CWM TAF COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW
OVERVIEW REPORT

Report into the death of a 38-year-old woman in May 2018

Shelly

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CONTENTS PAGE

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)

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

1. Preface

The Author and Panel members in this review would like to express their sincere condolences to the family of the victim in this case and hope that the recommendations made herein go some way to preventing a similar set of circumstances arising again.

1.1 This Domestic Homicide Review (DHR) concerns the death of a 38-year-old white woman and resident of Wales, who was found dead in her home in May 2018. Police were informed and attended the address, where the victim's partner was waiting outside. He stated that he had found his partner dead when he awoke in the morning. It was clear to the attending officers that the victim had suffered physical injuries and upon arrival, Emergency Services declared her life extinct.

1.2 To protect the identity of the victim's family, her real name has not been used and the pseudonym Shelly has been chosen by her family, which has been used by the Author throughout the report. In this case there is 1 perpetrator, who has also been provided with the pseudonym, Mike.

1.3 As the investigation unfolded it became clear that Shelly had died from a sustained assault consistent with the use of a fist, foot, knee or some blunt weapon, and Mike was subsequently arrested for her murder and remanded. In December 2018, Mike appeared before the Crown Court, where he was convicted by unanimous verdict of murder and was sentenced to 18 years in prison. Mike, a white man, who was also born and raised in Wales, was 50 years old at the time he was convicted of Shelly's murder.

1.4 This DHR report examines the agency responses and support given to Shelly prior to her death in May 2018. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed by Shelly within the community and whether there were any barriers to her accessing support. By taking a holistic approach the review seeks to prevent a similar set of circumstances from arising again.

2. Introduction

2.1 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 and reviewed in December 2016 . Under this section, a domestic homicide review means a review *"of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by -*

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death"

2.2 Where the definition set out in this paragraph has been met, then a DHR must be undertaken. It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

2.3 All agencies are required to complete an Independent Management Review (IMR) detailing their involvement prior to the incident. Statutory guidance determines that the aim of an IMR is to:

2.4 Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standard, and to identify:

- How those changes will be brought about; and
- Examples of good practice within agencies.

2.5 DHRs 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.

2.6 The Cwm Taf Violence against Women, Domestic Abuse and Sexual Violence Delivery Plan (VAWDASV) has adopted the definitions utilised in the VAWDASV National Strategy to define violence against women, namely all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological, or economic harm or suffering to women, including:

- Threats of such acts;
- Coercion or arbitrary deprivation of liberty; whether
- Occurring in public or in private life.

2.7 This encompasses, but is not limited to:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

2.8 Whilst women and girls are disproportionately affected by domestic abuse, rape and sexual violence, sexual exploitation, modern day slavery, forced marriage, female genital mutilation, child sexual abuse, stalking and sexual harassment, this does not negate the violence and abuse directed towards men, boys and those with alternative gender identities, or violence that may be perpetrated by women.

2.9 References to "violence against women, domestic abuse and sexual violence" or "violence and abuse" should be read to capture all forms of gender based violence, domestic abuse and sexual violence in recognition of the fact that violence and abuse can happen in any relationship regardless of sex, age, ethnicity, gender, sexuality, disability, religion or belief, income, geography or lifestyle.

2.10 Guidance[1] was provided to IMR Authors through local and statutory guidance. Most of the IMR reports were of a good standard, providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt. It was necessary to ask some agencies to provide additional detail and analysis, which they provided to the best of their ability. The Panel identified additional learning above and beyond that identified in the IMRs and made further recommendations which will be adopted by their agencies.

[1] Home Office Guidance 2016 Page 20

3. Timescales

3.1 This review began on the 12/10/2018 and concluded in October 2019. It was agreed at the meeting held on the 12/10/2018 that, considering the ongoing investigation and murder trial, the Panel would not begin its substantive work until the conclusion of criminal proceedings in December 2018.

3.2 It was decided that the review would focus on agencies' involvement with Shelly and Mike from May 2015 to May 2018. The Panel opted for this timeframe, on the basis that it would take account of the range of issues and incidents that prevailed for Shelly and Mike and better illustrate her lived experience. It was also felt that 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.

4. Confidentiality

4.1 The findings of the review are confidential until published. Until then information is available only to Shelly's family, participating officers/professionals and their line managers. Pseudonyms have been used in the report to protect the identity of the individuals involved and their families.

5. Terms of Reference

5.1 The aim of a DHR[2] is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what the 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;
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working;
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

[2] Home Office Guidance 2016 page 6

5.2 With reference to this review, it was identified by the Panel that to do this it needed to focus on:

- Any evidence that agencies' responses to Shelly's alcohol and diazepam misuse resulted in a failure to recognise the level of domestic abuse she was experiencing and created organisational barriers to her receiving the support she required?
- 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?
- Was there any evidence that the anti-social behaviour sometimes exhibited by Shelly negatively and prejudicially impacted on the way agencies and the wider community recognised, perceived and responded to her vulnerability?
- 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?

6. Methodology

6.1 In compliance with Home Office Guidance, Police notified the Chair of the local Community Safety Partnership (CSP) on the 12/06/2018, that Shelly had been fatally injured following an assault at her home address. Her partner, Mike was arrested, remanded and subsequently charged with her murder.

6.2 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 DHR should be undertaken. The Chair of the CSP ratified the decision. The DHR process began with an initial scoping exercise prior to the first Panel meeting. The scoping exercise was completed by the local CSP to identify agencies that had involvement with Shelly and Mike prior to the homicide.

6.3 The Chair of the CSP advised the Home Office on the 20/07/2018 that the circumstances did meet the criteria for a DHR and as such a review should be

conducted under Home Office Guidance as well as guidance from the Community Safety Partnership Board.

6.4 An independent person was appointed to chair the DHR Panel and to write the Overview Report. At the first meeting of the Review Panel on the 12/10/2018, terms of reference were drafted. On the 14/11/2019 the CSP Board approved the final draft version of the Overview Report and its recommendations.

7. Involvement of Family, Friends, Work Colleagues and the Wider Community

7.1 Home Office Guidance[3] requires that:

"Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related Police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

7.2 The 2016 Guidance[4] illustrates the benefits of involving family members, friend and other support networks as:

a) assisting the victim's family with the healing process, which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide;

b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions.

7.3 In this case the Author made contact with the Senior Investigating Officer (SIO) from the Police at an early stage to discuss the investigation, the impact on the family and their likely preparedness to engage with the DHR once initiated.

7.4 The SIO was invited to the first Panel to update members on the investigation and to allow discussions on the appropriateness of the DHR starting before the criminal proceedings had concluded. It was agreed at this meeting that the DHR would not start until after the criminal proceedings had ended to protect the criminal investigation. It was also accepted that Shelly's family were already under considerable pressure because of the trial and it was not reasonable to expect them

[3] Home Office Guidance 2016 page 18
[4] Home Office Guidance 2016 Pages 17 - 18

to cope with the implications of another review at the same time. Letters were sent to family members setting out the process of the review and inviting them to contribute once the trial had concluded.

7.5 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.

7.6 In line with the family's wishes, members of the community were not approached to contribute to the review and when the Author talked about the possibility of visiting Mike in prison, Shelly's step-mother was surprised and expressed concern for the Author's safety, also suggesting that Mike might try and manipulate her. When it was explained why the Author would visit and under what conditions, Shelly's stepmother could understand why and noted that she would like to ask Mike why he had done it. The Author agreed to inform the family if she visited Mike.

7.7 The family also sought and were provided with reassurances that they would be able to review the draft report in private and with plenty of time to do so and could comment and make amendments if required. As agreed once complete, the Author visited the family with the draft report, and over two visits that occurred on consecutive days, took them though the Report and Action Plan and answered their questions.

7.8 Shelly's step-mother was very concerned that the Executive Summary should not contain real names or photos of Shelly, as Shelly's step-mother explained that the local media had used photos specifically against their wishes, which they had found distressing. The Author guaranteed that this would not happen.

