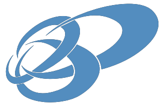

Cwm Taf Partneriaeth Diogelwch Cymunedol
Community Safety Partnership

Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board

# CWM TAF COMMUNITY SAFETY PARTNERSHIP

## DOMESTIC HOMICIDE REVIEW

## EXECUTIVE SUMMARY

## Report into the death of
# Shelly

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October 2019

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# List of Abbreviations

ASB – Anti Social Behaviour

AAFDA - Advocacy After Fatal Domestic Abuse

AAR – Adult at Risk

ATR - Alcohol Treatment Requirement

BMI – Body Mass Index

CBO - Criminal Behaviour Order

CPN - Community Protection Notice

CRC - Community Rehabilitation Company

CSP - Community Safety Partnership

CTSB - Cwm Taf Safeguarding Board

CTMSB - Cwm Taf Morgannwg Safeguarding Board

DAPO - Domestic Abuse Protection Order

DAPN - Domestic Abuse Protection Notice

DART – Domestic Abuse Resource Team

DHR - Domestic Homicide Review

DIP - Drug Intervention Program

DVPN - Domestic Violence Protection Notice

DVPO - Domestic Violence Protection Orders

DYFODAL – Project providing support to people with drug and alcohol issues in South Wales

GP - General Practitioner

IDA - P Intensive Domestic Abuse Programme

IDVA - Independent Domestic Violence Advisor

IOIS - Integrated Offender Interventions Service

IOPC - Independent Office of Police Conduct

IMR - Individual Management Review

LA - Local Authority

MARAC - Multi-agency Risk Assessment Conference

MASH - Multi-agency Safeguarding Hub

MCA (2005) - Mental Capacity Act (2005)

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NPS - National Probation Service

NPT - Neighbourhood Police Team

OASYs - Offender Assessment System

OPT - Opiate Substitute Therapy

Perpetrator – Mike

PCSO - Police Community Support Officer

PIN - Police Information Notice

PPU - Public Protection Unit (Police)

PPN -Public Protection Notification

PSC – Public Service Centre

PSS – Post Sentence Supervision

RAR - Rehabilitative Alcohol Requirement

SIO - Senior Investigating Officer (Police)

SMART - Specific, Measurable, Achievable, Realistic and Time-limited

SSWB (2014) - Social Services and Well-being Act (2014)

TEULU - Multi Agency Centre One Stop Shop providing support to victims of domestic abuse

VA - Vulnerable Adult

VAWDASV - Violence Against Women, Domestic Abuse and Sexual Violence

Victim - Shelly

WAST - Welsh Ambulance Services NHS Trust

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## 1. The Review Process

1.1 This executive summary outlines the process undertaken by Cwm Taf Community Safety Partnership (CSP) in reviewing the circumstances of the death of Shelly at the hands of her partner Mike in the summer of 2018.

1.2 Pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family members.

1.3 Shelly was found dead in her home by her partner and despite Mike's initial assertion that Shelly must have been killed by falling down the stairs, the Forensic Pathologist was clear that her fifty external injuries, twenty-eight rib fractures, fractured skull, major chest injury resulting in heart and lung damage, torn kidney and internal bleeding, were the result of a sustained assault consistent with the use of a fist, foot, knee or some blunt weapon.

1.4 Mike was subsequently arrested and during their enquiries, the Police became aware that on the day prior to her death, Shelly and Mike had engaged in a verbal and physical argument, which had occurred over a period of hours within the home and had also spilled out into the street. The post mortem also identified defensive wounds on Shelly's body, and it was apparent from the neighbours' accounts of the argument they had witnessed between Shelly and Mike, that she had attempted to defend herself. Shelly was naturally diminutive in size, physically frail and ultimately ill-equipped to defend herself from such a savage attack. Mike was duly charged with her murder.

1.5 Following Shelly's death, agencies were asked to review their records to establish any contact with Shelly or Mike. It became apparent that many agencies had involvement with Shelly and Mike, and that some agencies had had significant involvement with them.

1.6 The local CSP with other agency representatives reviewed the circumstances of this case against the criteria set out in government guidance and recommended that a Domestic Homicide Review (DHR) should be undertaken. The Chair of the CSP ratified the decision and Mrs Julie Clark, an independent person was appointed to chair the DHR Panel and to write the Overview Report and Executive Summary.

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1.7 The DHR examined the agency responses and support given to Shelly prior to the point of her death and also examined the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed by Shelly within the community and whether there were any barriers to her accessing said support.

