late May 2022 the case was withdrawn by the Crown Prosecution Service (CPS) after George had withdrawn his support for prosecution. The second call to the Police that month came from Paula alleging that George had taken a computer stick from her property. The Police responded and attempted to resolve the matter. The following day, Paula was 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 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 out of control.

4.28 Paula's final contact from Mental Health Services prior to George's death was through the Alcohol Liaison Nurse (ALN) in mid-February 2022 when Paula was admitted to hospital following alcohol related seizures. She was described as 'drinking daily with her partner (and that) she wants help.' The IMR states a "Thorough assessment (was) undertaken which included detail of past conviction and DV." An assessment was carried out following that contact which described

[3] 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/

Paula as 'covered in bruises' though on direct questioning she detailed past domestic abuse, she denied experiencing any abuse at that time". Paula accounted for her injuries as being due to her drinking. Paula's mother supported this. Records state the ALN gave "appropriate advice to ward staff around management of alcohol withdrawals and made referrals to BAROD and CDAT." It is acknowledged within the IMR that the ALN did not contact the MASH regarding this information, nor seek advice concerning a referral to MARAC, which does not appear to have been considered, they did suggest to the ward staff they may wish to refer to MASH if they had further concerns. Attempts to contact Paula by CDAT and Mental Health services in early March 2022 received no response from Paula and her case was closed by CDAT.

4.29 In early April 2022, a member of the public called the Police stating that he had found Paula bleeding on the street near what turned out to be her home. Paula told the Police Officer attending that she had been assaulted by George at her flat. Paula was in breach of her Bail Conditions by allowing George into her flat a month after those conditions had been imposed. George was arrested and denied harming her, the advice from the CPS to seize his 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 Health were informed. She was encouraged to seek support via the 'Live Fear Free' helpline. 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. That neither had children residing with them was also seen as a factor in this decision.

4.30 Later in April 2022 Paula again rang '999' and alleged that George had 'ripped the pipes out of her flat' and thrown her out of bed and injuring 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. The Police Officers left the property to look for George and returned later to take a statement which Paula refused to co-operate with. Officers were unable to complete a DASH 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' and declined support, she did not feel able to accept a safety pack offered to her stating she knew where to get help. The case was heard at MARAC twelve days later in May 2022 with only one action being recorded for 'target hardening' measures to be put in place at Paula's flat, with not all agencies were present at the MARAC as described before It was not specified what this involved, though the referral was not actioned by RCT DAS. Given the couple remained in a relationship such measures would have been of limited use had they been carried out.

4.31 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 made an allegation of assault against George which had been witnessed by her mother on 'facetime.' Her mother when interviewed described George and

Paulas' 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 that Paula had then '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'. Four attempts had been made to contact Paula before the MARAC by the IDVA with no success, a new number for Paula was shared at MARAC and a further unsuccessful attempt was made to contact her following that MARAC. The IDVA then informed Trivallis of this and asked if they had contact to pass on to Paula the IDVA's number.

4.32 The Police were again called to George's property in mid-June 2022 by a friend of his who was worried about him. The officers entered the property and found George's body. The presence of a stab wound triggered a murder investigation, which 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 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, thinking instead his symptoms were due to a 'stomach upset' for which he attempted to self-medicate.

4.33 George's family believe that he was subjected to Coercive and Controlling Behaviour by Paula in that she prevented him from seeing his family and the friends, his mother and sister describe trying to persuade George to leave her fearing that she would harm if not kill him. George's mother described receiving photos of him with black eyes and split lips. She and his sister decided "to be nice" to Paula so that they could still see him. His sister advised 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 nearer their home, the review could not find any records of an application to move or swap properties on agency records. His mother and sister believe Paula prevented George from working. According to them George had been working 'unofficially' though was not an employee of a company or organisation, the review has been unable to confirm this.

5 Overview

George

This enquiry has within its scope of agencies involved, South Wales Police, the Community Drug and Alcohol Team (CDAT) BAROD, Rhondda Cynon Taf County Borough Council, Cwm Taf Morgannwg University Health Board and Trivallis Housing.