7.9 The first home visit involved Shelly's father and step-mother and took place on the 27/2/2019 and was attended by the Family Liaison Officer (FLO) at the couple's request. It was clear that the views of the FLO were very important to them, and they clearly trusted her opinion and deferred to her a few times, seeking her agreement on what they were saying. The relevant Home Office DHR leaflet was provided, along with leaflets from AAFDA.

7.10 The couple seemed uncertain initially about what the purpose or eventual benefit of the DHR might be, and Shelly's father was concerned that the DHR had no real power. He admitted that he was sceptical about the benefits of any wider agency learning that might come out relating to contributing agencies (who as far as they knew had had no involvement with Shelly because she would not engage with them); although they mentioned that her GP had tried to help her and had been supportive. The Author explained that the information provided by agencies would help the Panel to reflect on their involvement and help identify learning and what, if anything, might have been done differently. The Author reiterated that the DHR was not set up to apportion blame; the Courts had already determined that, when they found Mike guilty and sentenced him to 18 years.

7.11 Shelly's father was consistent that his primary focus was whether the Panel members could ensure that the Police were given more powers to arrest people abusing their partners (which he thought might need a change in the law). Shelly's father explained that police officers had told him that there was only so much that they could do to help Shelly because she would not make a complaint against Mike, and cited the number of times police had been called to the address and had seen Shelly with injuries; something he was clearly struggling to understand. Shelly's father asked whether he was the only person saying this and queried why other people had not asked for this before.

7.12 Shelly's father was clear that in respect of the IOPC investigation underway, he was not interested in blaming anyone, he just wanted the Police to have better powers to stop abuse from escalating and to remove people from an address when it was obvious that an assault had taken place or might.

7.13 The Author explained which agencies sat on the Panel and why, and that the terms of reference would focus the review on some key areas in the case; the use of existing legislation and the need for new legislation being areas the Panel would look at. Shelly's father seemed reassured by this and by the end of the visit recognised that any other identified learning was also important. The Author gave Shelly's parents the chance to meet with the Panel (formally or informally), but their initial reaction was that this was not something they would want, and they were reminded that they could change their mind about this at any point. The Author also encouraged them to think about how and when they might want the Author to keep in touch with them about the Review progress and recommended that they think about involving AAFDA, who would be a good support to them.

7.14 The couple clearly had some experience and insight into the impact of domestic abuse and described people they knew who had suffered it. Shelly's step-mother had also been watching television programmes about domestic abuse and when a discussion was held about why it might have been so hard for Shelly to leave Mike; they both evidenced some understanding of the effects it has on victims and their self-esteem. When the Author mentioned coercive-control, Shelly's step-mother had heard of this and described Shelly sitting on her sofa the Wednesday before her death, still refusing to say anything against Mike because she loved him. Shelly's step-mother described Mike as being very nice at the beginning of the relationship, but that this had not lasted long. When the Author asked Shelly's step-mother if she would be prepared to meet with her to share her insights into Shelly and Mike's relationship, she agreed. Shelly's step-mother told the Author that while Shelly was not her birth daughter, she had loved her and treated her like she was. Shelly's step-mother thought it unlikely that Shelly's father would want to be involved in any further meetings.

7.15 By the end of the visit, the Author had explained the purpose of the review, her role as the Chair and Reviewer and the publication process in some detail; and why the Panel wanted their contribution. The family made the decision following discussions with the Author that they did not want the help of a specialist and expert advocate. The family also indicated that whilst they were happy to receive regular communications from the Author, they did not want to meet with the Panel; a decision they understood they could change their mind about at any time.

7.16 The second home visit took place on the 27/3/2019 and was attended by Shelly's step-mother only. On arrival, Shelly's step-mother explained that Shelly's house had just been sold, which she had mixed feelings about, as it felt like the final severing of ties with Shelly.

7.17 During the visit Shelly's step-mother talked about feeling guilty for what happened, which the Author suggested was a natural, if misplaced, reaction, but she persisted with the view that the family had known what was happening and could have done more to stop it. Shelly's step-mother talked with considerable insight into how Shelly's death had negatively impacted on different family members.

7.18 To assist with her recall, the Author had prepared some questions for Shelly's step-mother to consider and the information she provided has been included in the chronology and analysis section of the Report.

8. Contributors to the Review

8.1 The following agencies were requested to prepare chronologies of their involvement with Shelly and Mike and to carry out Individual Management Reviews:

- South Wales Police
- Health, including both Primary Care and Secondary Health Care
- Safer Merthyr Tydfil - Domestic Abuse Resource Centre and Independent Domestic Violence Advocates
- Adult Services Merthyr - Mental Health Services and Adult Protection
- Wales Community Rehabilitation Company
- National Probation Service
- HM Prison Service - Eastwood Park
- Public Protection and Housing Merthyr - ASB Team
- Welsh Ambulance Services NHS Trust
- Royal Society for the Protection of Animals

8.2 Reports were requested from the Department for Work and Pensions and the Post Office, but these were not forthcoming. Letters were sent to both and no response was received. They were also contacted by telephone by the Safeguarding Board Administration Officer, Mrs L Morgan with no success. Mrs Morgan did manage to get through to someone in the DWP several times and requested to speak to a manager, but despite being told that someone would return her calls, no-one ever did. Mrs Morgan was only ever able to access an automated service when she contacted the Post Office and was unable to source the assistance she needed.

8.4 Mike was also written to by the Chair of the Review Panel, and the purpose of the DHR was also explained and discussed with him by his Offender Manager. Mike was given the opportunity to contribute to the review in the manner of his choosing (interview or written response to questions) but declined the offer to engage with the process.

9. The Review Panel Members

9.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

9.2 Mrs Clark chaired the Panel, which met nine times. The members of the Panel and their professional responsibilities are as follows:

Mrs Julie Clark (Chair)	Head of Children's Safeguarding RCT County Borough Council
Mr Paul Mee	Director, Public Health & Protection & Community Services, RCT County Borough Council
Ms Deborah Evans	Cwm Taf Regional Advisor Violence Against Women, Domestic Abuse and Sexual Violence
Mrs Nicola Mahoney	Chief Executive Officer, Safer Merthyr Tydfil
Ms Beth Aynsley	Independent Protecting Vulnerable Persons Manager, South Wales Police
Mrs Cheryl Emery	Housing Options, Homelessness & Supporting People Manager RCT County Borough Council
Mrs Louise Mann	Head of Safeguarding, Cwm Taf Morgannwg University Health Board
Mr Jon Eyre	Safeguarding Principal Manager, Merthyr County Borough Council
Mrs Fiona Davies	Welsh Ambulance Services NHS Trust
Mrs Amanda Lewis	Deputy Local Delivery Unit Head, National Probation Service
Mr Paul Lewis	Head of Protection and Safety Services, Merthyr Tydfil County Borough Council
Mr David Bebb	Wales Community Rehabilitation Company (CRC)

9.3 Barod (Welsh for Ready), a third sector substance misuse service who provide a range of services to those who are vulnerable and marginalised as the result of their own or someone else's drug and/or alcohol use, were also invited to attend the Panel to provide specialist advice, which they did. BAROD were also involved in finalising the report and Action Plan.

9.4 Mrs Clark chaired all the meetings of the Panel. The business of the Panel was conducted in an open and thorough manner and the meetings lacked defensiveness. The Panel also sought to identify lessons and recommend appropriate actions, to ensure that better outcomes for vulnerable people in circumstances like Shelly's were more likely to occur as a result of the review having been undertaken.

9.5 The Panel was supported by the Safeguarding Board Administration Officer, Mrs Leah Morgan and legal advice was provided by Ms Cara Miles, Solicitor.