1.8 It was decided that the review would focus on agencies' involvement with Shelly and Mike from the 29th May 2015 to the 29th May 2018, as this timeframe would provide sufficient information to enable the Panel to examine agency responses and support given to Shelly prior to the point of her death; unless it became apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended if any agency had any significant relevant information. This did not become necessary.

1.9 Criminal proceedings concluded in December 2018 and Mike was convicted by unanimous verdict of murder and sentenced to eighteen years in prison.

1.10 At the appropriate time following the conclusion of the trial the family of Shelly were contacted by the author to establish if they wished to engage with the Review. With their agreement two home visits were undertaken to discuss the review, gather information and develop the terms of reference with them to assist with the scope of the review. The author's discussions with Shelly's family proved invaluable in providing her with an insight into some of the adverse childhood experiences Shelly had faced, which triggered a life-long dependency on alcohol and latterly prescription medication, which was compounded by the domestic abuse she was experiencing; all of which affected her health. It was clear to the Panel that Shelly had been very loved by her family, but that their long-standing efforts to support and protect her were frequently rejected.

1.11 Mike declined the opportunity to contribute to the review, and in line with the family's wishes, members of the community were not approached to contribute to the review

1.12 The review began on the 12/10/2018 and concluded in November 2019.

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## 2. Agencies Participating in the Review:

- Public Health & Protection & Community Services, RCT County Borough Council
- Cwm Taf Regional Advisor Violence Against Women, Domestic Abuse and Sexual Violence
- Safer Merthyr Tydfil
- South Wales Police
- Housing Options, Homelessness & Supporting People,
- RCT County Borough Council
- Cwm Taf Morgannwg University Health
- Board
- Merthyr County Borough Council
- Welsh Ambulance Services NHS Trust
- National Probation Service
- Protection and Safety Services, Merthyr Tydfil County
- Borough Council
- Wales Community Rehabilitation Company (CRC)

2.1 All agencies were requested to prepare chronologies of their involvement with Shelly and Mike and to carry out Individual Management Reviews, and the following agencies, whilst not members of the Panel were also asked to complete chronologies and IMRs:

- HM Prison Service - Eastwood Park
- Royal Society for the Protection of Animals (RSPCA)

2.2 Family have also contributed to this Review.

## 3. Purpose and Terms of Reference for the Review:

3.1 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

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## 4. Terms of Reference for the Review:

4.1 It was identified by the DHR Panel and family of Shelly that the Panel needed to focus on:

- To what extent was Shelly's alcohol and diazepam misuse a barrier to her receiving support for domestic abuse and vice versa?
- What consideration, if any, was given to the impact Shelly's alcohol and diazepam use and history of domestic abuse had on her capacity to refuse consent?
- What impact did Shelly's general reluctance to disclose abuse have on the functioning of agency responses?
- What impact, if any, did Shelly's anti-social behaviour have on the way her vulnerability was perceived and responded to by agencies and the wider community?
- Were professionals and agencies involved with Shelly suitably curious about her situation and if not, is there any evidence that they had become fatigued in their responses e.g. understanding and exploration of begging, coercive control and the presence of animal cruelty.
- Were the range of relevant protective and legal measures, including those concerning controlling and coercive behaviour, appropriately applied in this case?

## 5. Key Issues Arising from the Review

5.1 Shelly was 38 years old at the time of her death and had resided in the same community all her life. Shelly had been known to South Wales Police since 1998 and was the reporting person and victim in relation to a variety of calls to the police. Shelly was a victim of domestic abuse from two previous partners and was risk assessed as medium in these relationships.

5.2 Shelly owned her own home and she shared this with her partner of 6 years, Mike. Shelly was childless and Mike had older, adult children from a previous relationship.

5.3 Mike had been known to South Wales Police since 2002, primarily in relation to arrests and intelligence reports. Mike was the reported domestic abuse aggressor with two previous partners, one assessed as high risk and the other medium.

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5.4 Shelly suffered several significant and traumatic events in her life, including experiencing adverse childhood experiences following the breakup of her parent's relationship, the death of her mother and grandmother and a violent assault that left her physically disabled. All these events were precursors to a deterioration in her emotional wellbeing and behaviour and triggered the start of an unhealthy lifelong relationship with alcohol that led to a marked and steady deterioration in her physical and emotional well-being.

5.5 It would have been quite apparent to the professionals who met Shelly that she drank excessively, and various professionals had concerns about Shelly's alcohol use and her GP was also aware that she was misusing diazepam. In truth, Shelly did not deny the extent of her or Mike's alcohol consumption. In fact, Shelly would use her inebriation to explain her domestic abuse injuries, which had the effect of obscuring the impact of both on her.