South Wales Police

SWP had extensive knowledge of both perpetrator and victim. This knowledge was gained from their contact with both parties as at various times as both alleged victims and perpetrators. In relation to George, there are eighty-six occurrences recorded as both as victim and perpetrator from 2003 until his manslaughter in 2022. Most of the above-mentioned incidents relate to domestic abuse.

Trivallis (Housing)

Landlords of the property for George. Housing Officers attempted to contact George, who both refused to engage with any support from Trivallis or to agree for a referral to be made to a third sector organisation. George had not made any representations to be moved from his property as his family believed.

Local Primary Mental Health Support Service- including substance use & mental health services. (LPMHSS)

There are four recorded referrals to the LPMHSS and all referrals detail anxiety and low mood. For three of these referrals, George did not respond to an opt in letter sent out by the LPMHSS and one occasion George did not attend an appointment offered to him in early July 2017 and so was discharged from the service as is the usual practice in cases of non-attendance without an explanation.

GP Services

There were six encounters between George and primary care, his low mood was managed within primary care and attempted follow ups to review his care. George was referred on three occasions when primary care became aware of George's low mood and social isolation. There was a referral to primary mental health service, and he was advised to self-refer to BAROD for support with his drinking. There appeared to be transient engagement, with George seeking help but not attending follow up appointments. There was appropriate follow up following consultation.

Children services

George did not have children himself or contact with Paula's children. All Children's Services notifications came via PPNs from the Police and there were eight in total.

Paula

GP

There were nineteen contacts between 2018 and 2022 with Primary Care Services, most were kept. Paula's principal health concerns were her fluctuating mental health, which was managed by both mental health services and CDAT and the GP. Alcohol was identified in several consultation within primary care and for both A&E admissions.

RCTCBC – Housing Solutions Team

Processed an application from Paula for housing assistance, after fleeing domestic abuse from her partner and placed in Refuge with RCT Domestic Abuse services. Offered and accepted the tenancy which discharged the authority's legal duty to her.

Childrens Services.

There were eleven contacts with Childrens Services either from or in respect of Paula. Most were in connection with her two children and their welfare.

BAROD (Alcohol recovery service)

Involved with Paula from September 2020 to May 2021 in online recovery groups. Did not respond thereafter.

Trivallis (Housing)

Landlords of the property for Paula. Housing Officers attempted to contact Paula who both refused to engage with any support from Trivallis or to agree for a referral to be made to a third sector organisation.

Adult Services

There was limited information held by Adult Services, one PPN relating to Paula in January 2021.

RCT Domestic Abuse Services

Refuge staff supported Paula to obtain her new tenancy, at the time there were no available supported housing spaces available. On the day of the move in late May 2021 the refuge team assisted her to settle into the property and taken on by the floating support scheme which provides tenancy support to integrate a person into their property, for example to assist with utilities, bills, safety etc. The support was provided between May and the end of September 2021. During her support with the scheme, she had twenty-five appointments with her support worker, attending fourteen and engagement was ended after eleven missed.

6 Analysis

6.1 The stabbing of George by Paula was not, as recognised by the Court that sentenced her intended to be fatal. George and Paula had been, the Panel believe in a relationship from February 2021 until George's death in June 2022. The first known incident of domestic abuse was recorded in March 2021 and continued thereafter, with variously George and Paula alleging and alleged to be victim and perpetrator. There were twenty-four attendances by SWP in response to calls, many of them emergency calls over this sixteen-month period in which allegations of violence and abuse concerning their partner were variously made by both Paula and George. SWP who had significant contact with George and Paula described the relationship as 'volatile.' In addition, both George and Paula had in previous relationships exhibited similar behaviours that had resulted in Police involvement, and in Paula's case criminal convictions related to domestic abuse and she had lost the custody of her children to her ex-partner through her own behaviour often affected by her substance use. This pattern continued into George and Paula's relationship with each other. Both George and Paula were, as outlined in the chronology heavy and long-term users of alcohol and other drugs and were suffering from chronic symptoms of associated poor mental health such as depression and anxiety particularly, and both at times had tried to access local services to help. These symptoms are known to be high level risk factors in terms of domestic abuse. 'Safe Lives' research identifies eight risk factors of being a victim of domestic abuse of which six applied to both George and Paula[4]. Both had known each other from early adulthood and had shared friends as they grew up, often being at the same community events, clubs, and concerts etc in the area.