10. Independent Chair and Author of the Overview Report

10.1 Home Office Guidance[5] requires that;

"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on evidence the review panel decides is relevant," and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

10.2 The CSP decided in this case to use Mrs Julie Clark, an independent Chair and Author, who, prior to this review process, had no involvement either directly or indirectly with the members of the family concerned or in the delivery or management of services by any of the agencies involved. Neither is Mrs Clark a member of the CSP.

10.3 Mrs Clark has been qualified as a social worker and practice teacher for over 25 years, and has an MSC Econ in Applied Social Studies and a Master's degree in Public Services Management, in addition to a Diploma in Social Work qualification and BA Hons in Psychology. Mrs Clark has been employed as a senior officer with RCT Council for over 8 years, and has extensive experience as a practitioner and manager, having worked in both children's and adult safeguarding. The Author is jointly trained and has considerable experience of undertaking complex safeguarding investigations.

[5] Home Office Guidance 2016 page 12

10.4 Mrs Clark has throughout her career worked with service users experiencing substance misuse and / or domestic abuse (including perpetrators) and has designed and delivered risk management strategies in response. Mrs Clark has in her management capacity, developed policy and procedures in response and contributed towards service design in these areas. Throughout her career Mrs Clark has undertaken suitably relevant training courses to enable her practice to remain professionally current. In addition, the Author has over 10 years' experience in contributing to Serious Case Reviews, Child Practice Reviews, Adult Practice Reviews and more recently DHRs.

11. Parallel Reviews

11.1 The Coroner's Inquest was opened in early June 2018 and adjourned as there was a criminal investigation ongoing. Following the end of the criminal trial, the Coroner received notification from the Crown Prosecution Service that Mike had been found guilty and sentenced for the relevant crime against Shelly. The Coroner determined that as all the evidence had been heard, he was not required to hear the inquest.

11.2 The DHR commenced following the conclusion of the criminal proceedings, the Panel having agreed that it would not begin its work until then.

11.3 An independent investigation was also undertaken by the Independent Office for Police Conduct (IOPC) following a self-referral from South Wales Police in May 2018, made because officers had had contact with Shelly and Mike on the day of Shelly'S death. The investigation concluded that no police officer had committed a criminal offence or behaved in a manner that would justify the bringing of disciplinary proceedings.

12. Equality and Diversity

12.1 Home Office Guidance[6] requires consideration of individual needs and specifically: *'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'*

[6] Home Office Guidance 2016 page 36

12.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

12.3 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The review gave due consideration to all the Protected Characteristics under the Act.

12.4 Whilst Shelly had been disabled by a violent assault in 2009, which left her blind in one eye and for which she claimed benefits, this did not appear to have affected her normal day-to-day activities. Shelly also had full access to services if she chose, and there is no evidence that services discriminated against her in contravention of the Equality Act 2010.

13. Dissemination

Julie Clark	Head of Children's Safeguarding RCT County Borough Council
Paul Mee	Director, Public Health & Protection & Community Services, RCT County Borough Council
Deborah Evans	Cwm Taf Regional Advisor Violence Against Women, Domestic Abuse and Sexual Violence
Nicola Mahoney	Chief Executive Officer, Safer Merthyr Tydfil
Beth Aynsley	Independent Protecting Vulnerable Persons Manager, South Wales Police
Cheryl Emery	Housing Options, Homelessness & Supporting People Manager RCT County Borough Council
Louise Mann	Head of Safeguarding, Cwm Taf Morgannwg University Health Board
Jon Eyre	Safeguarding Principal Manager, Merthyr County Borough Council
Fiona Davies	Welsh Ambulance Services NHS Trust

Eirian Evans	Assistant Chief Officer National Probation
Paul Lewis	Head of Protection and Safety Services, Merthyr Tydfil County Borough Council
Natalie Bevan	Wales Community Rehabilitation Company (CRC)
Cara Miles	Legal Services Merthyr Tydfil County Borough Council

Her Majesty Prison Eastwood Park

Royal Society for the Prevention of Cruelty to Animals (RSPCA)

Cwm Taf Morgannwg Safeguarding Board Members

The report will be published on the Cwm Taf Morgannwg Safeguarding Board's website WWW.CTMSB.CO.UK

14. Background Information (The facts)

14.1 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.

14.2 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.

14.3 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.

14.4 In May 2018, Mike contacted Police to report finding Shelly dead on the sofa when he awoke that morning, maintaining that she had been alive when he went to sleep. Considering the visible injuries observed on Shelly's body by attending emergency services, Mike was arrested, and a murder investigation initiated.

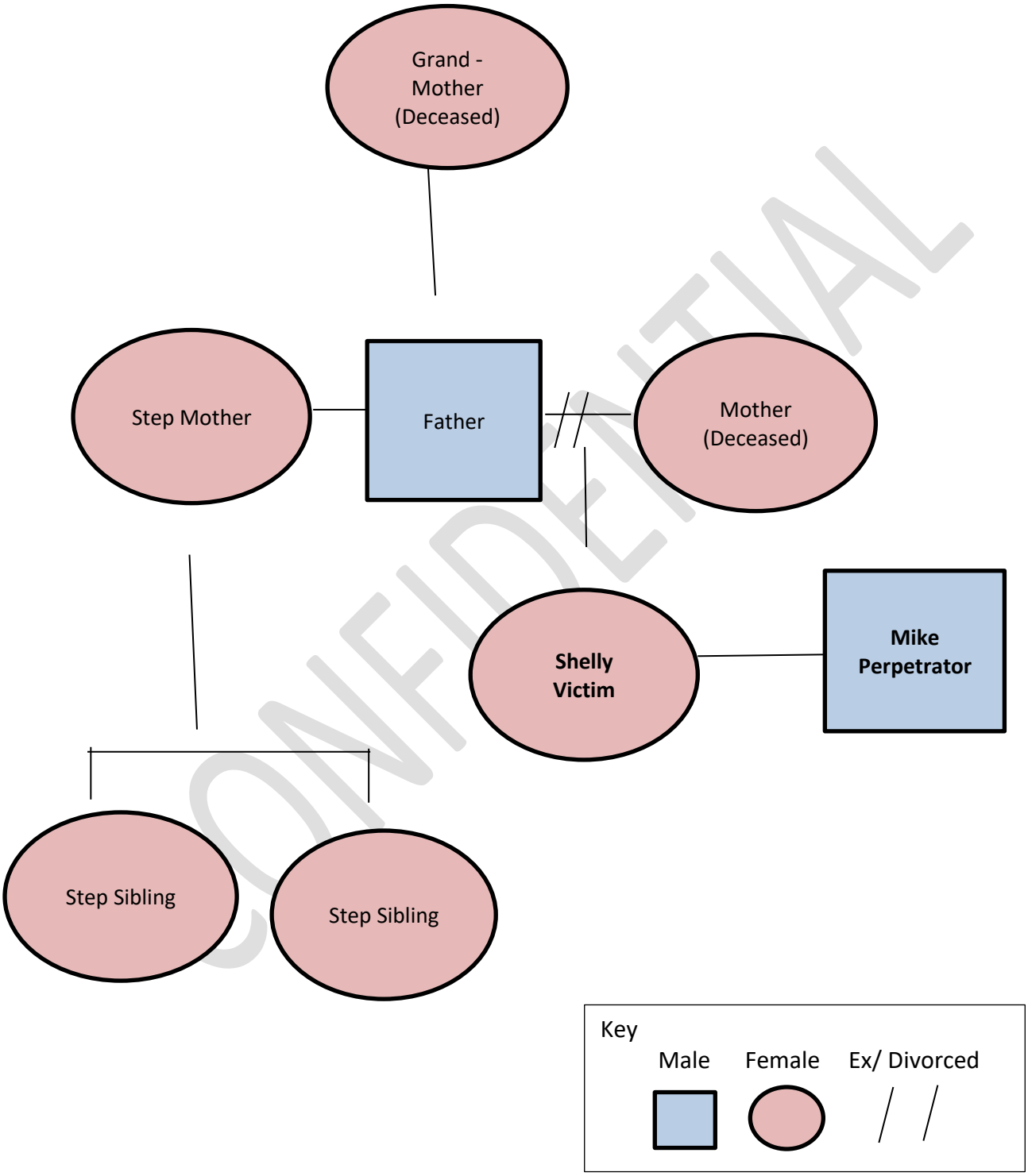
14.5 Despite Mike's initial assertion that Shelly must have been killed by falling down the stairs, the Forensic Pathologist was clear that her fifty external injuries, twenty-eight rib fractures, fractured skull, major chest injury resulting in heart and lung damage,

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.