5.6 Shelly's alcohol misuse and perceived lifestyle choices negatively punctuated the relationship with her family, which could be fractious but also thoughtful and protective. Whilst Shelly's father did not approve of the way Shelly lived and they would often argue, theirs was a complex relationship and they loved one another very much. Following the start of her relationship with Mike, and as she became more coercively controlled by him, Shelly's family were kept increasingly at arm's length and were not allowed to visit her home. From that point on contact was usually precipitated by a crisis. Shelly's father tried on several occasions to get Shelly to see sense about Mike, or to warn Mike to leave her alone, but in part because of the coercive control she was experiencing, Shelly would reject the help and threaten her father with the Police. Although Shelly and her father had enjoyed a very close and loving relationship, and there is no doubt that Shelly's family recognised her alcohol dependency and vulnerability and tried to assist her with this, they had become estranged in the months prior to her death because Shelly rejected them and they felt powerless to intervene.

5.7 Shelly's and Mike's relationship was characterised by alcohol fuelled domestics and alcohol was clearly a very significant factor in perpetuating the abuse and violence. Shelly's family believe, reasonably, that the effect of the violence Shelly had experienced before and during her relationship with Mike had fundamentally damaged her confidence and sense of self-worth, and was also a trigger for her to misuse alcohol and prescription medication as a way of coping with the trauma she had experienced.

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5.8 While advice was provided to Shelly on more than one occasion about her alcohol and prescription use, there was no evidence of additional clinical strategies being discussed with her to mitigate the risk to her health, safety and well-being in light of these dependencies. There is also no evidence that any health professional referred onto other services with expertise in drug and alcohol dependency.

5.9 During the period under review, the Police attended 126 incidents involving Shelly, which included numerous calls in relation to her begging in the street and at a local retirement housing complex, and a Criminal Behaviour Order was issued to her in April 2017 as a result of these. Shelly and Mike were also known for several domestic related calls. Most of these calls were made by neighbours after hearing shouting and arguing coming from Shelly's address and on occasions also witnessing assaults.

5.10 Mike had a pattern of controlling and violent behaviours in his relationship history and the DHR Panel found evidence that Shelly was being coercively controlled by him, as she had suffered repeated acts of assault, threats, humiliation and intimidation designed to harm, punish and frighten her, many of which had a serious effect on her. Shelly was subordinate to Mike and dependent on him, as she was isolated from sources of support, increasingly exploited and incapable of asserting her independence.

5.11 Shelly often reported that her injuries were as a result of falls, usually reproaching the family dog as the cause. Although there is no documented evidence that Shelly was asked directly by her GP whether she was the victim of abuse and no evidence of a referral for further advice, it was documented that the GP practice had an understanding that Shelly was experiencing domestic abuse; as there were numerous presentations with both significant and less serious injuries over many years. Despite the GP practice being IRIS facilitated (Identification & Referral to Improve Safety) a referral to IRIS was never made.

5.12 When offered support Shelly usually declined this and rarely disclosed the truth abuse the abuse she was suffering at the hands of Mike, always retracting a disclosure. Shelly's repeated denials that she was in a domestically violent relationship is unsurprising as victims of controlling or coercive behaviour may not recognise themselves as such, or be fearful of the consequences of disclosing what is happening to them. In addition, because Shelly used alcohol and medication as a coping mechanism, likely to block out what was happening to her, it is important to consider how this might have contributed to her additional needs and presented

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barriers to her ability and willingness to recognise or report abusive behaviour. The Review has identified that Agencies were not sufficiently cognisant to this, which hindered appropriate agency support and interventions being provided to Shelly.

5.13 Shelly's review has identified that positive action was taken in response to domestic incidents by South Wales Police, with Mike being removed from the premises and arrested for breach of the peace where no other offences were evident or information forthcoming. In addition, evidence based prosecutions did take place twice in Shelly's case; which are intended to take responsibility away from vulnerable victims who may feel unable to support a prosecution due to fear, intimidation or multiple other reasons.

5.14 However, as Shelly's family identified, there were also times when the Police seemed unable to intervene in Shelly's case because no violence had taken place and no complaint had been made. The Crime and Security Act 2010 states that violence or the threat of violence is required before a Domestic Violence Protection Notice (DVPN) can be issued and a Domestic Violence Protection Order (DVPO) be granted. On such occasion's officers arrested Mike for breach of the peace or removed him from the address to an alternative location.