6.2 Paula had successfully sought help with her alcohol use in July 2020 and with the help and continued support of specialist agencies remained alcohol free until December 2020, at which point it is reported she maintained 'controlled drinking' which in the Panel's view steadily returned to her previous pattern of heavy alcohol use. Despite this, with the help of her GP and the CDAT and other agencies she entered a local women's Refuge in February 2021. This was a turning point in her life and was the opportunity for her to make significant changes, which she made the most of, obtaining help with her long-term problems such as alcohol, depression and anxiety and was successfully being rehoused to a new property which could have heralded a fresh start for her. Within this it is known that whilst at the Refuge and possibly even before, she had met George and had it seems likely began a relationship with him probably by February 2021. The Panel know that in late April 2021 South Wales Police received an application for a Clare's Law Disclosure request from Paula regarding George, so it can be assumed they had begun a relationship by then if not before. Paula informed the Police officer involved that she was shocked by the disclosure and that she would end her relationship with George as a result. This was not to be the case.

6.3 Both George and Paula had both sustained significant loss and hardship in their lives by the time they began their relationship, George from the multiple and tragic bereavements of loved ones, his childhood disability and poor health, and Paula from the loss of her children, and being a repeat victim of controlling and abusive behaviours by past partners, and the Panel assume, although there is no evidence to confirm this, from the termination of Paula's pregnancy in October

[4] Safelives.org.uk/policy/evidence.uk

2021. Paula stated that although the termination was her idea, and that George was upset about it, he accepted that they were not in a position to bring up a child at that time. These losses coupled with their endemic substance use and poor mental health, would potentially have been a barrier to sustaining any change that either George or Paula were able to achieve. Significantly in trying to understand the lack of engagement by services, there is no record of any agency apart from the SWP and the Refuge having any knowledge of this vital information concerning the past history of both individuals and its significance to their lives currently. This was a clear gap in information gathering or sharing or both by services involved with both George and Paula, and in the Panel's view the impact of these past events contributed to increasing the likelihood of substance use, violence and abuse continuing into George and Paula's relationship. Records indicate the staff at the Refuge were aware of the relationship between Paula and George and that they knew his name. The Panel have seen no evidence of this information having been shared by the staff at the Refuge with another agency other than the Police. So, in summary not all agencies had the whole picture concerning the history of George and Paula at this time, and that there was no point, and no mechanism used at which all parts of the separate pieces of information held by the various agencies working with them could be brough together. The MARAC could have been this mechanism, but due to the non-attendance of CDAT representatives on the MARAC this route was blocked.

6.4 The speed of Paula's move from the Refuge into independent living in May 2021 in the Panel's view contributed to increasing the risk of her relapse and linked risky behaviours, at the time there were no supported housing options available which may have been able to provide the support she increasingly appeared to need. Once Paula had left the community and moved into refuge it appears community services stepped away from her. It does not appear to the Panel that Paula's move from the Refuge to independent living was seen in terms of potentially adding to her existing risk factors either as perpetrator or a victim. This seems curious to the Panel as such a significant change in circumstances although potentially a good thing was always going to carry with it potential risks to her and possibly others. In addition, as Paula did not consent to referrals being made to other agencies, there was no multi-agency plan to prepare for Paula's return to the community and the challenges and risks it would bring. It seems also that the services that had been involved prior to her move into the Refuge, such as the LPMHSS, the drug and alcohol team, BAROD, were not able to sustain the level of involvement with Paula once she had left the Refuge that had existed prior to her admission. At interview she described feeling 'abandoned by services' once she left the Refuge, believing that she always kept appointments, which was not the case. Crucially it is evident there was no knowledge of Paula 's relationship with George at this time by those agencies, Refuge knew his name but not his domestic abuse history and Paula assured them it was not an abusive relationship.