14.6 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.

14.7 Mike was subsequently charged with Shelly's murder and remanded into custody. A trial date was set for December 2018. During the trial the jury was not persuaded by Mike's defence that Shelly had died at the hands of an unknown assailant who had entered the home during the night and found him guilty by unanimous verdict of murder. He was sentenced to 18 years in prison.

15 **Genogram**



16. Chronology

16.1 Prior to May 2015

16.2 Shelly's parents split up when she was three years old and following their divorce Shelly spent a lot of time at her father and step-mother's home growing up.

16.3 Shelly was described as a challenging teenager at times and her mother threw her out on a few occasions, which resulted in her father putting her up in a flat (which didn't work out for them). Shelly's paternal aunt was identified as being very good with Shelly and tried to help when her partying and drinking got out of hand.

16.4 When Shelly was 22 years old, her mother died of Cirrhosis of the liver and Shelly was bequeathed her house to live in, mortgage and rent free.

16.5 Shelly would not allow family members into her house and rarely visited them unless she was in trouble. However, she visited her grandmother every day and this was often where Shelly's step-mother would see her. By 2014, Shelly's demands on her grandmother became too much for her and family had to intervene to help, as Shelly had physically assaulted her grandmother when she would not give her money.

16.6 Prior to meeting Mike, Shelly's step-mother recalled her having two relationships lasting four years and two years respectively. She recalled that both men 'liked a drink', but Shelly's step-mother considered them 'positive' individuals and she had no knowledge of domestic abuse in the relationships.

16.7 The Panel became aware from the Police IMR that Shelly had experienced abuse in a relationship between 2010 and 2013. It was unclear whether Shelly and the individual were in fact in a relationship, as he was sometimes referred to as her friend. Police clearly suspected a relationship and as such submitted PPD1s (precursor to the PPN) when incidents were reported. These were, in the main, verbal arguments and on attendance both Shelly and the individual were observed to be intoxicated. On a few occasions, Shelly reported an assault and then denied this when officers attended. This male was convicted of a common assault against Shelly in 2012.

16.8 The Police IMR also identified other incidents that occurred between Shelly and another male in 2015 and 2016, who Shelly had on one occasion described as her ex-

boyfriend. However, it is recorded that it was later established that they had never been in a relationship.

17. May 2015

17.1 On the 30/05/2015 Shelly reported to Police that her parents would not give her the deeds to her house and the following day her niece reported that Shelly was verbally abusive towards her (Shelly's) step-mother and grandmother. No further details were disclosed regarding the alleged abuse. All parties were spoken to and it was determined that the argument over the deeds was a civil dispute. A PPN was submitted appropriately for Shelly's grandmother and the incident was dealt with in accordance with South Wales Police policies and procedures.

18. June 2015

18.1 Shelly attended at a neighbour's house on the 7/6/2015 and asked them to contact the police. She had marks on her elbow. Police attended and spoke to Shelly and her partner Mike. It was established that there had been a verbal dispute over alcohol and Shelly stated she hadn't been assaulted. A PPN was submitted and risk assessed as medium which was appropriate as this was the first reported incident between the couple. The IDVA service was notified and efforts were made to contact Shelly, but her number was out of order and it was deemed unsafe to send a letter to the home address.

18.2 On the 13/06/2015 a member of the public reported to the Police that they could hear a female in Shelly's address shouting 'get off me,' and this had been going on for some time. The caller was not sure if the female was vulnerable. Police attended and Shelly and Mike were in bed, and there was no domestic apparent.

18.3 Shelly reported to Police on the 19/6/15 that she had been assaulted by a male known to her, but not her partner. Shelly had a black eye, bruising to her right side and a small laceration to her hand. Whilst at the address officers noted that the property was in a poor state of repair. The male was interviewed and denied the offence. Mike was also spoken with and stated he had not witnessed any assault and provided a negative statement. Shelly later withdrew her complaint and due to the lack of evidence the matter was finalised.

18.4 On the 23/06/2015 a member of the public reported a violent domestic to the Police at Shelly's address as a female was shouting 'get off'. Police attended and spoke with the informant who stated that he had made a mistake and that the noise was the couple having sex. Shelly and her partner were spoken to and both were safe and well. Details of the partner were not obtained by the attending officers, so the review cannot assume that this was Mike.

18.5 A member of the public reported to Police on the 27/06/2015 that there was screaming coming from Shelly's address and a female was shouting 'ow ow'. On the 28/06/2015, Police received another report from the public that they could hear a female in Shelly's address shouting 'get off me, help.' On both occasions, Police attended and spoke to Shelly and Mike. They denied that there had been a domestic and PPN's were not submitted, as there was insufficient evidence to suggest that an altercation had taken place.

19. <u>July 2015</u>

19.1 Shelly contacted the Police on the 5/7/2015 to report that her boyfriend Mike was beating her up. Police attended and Shelly stated he had hit her and was upstairs. Mike admitted slapping Shelly and he was arrested. Shelly stated that she didn't want him arrested and would not provide a statement or agree to be medically examined. Mike was interviewed and admitted the offence. He was charged and received 6 weeks imprisonment.

19.2 Even though Shelly did not, on this occasion, feel that she could support a prosecution, officers continued with the investigation and a positive conviction was secured at Court. The PPN was shared with the local specialist domestic abuse agency for support to be offered to Shelly.

20. <u>August 2015</u>

20.1 On the 3/8/2015 Shelly was admitted to hospital with a history of collapse, drinking alcohol and taking diazepam. She was reported to be intoxicated on admission and claiming to be 8 weeks pregnant; which was not positive on testing. Shelly was admitted for 24-hour observation. Mike was named as her partner and next of kin in hospital documentation. Shelly was subsequently discharged on the 4/8/2015.

20.2 During her admission, the Management of Acute Alcohol Withdrawal Pathway was initiated, but not carried through to its conclusion. Pabrinex was given, which is the trade name for an injection that contains Vitamin B and C. Pabrinex is used in

patients with alcohol dependency to prevent the development of Wernicke's encephalopathy, which is a serious problem affecting memory, caused by a lack of these vitamins. Treatment should be commenced early and is usually administered for three days. A referral to the Mental Health Crisis Team was also made as per pathway. However, Shelly was not seen, as the treating physician felt she had capacity and was not expressing suicidal thoughts; although it is unclear whether this was formally assessed. There is no evidence of the completion of an alcohol screening tool or alcohol history being taken, which may have provided a greater understanding of Shelly's capacity and social circumstances. There was also no evidence of discussion around sexual health or a referral to substance misuse agencies on discharge.

20.3 Shelly attended her GP Practice on the 11/08/2015 with Mike, requesting diazepam as she reported she was not sleeping and drinking 1 litre of cider per day. Shelly refused a referral to the Drug & Alcohol Team during the consultation. Shelly was prescribed diazepam 5 mgs to keep her calm (fourteen tablets given) and was advised to reduce her alcohol intake and return if experiencing problems. There is no evidence in the record of exploration of any underlying issues and Shelly's mental capacity was assumed by the GP.

20.4 On the 19/8/2015 a member of the public reported to the Police a disturbance coming from Shelly's address. Officers attended and noted that Shelly and Mike were intoxicated, Shelly also had bruising to her eyes and dried blood to her mouth. Shelly stated she had fallen over the dog and down the stairs. Shelly was persuaded to attend the hospital and once in the police car outside the address, disclosed that she had in fact been assaulted by Mike. Shelly was taken back to the premises for Mike to be arrested. Shelly then refused medical assistance and reverted to her original account that she had fallen down the stairs. Shelly also refused to be photographed. Mike was interviewed and denied the offence.