5.15 Between the 12/6/2015 and 8/5/2017, in response to Public Protection Notices (PPN's) received, the IDVA Service attempted twenty-two contacts with Shelly. As the IDVA service is accessed on a voluntary basis, it has no means of engaging with victims other than through attempting contact and offering information on support, recovery and advocacy options. The service will collaborate with other agencies to increase the possibility for engagement, but in Shelly's case the IDVA Service was unaware of other agency involvement other than that of the Police.

5.16 During 2015, in response to the high volume of referrals to MARAC, an internal Police process was implemented which was not in line with the Safe Lives best practice model, which is if a case is high risk it gets referred to MARAC, as do all repeat cases. As a result, information on high risk cases was always shared with the IDVA service, but some high-risk cases, dependent on the current incident, were not referred to MARAC. The unintended consequence of this was that for a significant period, MARAC meetings were not held for Shelly when they should have been, which had the unintended consequence of disguising the level of risk that existed for Shelly, and hampered robust multi-agency risk analysis and management and the development of suitable interventions to address Shelly's care and support needs. Once challenged by partner agencies there was an immediate reversal of the process.

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5.17 Towards the end of 2015, the interventions with Shelly were mainly focussed on her status as a victim of domestic abuse alongside her anti-social behaviour. Shelly's vulnerabilities were recognised by the Police and information was shared with partner agencies via PPNs. PPN's, where submitted, were shared appropriately with a variety of partner agencies, including the IDVA Service and Adult Services. Consent was also considered and overridden at times, due to the risks identified. One PPN was submitted by attending officers in November 2015 on a vulnerable adult basis though this was not shared due to Shelly's lack of consent. It was of concern to the Panel that Drug Aid (renamed BAROD in December 2017) had no record of any of the referrals made to them by the Police on behalf of Shelly during the timeframe of the review; which Drug Aid had no explanation for.

5.18 The Review identified evidence that Shelly's access to money had become increasingly compromised during the timeframe under review. Whilst this may have been partly attributable to the amount of household money being spent on alcohol, the examples within the chronology of Shelly begging, reporting that the money was for Mike and also stealing food, strongly suggest that money was being taken and withheld from Shelly by Mike, which would support the view that she was becoming increasingly exploited in her relationship and was a victim of hunger and poverty as a result; making it harder for her to leave the relationship.

5.19 Shelly was also threatened and assaulted in her own home by associates and / or 'friends' of her and Mike's when she could not supply diazepam or was reluctant to sign paperwork that she suspected might implicate her in fraud. Whilst these individuals would probably have been described as 'friends' by Shelly, there is sufficient evidence to suggest that they were taking advantage of her vulnerability and using her home for nefarious purposes.

5.20 During May 2016 there were several examples of inadequate information sharing within health and a disclosure of assault by Shelly was not picked up and responded to as a result. Opportunities to explore domestic abuse, alcohol misuse, levels of risk, and referrals to support agencies for Shelly were also not taken advantage of. Whilst it is noted that up to this point services had not been able to make links with Shelly, during Mike's detention, the opportunity to try and engage with Shelly when he was not around was not considered.

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5.21 The Panel was of the view that the level of domestic abuse callouts alone during September 2016 (seven in total) should have alerted agencies to the fact that Shelly and Mike were living together, supported by the fact that Mike was trying to mislead his Offender Manager on his living arrangements and avoiding appointments. Information provided by Mike and Shelly was also taken at face value by NPS and was not corroborated and discussed with Police. The Panel also considered that the number of domestic abuse incidents known to Police should also have caused a referral to MARAC, where effective multi-agency working could have enabled the contradictory information being provided by Mike and Shelly to be challenged, and multi-agency risk management opportunities to be maximised.

5.22 Domestic abuse incidents continued into early 2017 and there is no evidence that NPS were being made aware of the ongoing domestic abuse incidents at Shelly's address and without referrals to MARAC, multi-agency risk management opportunities were therefore missed. The introduction of the Reportable Incidents Model (RIM) between the Police and NPS has sought to address this.

5.23 Towards the latter end of 2017 the number of incidents of Shelly begging increased, along with complaints about her engagement in public nuisance incidents. Shelly also sought to access her diazepam prescriptions early from her GP. In December 2017, Police attended Shelly's address following the report of an argument and a PPN was submitted due to the concerns the officers had for the condition of the house (described as uninhabitable) and their concerns for Shelly's health, which was shared with Adult Services with Shelly's consent. Although the officers were attending the address for an unrelated incident, they correctly identified that Shelly was vulnerable and in need of support regarding the condition of her home, which was well documented by the officers with a full and thorough description of their concerns.