6.5 The Panel believe this could have been an instance of 'professional over optimism.' As described in the chronology there was no effective follow-on services negotiated with Paula to reduce her risk in her unfamiliar environment. The Panel are aware that some Covid pandemic restrictions were in place at this time, and that her key worker was absent for part of this time, but that this cannot be the full explanation. It seems by this point the momentum was lost, as Paula was deeper into her relationship with George and there were already the signs of both parties

repeating the pattern of previous relationships- substance use, arguments and violence, Police attendances and court appearances.

6.6 This gap in support from services was compounded by another serious risk to Paula and her hopes of sustaining a recovery, a previous abusive partner who had been released from prison to the area in February 2021 following a sentence imposed due to his assault and harassment of her. The harassment had taken the form of bombarding her with mobile calls and pursuing her at her workplace and home with his associates. Paula stated to the Chair in interview following her sentence in June 2023 that she was in fear of him and described him following and intimidating her after his release. On one occasion Paula told the author that she drove to the Police station and parked outside to convey the message to him that she would report his behaviour if it continued.

6.7 By the end of December 2021, Paula and George were in a relationship that appeared mutually destructive, now referred to as bi-directional violence[5]. Research by Machado et al a meta-analysis of 42 studies into bidirectional violence published between 2012 and 2020 showed the of reported violence demonstrated this was the most common pattern, and equally reported by women and men Of course, the Panel cannot say if Paula would have returned to this lifestyle and linked events had she had been supported more effectively by services after leaving the Refuge. During her interview with the Chair in prison in June 2023 Paula stated that she herself did not believe it necessarily would have made a difference. When Paula left the Refuge, she was already in a relationship with George and had returned to drinking, with the intention of controlling it, but that intent due to her circumstances proved too hard to maintain. Paula leaving the Refuge as she did with little support or planning made that outcome more likely, although it would in any given circumstances have been a risky transition.

6.8 The Panel discussed the management of cross allegations with both parties presenting multiple times as victims or perpetrators. SWP's response to the majority of the incidents risk assessed and managed the presenting risks whilst acknowledging the vulnerability of both parties. Both George and Paula had been assessed by SWP as high-risk perpetrators and high-risk victims, and three MARACs had been convened since their relationship had begun due to violence and abuse. They both were known to have had high risk factors such as reported use of weapons (in Paula's case), long standing drug alcohol and mental health issues, along with other longer-term issues linked to previous trauma, loss, and multiple bereavements. In addition, Paula was known to be at risk from another perpetrator, her ex-partner of whom it was said she was extremely fearful of and who was at this time in the area and seen as posing an active threat to her.

6.9 The three MARACs that were held do not seem to have been able to have responded with actions that were proportionate to both the level and imminence of risks that existed. There was no

[5] Machado A, Sousa C, Cunha O. Bidirectional Violence in Intimate Relationships : A systematic Review. Trauma Violence and Abuse.2024Apr;25 (2):1680-1694.doi:10.1177/15248380231193440.Epub 2023 Aug18. PMID:37594220

discussion of the management of bidirectional domestic violence by agencies. Stover et al's research[6] published in 2025 recognises further research is required to define.

"bidirectional IPV (Inter Personal Violence), especially when partners do not agree in their reports of IPV."

The MARAC seemed to be or to feel restricted to responding by information sharing within services and the victim, serving notices, and offering MARAC support to victims which was invariably turned down. The MARAC was stymied by the fact that George and Paula were both perpetrator and victim at various times, and mostly had limited contact with services, other than the attendance of Police Officers to remove the alleged perpetrator at times of violence. The agencies within the MARAC found it difficult to engage Paula or George and the only response within its power was to share information. The Panel is aware that the MARAC did not have representatives from CDAT, mental health services, nor a link via other health colleagues into the GP services, who George saw infrequently. The Panel would ask had these services been at MARAC whether a more pro-active approach may have been considered. However, the MARAC at that time appeared to rely on information sharing only with limited actions being offered by those agencies attending. This has been identified as a thematic issue; the author observed the three MARACs in the area in January 2023 and this was the pattern with agencies relying on the Chair of the MARAC to task them with actions. (Following these observations, a training programme was put in place in March and April 2023 to address these failings.)