20.5 On the 19/8/2015 Shelly requested further diazepam from her GP and was prescribed 5mg, one or two tablets to be taken at night. Fourteen tablets were provided and Shelly was advised that no further prescription would be offered to her 'beyond this week' as only eight days had expired since the last fourteen day prescription had been dispensed; albeit the fourteen diazepam tablets were requested and provided without any exploration of Shelly's underlying issues.

20.6 During the rest of August 2015, the IDVA service attempted telephone and written contact with Shelly and on the 20/8/15, Mike was seen by his Integrated Offender Interventions Service arrest referral worker (IOIS), following his assault on Shelly. Relative harm minimisation advice was provided in custody, which provided continuity of care and he was offered an appointment with IOIS on the 24/8/2015. Mike failed to attend his appointment on time and had to be issued another appointment for the 02/09/2015. Mike's Offender Manager was informed.

21. <u>September 2015</u>

21.1 On the 2/9/2015 Shelly contacted the Police to complain that she had not been allowed to visit her grandmother, as her step-mother had refused her entry. When Police attended. Shelly's step-mother stated that Shelly was welcome at the house and no concerns were raised.

21.2 A MARAC discussion on Shelly was held on the 3/9/2015, as a result of the incident on the 19/08/2015. During the meeting, the Police were actioned to make contact with Drug Aid (the contracted service for drug and alcohol service users before DYFODAL), presumably to seek support for Shelly. This was completed by the Police, who recorded that Drug Aid had stated that as neither party were known to them, they would not make contact. Drug Aid have no record of receiving this contact and are clear that such an approach was not established practice at that time or subsequently.

21.3 On the 04/09/2015 the IDVA service tried to ring Shelly on the new number given to them by the Police, but this went straight to answerphone.

21.4 On the 08/09/2015 IOIS made an appointment with Mike via post for the 14/09/2015, which he failed to attend.

21.5 Shelly's step-sister contacted the Police on the 29/9/2015, reporting that Shelly had approached her in the street and screamed at her. Police spoke to the reporting person and she did not perceive Shelly's words as a threat and it was agreed for a Police Information Notice (PIN) to be served on Shelly. A PPN was submitted and shared and the incident was dealt with in accordance with Police policies and procedures.

22. October 2015

22.1 On the 01/10/2015 Shelly contacted the Police to report that she had been assaulted by her aunt but refused to assist Police with the investigation. Shelly's aunt was spoken to and stated that Shelly had turned up at her address intoxicated and she refused her entry. No offences were disclosed.

22.2 Mike failed to attend a pre-arranged appointment with IOIS on the 5/10/2015 and another appointment was sent out for the 13/10/2015, by which point Mike was in custody.

22.3 On the 12/10/2015 the IDVA service made contact with Shelly and support was refused.

23. November 2015

23.1 On the 23/11/2015 IOIS was informed by Mike's Offender Manager that he was in breach of his Alcohol Treatment Requirement (ATR).

23.2 The Police were contacted by a member of the public on the 26/11/2015, as they could hear screaming and someone shouting 'stop' coming from Shelly's address. Police attended and both Shelly and Mike were heavily intoxicated but denied arguing. Mike was removed from the premises to prevent a further breach of the peace and taken to a friend's address. The reporting person was spoken with to establish exactly what they had seen or heard but they could only provide evidence of a verbal argument. A PPN was submitted and risk assessed as high by PPU staff.

24. December 2015 and January 2016

24.1 During early December 2015, following the most recent domestic incident, the IDVA service made two further attempts to contact Shelly and offer support, eventually leaving their contact details with one of Shelly's relatives.

24.2 On the 11/12/2015 a member of the public reported to the Police that they could hear Shelly shouting 'help, help, get off'. It was believed her partner had just come out of prison. Police attended and all was quiet on arrival. Shelly stated she was fine and that the dog had jumped on the bed and she was shouting at it. Mike was conveyed to his home address as a precaution and a PPN was submitted.

24.3 A PPN was received by the IDVA service on the 17/12/2015 and when they managed to speak to Shelly, she demanded that they stop ringing her because she was not being abused. Nevertheless, a letter was sent offering support on the 19/01/2016.

25. <u>February 2016</u>

25.1 A member of the public contacted Police on the 10/2/2016 stating that they could hear Shelly screaming for help from inside her address, and that Mike was also screaming and shouting at her. Police attended and both were intoxicated. Shelly was laughing and stated she fell over the dog. The couple were told to calm down but refused. Mike was arrested to prevent a breach of the peace and because he was wanted on warrant, he appeared before the Court. A PPN was submitted for Shelly due to her substance misuse, however as she did not provide consent, the PPN was not shared with partner agencies.

25.2 On the 19/02/2016 the IDVA service closed Shelly's case as they had received no response to their letter offering her support.

26. <u>March 2016</u>

26.1 A relative of Shelly contacted the Police on the 1/3/2016 to state that she had seen Shelly and Mike in the street, and she had told Mike to keep his hands-off Shelly and stop using her as a 'human punch ball'. The relative had felt intimidated by his response and was spoken to by officers, and provided reassurances that she had not been harassed, alarmed or distressed and just wanted Mike spoken with. Mike was spoken to and suitably advised.

26.2 On the 15/3/2016 Shelly reported to Police that she had been slapped across the face by her ex-partner, who it was later established was not in fact an ex-partner. Mike was present in the house at the time of the alleged assault. Police attended and arrested the male for common assault; Mike would not provide any information. The male was interviewed and responded 'no comment' to all questions. Shelly subsequently withdrew her complaint and as it was established that as they were not ex-partners, a PPN was not completed.

27. <u>April 2016</u>

27.1 A member of the public reported to Police on the 2/4/2016 that Shelly had approached her and asked for money and was given £4. The reporting person and a neighbour were spoken to by Police and both confirmed that Shelly had asked them

for money. An Anti-Social Behaviour (ASB) referral was submitted and Shelly was served with a Police Information Notice (PIN).

27.2 On the 6/4/2016 Shelly rang the police; she was intoxicated, and stated Mike had taken the dog and she wanted it back. Police attended, but Shelly had no recollection of ringing them, stating that the dog had run off and she couldn't find it, although the dog was present in the property. No allegation of assault was made, and the incident was dealt with in accordance with Police policies and procedures.

27.3 A member of the public reported to Police on the 7/4/2016 that Shelly was asking her mother, who resided in sheltered accommodation, for money, and that her mother was scared of Shelly. It was reported that Shelly was asking residents for money, and that this was a common occurrence. Police attended and liaised with the housing provider for the complex, who confirmed they were willing to seek a Civil Injunction to prevent Shelly attending the complex. Police issued Shelly with a Community Protection Notice (CPN) letter, and Shelly advised that she was begging because she spent all her money on alcohol. As a result of her disclosure, the Police made a referral to Drug Aid for Shelly, to offer support to help her address what she disclosed to be the cause of her begging behaviour.

27.4 On the 13/4/2016 an anonymous caller reported that there were a group of boys in Shelly's house, and she was heard to say, 'please get off me, get out of my house'. Police attended and Shelly was observed safe and well and denied any disturbance. The house was searched, and no other person was present.

27.5 On the 24/04/2016 the Police were contacted by three members of the public, expressing concerns about Shelly. One reported that Shelly had asked her children to go to her house. She was concerned as Shelly and her partner Mike were ‘alcoholics.’ Police attended and advised Shelly regarding her behaviour. The other caller reported to the Police that Shelly had asked her 6-year-old son for cigarettes. The caller was concerned for Shelly's welfare and was aware that she had an alcohol problem. The reporting person was spoken to and the concerns regarding Shelly’s alcohol use were noted and a PPN submitted and shared with Drug Aid for their information and action.