5.24 Adult Safeguarding received four PPN's from South Wales Police between the 18.10.2017 and 19.12.2017, and despite Shelly's health and home conditions continuing to raise concerns, no Adult Safeguarding Referral was made / triggered in response. The first PPN shared serious concerns about home conditions and the Adult Services Safeguarding Co-ordinator made a referral to Environmental Health in response. A joint visit was planned by Environmental Health with the Police, but this never took place and was not escalated for resolution. A Environmental Health Officer also reported making contact with Building Control regarding the condition of Shelly's property, but neither the Police Officer concerned or Building Control have a record of this; leaving the Panel uncertain of the facts in this matter, but clear that record keeping and the completion of agreed tasks are areas for improvement across agencies.

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5.25 During the Review, it became apparent that agency recordings were not always sufficiently detailed and because information sharing between agencies was inadequate and untimely at times, the potential links between key pieces of information held by different agencies on Mike and Shelly were not made e.g. Mike's reported poverty and Shelly's begging. Panel also found some evidence that the information-sharing and support referrals made by the Police in respect of Shelly were passed from one agency to another, with limited evidence of actual offers of assessment or assistance arising from this. During October 2017, despite concerns being raised by the Police about Shelly, resulting in three PPN's being shared with Adult Services, Drug Aid and Environmental Health, no adult safeguarding referral was made and/or triggered in response to the PPN's. During the review it also became apparent to the Panel that Adult Services had processed some of the PPN's as for information purposes only, in the incorrect belief that consent had not been provided to share the information by Shelly and / or support was not wanted.

5.26 During December 2017, Shelly'S anti-social behaviour resulted in her arrest for attempted burglary and charges for breach of her Criminal behaviour Order (CBO). The CBO order was subsequently terminated and a new Suspended Sentence imposed with no requirements.

5.27 On the 29/12/2017 Shelly was sentenced to twelve weeks custody for breach of her CBO and was received into Prison. This was the first time Shelly had been in custody and after being identified as alcohol dependant, she was treated on the Detox Unit for alcohol detoxification and was provided with harm minimisation education. There were no visits from professionals to Shelly whilst she was in custody, which would have provided greater opportunity to explore her support needs in a safe environment away from Mike.

5.28 The Prison's Health Assessment, completed at the beginning of 2018, identified that Shelly had a low platelet count and an abnormal liver function test and a health condition that required further investigations and a referral to Herpetology. A copy of the discharge summary was sent to Shelly's GP practice, but there is no documented evidence of any health action on the recommendations being made following Shelly's discharge.

5.29 On the 08/02/2018, Shelly was released from custody and reverted to her previous begging behaviour immediately. On the 10/02/2018 Shelly was arrested for

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breaching her CBO and was remanded to the same prison. At a bail hearing on the 20/02/2018 Shelly was granted bail with conditions.

5.30 Police received a 999 call from Mike on the 27/2/2018, who reported that Shelly had been drinking and fallen down the stairs. Mike also sounded like he had been drinking. Hospital records indicate that Shelly had sustained a large laceration to the middle of her forehead, and she was described as intoxicated, aggressive, and un-cooperative with treatment. Shelly was recorded as having a history of anxiety and depression, and of being alcohol and diazepam dependent. A CT scan of her brain and facial bones was undertaken and a nasal fracture was seen. There is no evidence that WAST undertook a routine enquiry regarding domestic abuse with Shelly, or that Hospital staff had a discussion with her around alcohol and substance misuse or any questioning around the possibility of domestic abuse; which were missed opportunities to discuss domestic abuse and offer specialist support.

5.31 A PPN was also submitted by the Police due to the condition of the home, but Shelly refused consent to share the information with partner agencies. Considering Shelly's alcohol and diazepam use and the fact she was known to be a victim of domestic abuse, consideration could have been given to overriding the consent and sharing the PPN with Adult Services to offer support to Shelly.

5.32 On the 28/02/2018 Shelly attended CRC from hospital covered in blood, stating that she had fallen down the stairs in the house. Shelly's Offender Manager records that information from Police colleagues was that Shelly was intoxicated and had fallen down the stairs, and that there were no light sockets at the home and no bannister. No action was undertaken by the Offender Manager in response.

5.33 On the 3/3/2018 Shelly was arrested and pleaded guilty for breach of her bail conditions and was remanded to Prison, where she remained in custody until sentence on the 27/3/2018, when she received 20 weeks imprisonment. Following her remand Shelly was medically examined and identified as alcohol dependent. Her alcohol withdrawal was monitored on the Detox Unit and harm minimisation education was offered. Further investigations for a possible fracture following her fall down the stairs were also proposed.