6.10 Finally, one of the features of this case is the lack of involvement of Community Mental Health Services. On two occasions Paula's GP referred her to LMPHSS and Paula felt unable respond on both, and the referrals were closed. A referral by CDAT to Community Mental Health Services in May 2021 after Paula left the Refuge also appears to have elicited no response from LMPHSS, although LMPHSS state that they received no referral. This may suggest that the offer from Community Mental Health Services to chaotic individuals and those entrenched in anti-social and self-destructive behaviour, is not one that has traction at this point.

[6] Stover, C. S., Krauss, A., Yeterian, J., DeMoss, L., Funaro, M., Webermann, A., Presseau, C., & Portnoy, G. A. (2025). Scoping Review of Bidirectional Intimate Partner Violence Using Dyadic Data. Trauma, Violence, & Abuse, 0(0). https://doi.org/10.1177/15248380251316193

7 Conclusions

7.1 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 the expression of either anger or fear. The lifestyles and history of both George and Paula demonstrated they were a 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.

7.2 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 felt able to respond to referrals made or appointments offered and struggled 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, which relied on the individual contacting them. Paula also struggled to seek help and had a similar pattern to George however services were able to engage with her a period when she was the Refuge particularly worked well with both CDAT and domestic abuse services. Paula's resolve to stop drinking in July 2020 was probably linked to her 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 faced alcohol problems. 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 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.

7.3 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. 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 Health 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 Paula' 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.

7.4 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.

7.5 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.

7.6 In CTM 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.

7.7 Finally, the Panel recognise that George according to his family would have been reluctant to engage with services because of childhood trauma related to his repeated hospitalisation. Services were unaware of this added barrier that he faced. George's family describe how he did not see himself as a victim of domestic abuse and would have been reluctant to seek help. 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 was not referred by any agency. He was only assessed once 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. The model of care requires the service user to seek help which he did not feel able to approach. 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 feel able to seek this out herself.

7.8 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[7] 'Stomach, small bowel, and colorectal injuries occur more frequently following penetrating abdominal trauma than following blunt trauma. The small bowel is the organ most commonly 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.

7.9 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.

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

8 Lessons Learnt

Since this tragedy there have been three relevant service improvements:

- A Health IDVA is now co-located in A & E and works across the Out Of Hours service following an embedded process where they refer to Health IDVA for a next working day contact.
- The introduction of specific male worker in RCT DAS to address the added barriers to securing help male victims of domestic abuse face.
- The Area Planning Board have provided funding for three Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Substance Use Worker posts that sit within Substance use services (BAROD).The roles work alongside domestic abuse specialist services to deliver substance use interventions to people identified as having substance use needs and collaborate with other agencies, including Cwm Taf Morgannwg University Health Board, third sector agencies and local authority teams, to provide a holistic integrated substance use service.

This case has demonstrated four key learning points relating to services and how they manage marginalised people with few resources and to whom services respond or work with in either a voluntary, protective or enforcement capacity.

8.1 Firstly, it has shown the impact of poor communication and information sharing within and between agencies on the effectiveness of the agencies that worked George and Paula and those whose lives are affected by them. The statutory health services, both in-patient and community based were poor at sharing information both within their own organisations and with external agencies who were also working with George and Paula. This in the Panel's view significantly reduced the ability of services to manage and protect these two people and those affected by them.

8.2 Secondly this case has made clear that the community services available to George and Paula, 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. This lack of engagement clearly affected the lives of George and Paula, but their behaviour also affected the lives of those around them. This DHR has described the obvious determination and potential that George showed in his struggle with disability and personal tragedy through his life, Paula sought to address her own issues, triggered by the loss of her children. Yet it seems the community services were never able to engage and hold them long enough to help them in that. This suggests that the front-line services involved in their care, Primary and Secondary Health Services, mental health and substance misuse services must reconsider the offer that is made to people like George and Paula who services struggle to engage. The absence of Adult Services and the reasons for that in the life and care of George is also one that should similarly be considered in this regard.