27.6 The third caller reported that Shelly was knocking doors at the sheltered accommodation complex asking for money. This was a third-party report and the

person was unwilling to speak to the police. The Neighbourhood Policing Team (NPT) officer liaised with the Council and it was ascertained that the correct procedure for the CPN letter to Shelly had not been followed previously, which was rectified.

27.7 Information was also passed to Police on the 25/4/2016 that residents had been heard in a pub talking about Shelly's begging and that a meeting was going to be planned. On the same date, a member of the public also reported to Police that Shelly was calling at her house asking for money, and that a neighbour had told her Shelly had been seen trying her door recently. The reporting person did not want the police to attend the address and was advised to report any further incidents. Shelly was spoken to and suitably advised.

27.8 On the 28/4/2016 a member of the public reported concerns for Shelly to Police, as she had seen her with lots of cuts and bruises and blood coming from an ear. Police attended and spoke to Shelly, who reported that she had fallen while walking the dog. Shelly declined an ambulance or lift to the hospital. A PPN was submitted on a vulnerable adult basis, but not shared as consent had been refused.

27.9 On the 30/4/2016 a member of the public reported to Police that they had seen a comment on Facebook that a person had been walking past Shelly's address and had heard Mike bragging with other males that he had 'knocked' Shelly out and she was in a terrible state. Police attended Shelly's address, where she was alone, and Shelly reiterated that she had sustained her injuries from having fallen with her dog previously. Shelly stated that the call was malicious, and no offences were evident, however a PPN was submitted asking for the IDVA Service to make contact with Shelly.

28. <u>May 2016</u>

28.1 On the 03/05/2016 Shelly presented at her GP's with a Haematoma to her right pinna (ear), reporting that she had been knocked over a wall by her dog one week earlier. Shelly was requested to attend hospital for an urgent ENT assessment, but the injury explanation was not explored. Shelly subsequently made a 999 call to the Police as she wanted transport to the hospital and WAST arranged a taxi for her – although there is no recorded evidence that Shelly attended the hospital on this occasion.

28.2 A member of the public reported to Police on the 04/05/2016 that Shelly was getting beaten up in the street and was screaming for help. Police attended and spoke with the witnesses, who stated they saw Mike gripping Shelly around the throat and

throwing her to the floor, telling her that he would kill her. The witness believed Mike was going to kill Shelly. Shelly refused to make a complaint however Mike was arrested and replied 'no comment' in interview. There is no evidence of the PPN being shared with the GP by the Cwm Taf Multi-Agency Safeguarding Hub (MASH) Health representative. This incident was subject to a DV daily discussion in the MASH on the 11/05/2016 and was discussed in a MARAC on the 26/05/2016. No further action was taken by A&E.

28.3 On the 5/5/2016 members of the public contacted Police concerned for Shelly, as she was begging for money and had nasty looking injuries. It was established that the injuries were as a result of the assault the previous night by Mike. Shelly refused medical attention.

28.4 Shelly was admitted to her local A&E on the 6/5/2016 and was transferred for an ENT specialist opinion, complaining of swelling to the right ear. Shelly had a haematoma and developed a large abscess. The abscess was drained, and Shelly was given antibiotics. Shelly disclosed a history of being punched by her partner to the right side of the face and ear ten days prior to admission. The perpetrator was not named. Shelly reported having attended her GP Practice 3 days after the incident, where she was requested to attend Hospital, but did not until the 06/05/2016.

28.5 On the 09/05/2016 Shelly attended her GP practice for wound dressing. Purulent discharge from her ear was noted, extreme swelling and inflammation.

28.6 On the 10/05/2016 the IDVA service rang all four numbers they had for Shelly but had no response.

28.7 Members of the public contacted the Police on the 16/5/2016 to report that Shelly was calling at their homes asking for money. During this period, the sheltered housing accommodation provider was seeking a Civil Injunction against Shelly and she had been issued with a CPN letter. If this was breached Shelly would be issued with a Community Protection Notice, and after that, an application for a Criminal Behaviour Order could be sought.

28.8 On the 17/05/2016, Mike appeared at Court for an offence of Common Assault against Shelly. No report was ordered, but the Probation Service Officer at Court

noted that whilst Shelly had declined to support the prosecution on this occasion, there were two independent witnesses. Shelly was identified as a repeat victim of Mike, who would not engage with the relevant agencies (Domestic Abuse Resource Team DART) nor accept a Restraining Order. Mike was sentenced to twelve weeks custody and his case allocated to CRC.

28.9 As noted earlier, on the 26/05/2016 a MARAC was held.

28.10 The IDVA Service wrote to Shelly on the 27/05/206 offering support but received no response.

28.11 On the 31/05/2016, Mike's case was re-assessed by the Wales Community Rehabilitation Company (CRC) and transferred to the National Probation Service (NPS).

28.12 Shelly attended her GP Practice on the 31/5/2016 and reported that her partner had been imprisoned and that she was worried about her grandmother. Shelly was complaining of abdominal pain. The GP suggested anti-depressants, but Shelly requested the continuation of diazepam and a prescription was issued.

28.13 Shelly rang the Police on the 31/5/2016 to report that she was being harassed by a male, who had allegedly tried to run her over several times. Police attended and spoke with Shelly, but she was abusive and refused to co-operate. Further numerous attempts were made to contact Shelly with no success.

29. <u>June 2016</u>

29.1 Shelly rang the Police on the 2/6/2016 and reported that she had attended at her grandmother's house and her father had refused her entry. Police spoke with Shelly who was intoxicated. It transpired that she had been to her grandmother's house numerous times that day causing problems. Given that her grandmother was terminally ill she was advised to stay away.

29.2 On the 7/6/2016 a member of the public reported to the Police that her son had been a witness to an assault upon Shelly a few weeks prior and that Shelly was now threatening him that 'when Mike comes out and finds out it was you, he'll have you'. Police attended and spoke with the reporting person, but it was established that no

direct threats had been made, they just wanted Shelly spoken to. Shelly was warned about her behaviour and issued with a PIN, which she refused to sign.

29.3 One of Shelly's relatives contacted the Police on the 17/6/2016 stating that she was having problems with Shelly, and she was concerned as her mother was terminally ill and due out of hospital soon. Shelly also rang the Police alleging that her relative had threatened to assault her. Both parties were spoken to and Shelly stated that she had been refused entry into her grandmother's home while intoxicated and she was unhappy with this. Shelly was warned regarding her behaviour and advised not to attend at the address intoxicated.

29.4 Shelly attended her GP Practice on the 21/6/2016 and reported that her grandmother had died. Shelly advised that she was not ready to come off diazepam and a prescription was re-issued.

29.5 On the 26/6/2016 a relative of Shelly's contacted the Police to report that Shelly was still causing problems and was not welcome at her grandmother's funeral. Police spoke with both parties and a PPN was submitted. On the 27/6/16 Shelly contacted Police to say she had been assaulted by the same relative, which was investigated and not supported by witnesses. Another PPN was submitted and both incidents were dealt with in accordance with Police policies and procedures.

30. <u>July 2016</u>

30.1 On the 4/7/2016, Mike was released from prison and attended his induction appointment with NPS, having been sourced an address to reside at in the local area. Mike was observed to be obstructive, complaining that he had not been allowed to reside at Shelly's address. Mike also complained about the period of post sentence supervision that he would be subject to. Mike was provided a further appointment to report on the 7/7/2016.

30.2 On the same date, a member of the public reported that Shelly was knocking on people's doors asking for money. Shelly was spoken to and denied begging but was served with a new CPN.

30.3 Shelly's step-mother contacted the Police on the 5/7/2016 to report that Shelly had insulted another family member as she passed them in the street. The alleged victim

was spoken to by the Police and acknowledged that Shelly had difficulties and they did not want any Police action taken. A PPN was submitted as a vulnerable adult concern in relation to Shelly, but was not shared with partner agencies.