5.34 On the 14/3/2018 the CRC Team Manager e-mailed the Offender Manager to request an exploration of Shelly's alcohol use and poor home conditions, and on the 27/03/2018 Shelly's order was terminated following her twenty weeks custody for a new offence of Breach of CBO.

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5.35 On the 25/04/2018 Shelly tested positive for a blood condition and on her release from Prison a full induction was completed with her by CRC. Whilst proactively the CRC Manager had asked the Offender Manager to look into Shelly's poor home conditions and alcohol intake, there were no visits from professionals to Shelly whilst she was in custody and no evidence that the CRC Manager's instructions were followed up.

5.36 On the 4/5/2018 Shelly was released from prison and reported to CRC on the 8/5/2018 that her relationship with Mike had ended and as such she was consuming less alcohol. Shelly was advised to attend the DWP to address her benefits. No enquiries were made to establish if the relationship between Shelly and Mike had really ended, Shelly's account being taken at face value.

5.37 On the 9/5/2018 Shelly attended her GP requesting diazepam and a fit note, advising incorrectly that she was prescribed diazepam in prison, so no prescription was ultimately provided. On the 25/05/2018 a member of the public contacted the Police to report that Mike was refusing to let Shelly into her house, which resulted in her kicking and hitting the door. Shelly then contacted the Police to report that Mike had assaulted her. On arrival Shelly denied this but told Police she wanted Mike out of the house, and he was proactively arrested to prevent a further breach of the peace.

5.38 Positive action was taken in removing Mike from the property as requested by Shelly and the risk assessment of medium by the submitting officer was deemed appropriate given the presenting circumstances and information provided; there had been no reported domestic incidents for over 12 months and therefore the previous marker indicating that Shelly was a high risk victim had been archived in line with national guidance. Mike was released from custody at 05.25 hours, with no further action being taken.

5.39 On the 29/05/2018 Police received a 999 call from Shelly's neighbour, stating that Mike had found Shelly unresponsive in the morning. On arrival the attending ambulance crew noted that Shelly had been dead for some time and documented that she had observable physical injuries.

## 6. Conclusions

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6.1 The Panel is of the view that support services generally failed to recognise and respond to the complexity of Shelly's needs and situation; which included domestic abuse, alcohol and prescription medication misuse, mental health problems, past traumatic events including bereavement, a serious physical assault that had disabled her, self-neglect and exploitation by others.

6.2 The toxic relationship between Shelly's domestic abuse and self-neglect because of alcohol and prescription medication was poorly understood and appears to have been perceived as a 'lifestyle choice' by practitioners. This prevented a comprehensive analysis of the underlying causes for her behaviours and precluded attempts to address them. In Shelly's case, it also appears possible that her begging and criminal behaviour was often seen as a personal choice, rather than a symptom of her vulnerability and exploitation.

6.3 Research would indicate that in respect of self-neglect and mental capacity, practitioners assume having mental capacity implies someone can choose their lifestyle, however unpleasant and risky that that might be for them. Nevertheless, agencies still have a duty to safeguard adults, which can make finding the right balance between choice and protection challenging. Shelly was a vulnerable adult, who was particularly at risk because of her heavy drinking and that of her partner Mike. In this respect agencies did not sufficiently recognise Shelly as an adult at risk in need of safeguarding, and in the view of the Panel she would have met the threshold for this as both a victim of domestic abuse and substance misuser; which resulted in persistent barriers to Shelly receiving appropriate assessment, care and treatment pathways.

6.4 Mike was ultimately responsible for killing Shelly, but there were several factors that clearly complicated and exacerbated the circumstances that led to the tragic outcome that her family had sadly come to believe was inevitable. It is therefore incumbent on agencies tasked with taking care of the most vulnerable to ensure that challenging behaviour and a previous lack of engagement does not deter agencies from making every contact, particularly with those in our communities who are the hardest to reach, an opportunity to offer support.

## 7. Lessons to be Learnt from the Review

### 7.1 Victim Characteristics:

- Several traumatic life events contributed to and triggered Shelly'S alcohol and diazepam misuse.