8.3 Thirdly, 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.

8.4 Fourthly, that the emotional and financial cost of services not actively targeting and tailoring help and how they offer it in order to attract reluctant service users such as George and Paula and engage them to address their needs is unbearably high both for themselves and others they have contact with, and that the lack of engagement of reluctant service users with services offered must be reframed as a problem for all.

8.5 The Panel considered how male victims of domestic abuse know how and where to seek help, we understand it is inextricably linked with men's wider help seeking behaviour[8]. The British Medical Journal in June 2019 published research by Bristol University 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."

[8] 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.
http://orcid.org/0000-0001-9409-7891Alyson L Huntley1, Lucy Potter1, Emma Williamson2, Alice Malpass1, Eszter Szilassy1, Gene Feder1

9 Recommendations

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[9], 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 September 2023 has produced useful guidelines on this issue which will act as a useful starting point for local discussions and guidance. [10]
    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.

[9] 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
[10] https://soundcloud.com/domestic-abuse-podcast/counter-allegations-podcast

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[11] 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[12].
   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.)

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[13]. 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.

Appendix 1: Methodology for the overview report

Data analysis

The Panel discussed the chronology of events and draft recommendations in an inclusive and collaborative way, which involved all members in reflective learning. It was a generative process

[11] 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.

[12] 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

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

which encouraged us to ask the aspirational question – 'what a safe system would look like?' The outcomes from this process have formed the basis of the review recommendations. The recommendations were shared with George's families prior to the review being completed to ensure her family were as involved in the outcomes as possible.

It must be acknowledged that any review opens anxieties, but it was the panel's intention to create a culture of accountability and learning not of culpability or blame. The review panel were unanimous in wanting to value the actions and approaches that worked well, whilst facing the tough issues of what else could or should have been offered. This was to produce effective recommendations which seek to make others confronted by these complex situations safer.

The chair wished to adopt a 'no surprises' approach, to encourage meaningful discussion and to air differences of opinion. The draft overview report was circulated to the panel and marked Restricted. Until final comments were received the panel members had the right to share the draft report with those participating professionals and their line managers who have a pre-declared interest in the review.

The Home Office guidelines require the final report in full to remain RESTRICTED and must only be disseminated with the agreement of the Chair of the Domestic Homicide Review Panel.

Appendix 2 Terms of Reference

Home Office No: 202207210 0

Purpose of a Domestic Homicide Review

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 sixteen 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 RCT 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 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.

Circumstances of Concern

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

Questions to be Addressed.

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 are no parallel enquires. The coroner's involvement ended in ……. (victim) and the Prisons and Probation Ombudsman's investigation ended in ……. (perpetrator).

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.

Appendix 3 Individual Agency recommendations taken from the IMRs.

1.BAROD Actions	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Completed date**
1.Case note recording training to be updated as appropriate. 2.Performance review of Engagement Worker. 3. Ensure appropriate training given to staff and processes and procedures followed i.e., at referral and closure stage				
Trivallis: (housing)Action	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Completed date**
Action taken to assist those experiencing domestic abuse will be led by the survivor, and they may refuse support. In most cases, staff should respect these wishes. However, where the survivor is a sole tenant of a Registered Social Landlord and confirmation has been received that they left their property. The tenant's Housing Officer will make every effort to contact a survivor of domestic abuse, this will include in consideration of any risks to				

themselves, face to face contact is attempted to ensure all options to fully work with a survivor are considered to offer support, advice, and guidance in respect of their tenancy options and to offer referral to other agencies.				

Police recommendations

1. Following learning identified in another DHR, work has been undertaken with Domestic Abuse Unit staff to raise awareness around the misconception that Clare's Law disclosures can only be provided when parties remain in a relationship. A dip sample should now be undertaken to assess whether this learning has been embedded.

2. Work needs to be undertaken with risk assessors and receiving agencies to understand the barriers to sharing PPNs where there is 'no consent' from the victim.