30.4 On the 6/7/2016 Shelly attended her GP Practice, requesting that medication and diazepam is re-issued (twenty-eight tablets). Shelly was also advised that she would be removed from the GP practice if she continued to be rude to staff.

30.5 Mike failed to attend his planned NPS appointment on the 7/7/2016 and a warning letter was sent for him to attend on the 14/7/2016.

30.6 Police received intelligence on the 8/7/2016 that Mike had been released on licence until the 15th August 2016, with conditions not to seek or approach Shelly and not to enter the previous area he lived in.

30.7 Shelly requested a further prescription for diazepam on the 12/7/2016, advising her GP that she had not received the previous script issued on 06/07/16 - although this had been dispensed. The GP expressed concern that twenty-eight tablets have been taken in six days and Shelly's request was refused.

30.8 On the 14/7/2016 Mike failed to attend his planned NPS appointment and recall action was instigated. An OASys assessment was completed on the 15/7/2016.

30.9 Concerns were raised by neighbours of Shelly on the 18/7/2016 that she hadn't been seen for a few days and the dog was barking inside the premises. Police forced entry into the premises and Shelly was not present. The RSPCA were called regarding concerns for Shelly's dog, which was removed from the premises and the incident was dealt with in accordance with Police and RSPCA policies and procedures.

30.10 On the 19/7/2016 Mike was returned to prison on recall.

30.11 Shelly attended her GP on the 26/07/2016 and was prescribed diazepam to 'minimize harm,' reporting that she was grieving over her grandmother's death, her partner Mike was in prison and her dog had been removed by the RSPCA.

30.12 On the same date Shelly reported to Police that a male known to her was using her address to commit fraud and was threatening to hit her if she didn't sign documents. Police attended and spoke with her, but it was not felt there was any basis for the fraud allegation other than 2 letters in the male's name that had been delivered to her address, which he used to reside at.

30.13 On the 27/07/2016, an ambulance was requested by Police as Shelly had reported she had been assaulted by a friend, was covered in blood and thought she had a broken nose. Police attended and spoke with Shelly, who had a laceration to her forehead, reportedly caused by one punch. Shelly initially stated that she did not know who had done it, then reported three people, then finally that she did not know how she sustained the injury. The wound was dressed but Shelly refused to be transported to hospital for further assessment and treatment and it was documented by WAST that she had the capacity at the time to make that decision.

30.14 Shelly re-contacted the Police on the 27/7/2016 and stated that she could now recall who had assaulted her and named the male. The male was arrested and replied 'no comment' to all questions asked. Shelly later withdrew her complaint and the male was released with no further action taken.

30.15 On the 29/07/2016 Shelly contacted the police to report that 2 males were banging on her door, one had assaulted her the previous week and she was afraid to stay in the house. Police attended and it was quiet on arrival. Shelly appeared to want to discuss old incidents and that it was not the male initially mentioned that was banging on her door.

31. <u>August 2016</u>

31.1 NPS visited Mike in Prison on the 2/8/2016 following his recall, when he advised that his relationship with Shelly was now over and he reported recognising the negative aspects of this relationship. Mike discussed having made contact with his family again and the possibility of future visits. Mike was due for release in two weeks and identified that on release from Prison previously he had gone straight back into his usual pattern of behaviour, including drinking heavily. Mike agreed to engage with Drug Aid for support and nominated a release address.

31.2 On the 8/8/2016 Shelly reported to Police that her neighbour was banging on her door. The neighbour reported that Shelly had been shouting abuse at his ten-year-

old son and both parties were spoken to and advised accordingly. ASB referral forms were submitted for both parties.

31.3 Shelly was reissued diazepam by her GP on the 15/08/2016, for the same reasons recorded the last time she had attended.

31.4 On the 16/8/2016 a neighbour of Shelly contacted the police to report that she had attended at her front door and was shouting at her. Police attended and Shelly denied this. No action could be taken because of the Community Protection Notice, as this was specifically in relation to her begging behaviour and not general ASB conduct. Shelly was warned regarding her behaviour and an ASB referral was submitted.

31.5 On the 18/08/2016, Mike was released from prison and attended his first appointment with NPS, clearly inebriated and admitting to having drunk three quarters of a bottle of vodka before attending. Mike attended again on the 19/8/2016 as instructed, suffering from a hangover and admitting that he had continued to drink the previous evening. He was advised that reports had also been received of him attending a relative's address and causing a scene. Mike was issued with a PIN instructing him that action would be taken if he attended the address uninvited again. Mike was provided with the date of his next appointment and sent upstairs to Drug Aid office; there was no update on the system regarding how the appointment with Drug Aid went.

31.6 On the 30/8/2016 Shelly attended the GP with an injury to her right index finger, pain and swelling. Medication was prescribed. Shelly denied having been assaulted when asked and said she could not recall how the injury was caused. Shelly refused to attend hospital for further investigation.

31.7 An OASys assessment was completed with Mike on the 31/8/2016 by NPS and on the same date a member of the public reported Shelly knocking on her neighbour's door asking for a cigarette. Police attended and spoke with the reporting person and her neighbour. It was ascertained that Shelly was in fact asking for a cigarette for the neighbour. They did not want Shelly spoken to but were advised to continue to report incidents.

32. <u>September 2016</u>

32.1 Mike failed to attend his NPS appointment on the 1/9/2016, and Shelly contacted his Offender Manager on the 2/9/2016 to report he had broken his foot. Shelly confirmed she was Mike's girlfriend and that he was currently staying at her address. Mike's mobile number was provided, and he was contacted by his Offender Manager, reporting that he had chipped a bone in his foot. Mike confirmed he was at Shelly's address but said he had just 'popped over to see her'. Mike was challenged on his address, which had not been approved by NPS. Mike stated that he had taken a taxi to Shelly's and was adamant that he was still residing at the address provided on release.

32.2 On the 04/09/2016, members of the public reported that Shelly and Mike were fighting in the street. Mike had thrown Shelly and she fell to the floor. Police attended and both were intoxicated. There were no visible injuries, and both denied any assaults, stating they'd had a 'little argument'. Mike was arrested to prevent a further breach of the peace. Shelly was risk assessed as high and the PPN was shared with TEULU Multi Agency Centre, but not referred to MARAC.

32.3 Mike attended his NPS appointment on the 9/9/2016 as planned. He was not using crutches but limping slightly, advising that he was sure that he has broken a bone in his foot as it was painful, but that he had not been to the hospital for an X-ray. Mike advised that he was no longer at Shelly's address, suggesting that he only visited; although it is recorded that the Offender Manager was suspicious of this given the recent report of Police attendance at the address. Mike was advised that consideration was being given to returning him to Court for breach of his PSS, but that instead he would be issued with a warning letter. The Offender Manager reiterated the importance of him attending appointments.

32.4 On the 10/9/2016 a member of the public reported to Police that she was having problems with Shelly, who had sworn at the reporting person's daughter. Police attended and spoke with the reporting person. It was established that Shelly had been swearing in the street and it could not be determined if it had been directed at the reporting person's daughter or not. Shelly was advised and an ASB referral was submitted.

32.5 On the same day Shelly contacted the Police to report that she had been assaulted by a 73-year-old friend at the local sheltered housing complex. Police attended and spoke with Shelly, who was heavily intoxicated and no longer wishing to make a

complaint; providing a negative statement. Shelly had no visible injuries. A PPN was submitted but not shared.

32.6 On the 12/9/2016 a member of the public reported that Mike was kicking Shelly's front door and she was screaming for him to go away. The reporting person was concerned for Shelly's welfare. Police attended and Shelly and Mike were both in the house. Mike stated he had been banging the door to get in and Shelly couldn't hear him as she was shouting at the dog. There was no damage to the door. Mike was conveyed to a friend for the night and a PPN was submitted. Shelly was risk assessed as high and a PPN was shared with the IDVA service, but not referred to MARAC.