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- Shelly was a previous victim of domestic abuse and was also the victim of a serious assault that left her physically disabled.
- Shelly was coercively controlled by Mike, which was not sufficiently recognised by agencies.
- Shelly was the victim of significant violent assaults at Mike's hands and this was not responded to consistently by support services.
- Shelly presented with mental health difficulties and wider health problems, which were not adequately assessed or responded to by agencies.
- Shelly was exploited by Mike and by others in the community.
- Shelly exhibited a range of self-neglecting behaviours, but these were not recognised as such.
- Shelly could exhibit behaviours which were suggestive of someone in distress, but these were often responded to as antisocial behaviour incidents.
- Shelly's family were supportive and tried to protect her but were unable to intervene as they would have liked as they were kept at arm's-length.
- Shelly did not readily engage with services, and services seemed ill-equipped to respond to this.

**7.2 Practitioner Perceptions:**

- Shelly's behaviour appears to have been seen as a personal choice by practitioners and not as a result of the adverse circumstances she faced.
- Some professionals and agencies involved with Shelly and Mike did not appear suitably curious about their situation and evidenced some fatigue in their responses e.g. understanding and exploration of alcohol / substance misuse, coercive control, link between animal and human abuse, self-neglecting behaviours and begging.
- Some professionals and agencies involved with Shelly appeared to have taken the view that regardless of what interventions were provided, little was likely to change, so that the true extent of Shelly's alcohol and prescription medication misuse was underestimated.

**7.3 Effectiveness of Multi-Agency Working:**

- Shelly's general reluctance to disclose abuse and the reasons for this were not understood by practitioners and agencies, which appears to have had a negative impact on the functioning of some of the agency responses to her.
- Agencies frequently worked in silos and there was a lack of effective multi-agency working and ownership.

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- A holistic approach to assessment was not evidenced and resulted in incomplete risk assessments and analysis as a result, so that Shelly was not identified as an Adult At Risk when she should have been.
- Shelly's alcohol and diazepam misuse acted as a barrier for agencies to her receiving support for domestic abuse and vice versa, and specialist or clinical input was not considered or provided.
- Shelly's capacity to consent was not properly understood or considered in light of her alcohol and diazepam use and history of domestic abuse.
- Shelly's anti-social behaviour had a detrimental impact on the way her vulnerability was perceived and responded to by agencies, and as a result Shelly was not sufficiently recognised as an Adult At Risk.
- Policy and procedures were not always followed.
- Multi-agency meetings lacked focus and SMART outcomes were absent.
- The quality of agency recording, and referral management was questionable at times.

**7.4 Understanding and Implementing the Law:**

- The range of existing domestic abuse orders created some confusion in interpretation and enforcement for agencies in respect of what abusive behaviours were covered.
- Shelly's capacity was assumed, but not properly considered or assessed in light of her substance misuse levels, the level of violence and coercive control she was experiencing and the levels of self-neglect that were evident.
- There is a clear need for legal advice and 'legal literacy' in respect of The Mental Capacity Act (2005) and The SSWB Act 20014, as the range of relevant protective and legal measures that existed were not considered or applied.
- Guidance is needed for practitioners on recognising and responding to risk and managing the complex interplay between substance misuse, coercive control, domestic abuse, and self-neglect.

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## 8. Recommendations

**8.1 Recommendation 1: Agencies working with vulnerable and offending adults need to demonstrate an inquisitive approach to risk and evidence of information sharing practices that support safeguarding activity.**

a) Risk and vulnerability issues, with specific reference to domestic abuse, should be considered and explored as part of all routine contacts with service users and agency paperwork should be amended to ensure this, and any action taken is covered.

b) Ask and Act principles to be incorporated into agency screening and assessment tools

c) All agencies in contact with adults at risk must take ownership for taking the safeguarding lead and making referrals for support.

d) South Wales Police to remind officers that the Reporting person should be spoken with to clarify the report and obtain any additional information.

e) South Wales Police to remind officers to always separate parties when responding to domestic abuse incidents and record the same

f) MASH Health to share PPNs concerning adults with GP Practices.

g) An admission to Prison should trigger a domestic abuse screening.

h) There should be an improved use of home visits by the Offender Manager following a change in circumstances.

i) Risk and vulnerability issues must be considered as part of single and multi-agency meetings agendas.

**8.2 Recommendation 2: MARAC meetings need to focus on disrupting/managing perpetrators' behaviour, especially in the absence of victim engagement.**

a) MARAC concerns are shared in a timely fashion with partners.

b) Any PPN that is submitted for a 'High Risk' victim is shared at the next available main MARAC meeting for discussion or for 'Information' purposes.

c) MARAC to prioritise those client groups with no protective services in place, resulting in heightened risks.

d) PPU staff are to be reminded that an escalation in frequency of domestic incidents reported to police can indicate a high risk and should prompt consideration for the case to be listed for discussion at MARAC and other associated safeguarding measures.

e) All relevant agencies to be invited to MARAC meetings, including alcohol and substance misuse services, even if they are not currently working with the adult.

f) Non-attendance at MARAC will be recorded and escalated through relevant governance structures for attention.

g) MARAC to better utilise 'Drive.'