3. In situations where a previous victim of domestic abuse is now perpetrating violence against the same partner, there may be merit in sharing information with a specialist domestic abuse service for them to make contact with the person identified as the current aggressor, particularly where previous support/contact has been made with them, in order to better understand and assess the risk dynamics in the relationship.

Children's Services IMR recommendations

What needs to happen to get us there?	What would good look like?	Who will do it?	By when?	How will we know when we have made the difference?
Children's Services practitioners and managers will be reminded of the need to consider the needs of parents who do not have care of their children but are experiencing adverse life experiences and need support and advice, and to refer them to appropriate services or ask the referring agencies to refer them to the appropriate agency.	As well as addressing the needs of children and parents who care for them, practitioners and managers will recognise the needs of parents who do not have care of their children, but continue to spend time with them, and will provide assistance by trying to help the parent gain access to appropriate support services.	Service Director and Heads of Children's Services	By end May 2023	Case recording and assessments will demonstrate a holistic approach to assessment and care planning – there will be evidence of 'What matters most' conversations with parents who do not have care of their children, as well as the parents who do have care. Case records will evidence referral to other organisations and/or advice to referring agencies of the need to refer to adult orientated services.
Learning from this review will be shared with the team undertaking a review of the Children's Services Information, Advice and Assistance (IAA)Service with a particular emphasis on the potential value of inter-disciplinary case referral,	Learning from reviews informs service evolution and development.	Service Director Head of Early Help Institute of Public Care	By end July 2023	The Review of the IAA Service will make specific reference to current case referral, screening, and decision-making processes, and will recommend an optimum model.

screening, and decision-making processes.				

RCT DA Services recommendations

At the time of the incident domestic abuse support services within RCT were delivered primarily by two core service providers - the Council's Oasis Centre, an IDVA service to high-risk victims, and RCT Domestic Abuse Services (formerly Women's Aid RCT) providing Refuge (female only) and standard to medium risk intervention projects to people regardless of gender.

Recommendation 1
It is recognised that an individual's risk can both increase and decrease over time and a closer working relationship between the two organization would support increase communication, information sharing and improve outcomes for clients who may use both services.
In December 2022, DV services in RCT agreed to develop a 'one front door approach' to service delivery in the form of a joint partnership agreement.
This includes.

I. Staff members from both organisations to be co-located at each other's premises - April 2023

II. One phone number and website page for both services to make it easier for professionals and victims to access information and support - June 2023
III. Two separate client management systems that can talk to each other and alert / highlight when an individual is or has ever worked with the partner group and creates a network to share information July 2023.

Recommendation 2

Within RCT it is positive that the female standard to medium risk PPN's is actioned and contacted following an incident by RCT domestic abuse service. The aim of this is to offer an earlier intervention and support and or, information to people on their local dv support services.
In this case it does not appear that this service is currently being offered to male standard to medium risk PPN's.
In June 2023, RCT domestic abuse service employed a male dv worker to increase awareness and opportunities to support male victims of DV. This creates an opportunity for the male standard and medium risk PPN's to be actioned in the same way as female PPN's.
RCT domestic abuse service to discuss this with the Police safety unit and IDVA service June 2023.

Adult Services
No recommendation

Mental health and CDAT Services

1. The final DHR should be shared with Mental Health Services and CDAT for their reflection on practice.
2. The emergency department and Alcohol Liaison Team should ensure that all persons admitted to the department with alcohol withdrawal are referred for review by the Alcohol liaison Nurse to ensure that adequate follow up arrangements are made on discharge.
3. It is expected that BAROD and CDAT work together to support their patient group. These arrangements should be formalised so that each agency has a clear understanding of joint working arrangements.
4. The CDAT team along with the safeguarding team, should ensure that their nursing staff have a clear understanding of threshold levels for MARAC referral and other means by which they might signpost patients for support when the threshold for MARAC referral without consent might not be met.