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**8.3 Recommendation 3: Agencies working with vulnerable and offending adults need to trigger and adhere to care and treatment pathways that support safeguarding activity.**

a) IRIS (Identification & Referral to Improve Safety) Advocate Educator to offer refresher training to GP Practice concerned to highlight processes.

b) IRIS Advocate Educators to include learning from DHR in future training for all GP practices.

c) An audit of IRIS use by GP's needs to be undertaken by the regional advisor on a regular basis. The results need to be collected and shared with the UHB.

d) CTM Health Board to reinforce process to be followed when patients present at A&E with indicators consistent with domestic abuse.

e) CTM Health Board to develop a set of principles to take account of the lessons identified in this case, to include a guide on GP prescribing practices.

f) CTM Health Board to develop a set of principles to take account of the lessons identified in this case, to include a guide for GP's on providing a consistency of care to patients who have been released from the secure estate.

g) Prison visits by community agencies should take place with identified victims of domestic abuse.

h) Effective communication should routinely take place between NPS and Through the Gate Resettlement Services prior to a prisoner's release

**8.4 Recommendation 4: Social Care Workforce Development Partnership covering Cwm Taf (SCWDP) to review its training program on vulnerable people who are experiencing alcohol harm and / or abusing prescription medication.**

a) The training programme should be reviewed to ensure it considers cases in the context of the law and discusses how practitioners could better apply the relevant legislation to similar situations, as well as how the current guidance could better address the issue of alcohol-related self-neglect.

**8.5 Recommendation 5: Substance Misuse Area Planning Board in Cwm Taf to review its commissioning arrangements for substance misuse services, to ensure they are fit for purpose and equipped to deal with high-risk cases, which provide continuity of service delivery.**

a) Substance Misuse Services in Cwm Taf will ensure that they have provisions in place to;

- Respond to the needs of vulnerable and marginalised groups including but not limited to victim and perpetrators of domestic abuse.

- Actively engage with hard to reach groups and communities.
- Be responsive to targeting individuals who are misusing substances and who are not engaged in treatment.

b) All front-line staff in Cwm Taf Morgannwg working with vulnerable people should attend substance misuse training that is available in the area to raise awareness of substance misuse issues.

**8.6 Recommendation 6: Understanding of mental capacity and how to assess it needs to be more robust and knowledge of the Mental Capacity Act 2005 needs to improve: both as a concept that could be applied in cases and in terms of how to apply and assess it in practice when dealing with self-neglect.**

a) CTMSB to endorse the Multi-Agency Staff Guidance & Protocol for the Management of Cases of Serious Self-Neglect, supported by the delivery of a programme of multi agency training.

b) Training to be provided to frontline workers on the legal implications of self-neglect, and capacity and knowing the value of seeking legal advice at the point of crisis.

c) Training programme to cover coercive control and how it affects someone's capacity to make choices and protect themselves

**8.7 Recommendation 7: Agencies need to demonstrate robust recording and decision-making practices.**

a) Recording in case records should be structured, analytical, include the rationale for decision-making and include full details of actions taken.

b) Agencies need to routinely quality assure recording practices and address deficiencies where identified.

c) PPNs and referrals that indicate the need for support must be accurately responded to and processed by agencies.

d) If no response is received following a referral for services (excluding PPNs) that matter should be followed up in a timely fashion by the referring agency.

e) In the event of delay or agency disagreement on the course of action to be taken, the relevant escalation policy should be triggered and adhered to.

f) A rational for closing service involvement should be clearly recorded and communicated in advance to partners.

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**8.8 Recommendation 8: Agencies working with vulnerable adults need to cascade the learning from this review via their established learning and development groups, ensuring it is incorporated into their ongoing quality improvement plans. Individual feedback will be provided to the staff involved in Shelly and Mike's cases by their line manager or clinical lead.**

a) A Multi Agency Practitioner Forum to be held with those agencies that contributed to the review.

b) Lessons learnt from the review to be communicated to the MARAC Quality Assurance Group.

c) This recommendation and learning to be communicated to officers across the SWP force area via case study or similar method and quarterly PVP Bulletin.

d) RSPCA to cascade learning from this review and wider information and awareness regarding safeguarding and vulnerable persons, through bi-weekly newsletters, instructions to Inspectors and team meetings.

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