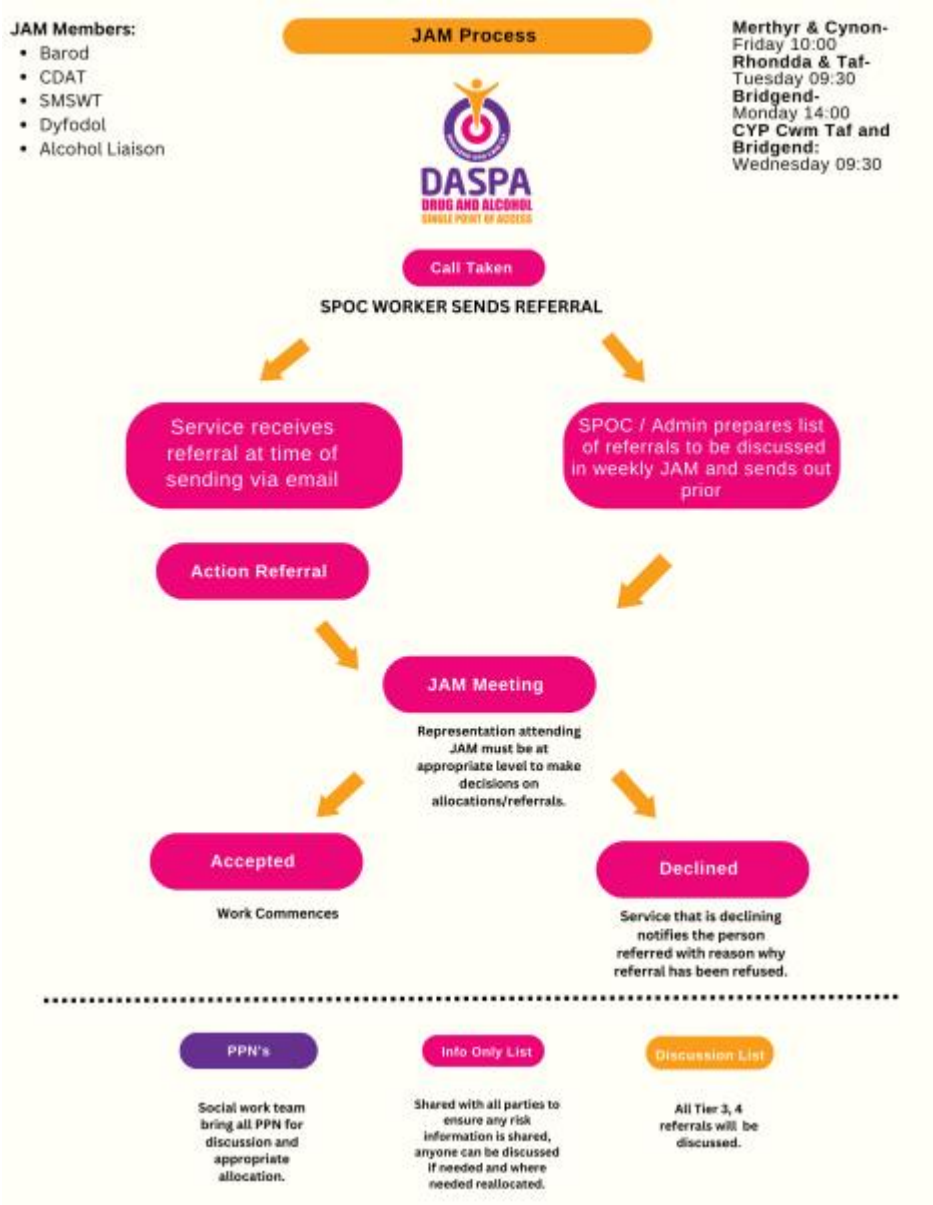
Appendix 4 The CWM TAF (Integrated Substance Misuse Service) multi-agency discussion forum to be known as Joint Allocation Meeting (JAM).

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
Merthyr & Cynon- Friday 10:00
Rhondda & Taf- Tuesday 09:30
Bridgend- Monday 14:00
CYP Cwm Taf and Bridgend: Wednesday 09:30
DASPA
DRUG AND ALCOHOL
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.

Appendix 5

The Health and Social Care agencies with the electronic system they use in relation to Paula are shown below in diagrammatic form.