32.7 Message received by NPS from Mike's neighbour on the 16/9/2016 that his 'foot is bad' and he could not attend his NPS appointment, followed by a call thirty minutes later from Shelly reporting the same. Shelly agreed she would pass on the message that Mike should attend on the 20/9/2016 instead, which he failed to do.

32.8 Police received an abandoned 999 call from Shelly on the 20/9/2016. Police attended, but there was no sign of any disturbance, Shelly stating she had dialled the wrong number.

32.9 Shelly contacted the Police on the 21/9/2016 to report that Mike wanted the police to attend and pick him up as he had broken his Probation, which she did not want to happen. Relevant checks on the police systems were undertaken but as Mike was not in breach of an order or bail conditions, no action could be taken. Police attended, and it was confirmed that Mike had not breached his licence or committed any offences.

32.10 On the 23/09/2016 a member of the public reported that there was a domestic ongoing between Shelly and Mike as they could hear screams coming from the address. Police attended and spoke with Shelly alone and then Mike. Both denied they had been arguing, stating the neighbour had it in for them and the call was malicious. The reporting person was spoken to and stated the screaming had stopped when the police arrived.

32.11 A member of the public reported to Police on the 25/9/2016 that Shelly had urinated in the street outside their property. Shelly was arrested and received a caution for the offence and an ASB referral form was submitted. The Police received a further call from the public to report that Shelly was in the street with a large group of males

and they were shouting, screaming and arguing. The informant wanted Shelly spoken to and warned about her conduct. Police attended and spoke with the reporting person; Shelly was also advised and an ASB referral submitted.

32.12 On the 26/9/2016 Shelly contacted the police stating that a male known to her and Mike had stolen a bag of Mike's from her house. Police attended and Mike was in bed, refusing to speak to the officer, stating that he had not had anything stolen. There was no confirmation of a crime occurring and no further action was taken. On the same day, Shelly contacted the Police to report that she had just been robbed by a male known to her, who had allegedly snatched £20 out of her hand, punched and kicked her in the face. Police attended and Shelly and Mike were highly intoxicated. They stated there had been no robbery and Mike had given the male the £20. Police revisited 3 days later when they hoped Shelly and Mike would be sober and Mike maintained that he had given the money to the male. Shelly could not recall the incident and had no visible injuries.

32.13 On the 27/09/2016 the IDVA service tried to make contact with Shelly in response to the PPN they had received and the NPS sent a Final Warning Letter to Mike for failing to attend. On the same date, a member of the public reported to Police that there was a disturbance between Shelly and Mike, as they were shouting and screaming at each other. Police attended and there was no evidence of a disturbance, and they both stated they had been in the street shouting for the dog.

32.14 A member of the public reported to Police on the 28/9/2016 that Shelly had been to the reporting person's mother's home and been given money for dinner when she said she didn't have any money to buy food. The reporting person's mother suffered with dementia. When Shelly was asked by the Neighbourhood Policing Team (NPT) officer why she was begging Shelly replied, 'I just need it'.

32.15 On the 28/09/2016 Shelly rang the Police asking for them to attend and remove Mike, as they had been arguing. Police attended and Mike advised that he wanted the police to give him a lift to town. Shelly then stated that she didn't want him to leave and would not open the door to the Police. Police advised that one of them would need to leave to prevent a further breach of the peace and Shelly decided to go and stay with a friend. A PPN was submitted, but Shelly did not consent to the information being shared. She was risk assessed as high and the PPN was shared with TEULU, but not referred to MARAC.

32.16 Shelly contacted the Police on the 29/9/2016 to report that her dog was lost, and that Mike had been verbally abusive towards her and locked her out of the house. Shelly was kicking the door and shouting for him to let her in. Police attended and established there had been a verbal argument over the dog going missing. Both Shelly and Mike were intoxicated. An ASB referral was submitted. Shelly was risk assessed as high and the PPN was shared with TEULU, but not referred to MARAC.

32.17 On the 30/09/2016 the IDVA service made further attempts to contact Shelly about the PPN received, but without success. An anonymous caller reported to Police on the 30/9/2016 that Shelly and Mike had been arguing for the last four hours and that Shelly was in the street shouting 'I'm going to kill all your kids'. Mike was also heard saying 'I'm going to batter that dog.' The caller reported that Mike and Shelly stop arguing when the police attend. Police attended and Shelly was arrested for threats to kill and subsequently charged with a Public Order offence for the comments made. Mike was also arrested and made subject to conditional bail.

32.18 The initial reporting person was traced and provided a statement stating he had witnessed Mike assaulting Shelly the previous day, by pushing her to the floor. Shelly had bruising to her right eye and hand. Shelly denied being assaulted by Mike and when interviewed, Mike also denied assaulting her. Mike was arrested and bailed with conditions not to contact Shelly and was later charged with assault, although the victimless prosecution was later dismissed in Court. A PPN was submitted and Shelly risk assessed as high, but not referred to MARAC.

33. <u>October 2016</u>

33.1 A medication review was held with the GP on the 3/10/2016. Shelly reported that she and her partner had split up, presenting with a black eye which she explained as being caused by a fall over her dog. The GP records that 'neither of us believe' the explanation and that Shelly does not wish to pursue the matter. Shelly reported to be still grieving for her grandmother and diazepam was re-issued.

33.2 On the 04/10/2016, the NPS contacted the Police to confirm the outcome of Mike's arrest on the 30/9/2016; conditional bail granted until the 12/10/2016 and Mike advised not to approach Shelly or enter the area she lived in. Police confirm DV reports on the 04/09, 12/09, 21/09, 23/09, 27/09, 28/09, 29/09 and arrest on the 30/09/2016. PPNs requested and shared and in response, breach proceedings were instigated by NPS.

33.3 On the 04/10/2016 the IDVA Service attempted to make contact with Shelly, with no success. Police received a call from 'Lifeline' on the 5/10/2016 stating that a female by the name of Shelly was ‘preying’ on the elderly in the area. Police attended at the premises, but no complaint was made.

33.4 A member of the public contacted the Police on the 7/10/2016 to report that Shelly was constantly harassing the reporting person's brother. Shelly reported to be on drugs and regularly urinating in public. Police spoke with the reporting person who stated that Shelly was asking her brother for money all the time, but he did not wish to provide a statement. An ASB referral was submitted, but a Criminal Behaviour Order (CBO) could not be progressed without a statement.

33.5 On the 11/10/2016 the IDVA Service sent a letter to Shelly offering support and NPS confirmed that Mike’s breach date at Court was set for the 21/10/2016. This was subsequently changed to the 26/10/2016.

33.6 Shelly was discussed at a Quality of Life Forum meeting held on the 14/10/2016, which was attended by representatives from the Police and partner agencies. Police updated the meeting that Shelly had been arrested for a Public Order offence and would appear in Court on 3/11/16, when a CBO would be applied for. It was noted that a CPN was in place, which had been breached, and it was recommended that the Police arrest Shelly for this.

33.7 Shelly was identified as a victim of domestic abuse and that her partner had been arrested and remained on bail until 20/10/2016.

33.8 On the 16/10/2016 a member of the public contacted the Police to report that Shelly had called at her mother's address asking for money. Police attended and ascertained that no money had been given to Shelly. The reporting person's mother was not able to provide a statement due to her dementia. A PPN was submitted for the reporting person's mother, identifying her vulnerabilities.

33.9 A member of the public contacted the Police on the 22/10/2016 stating that Shelly was at his grandmother's house asking for money and had let herself in. Police spoke to the reporting person's grandmother, who stated that she had been good friends with Shelly's grandmother, and she did not want to make a complaint and had not

given Shelly any money. The ASB co-ordinator was asked to review the occurrences. A PPN was submitted in relation to the reporting person's grandmother. A Sergeant also highlighted that a PPN should be submitted for Shelly and shared with Adult Services due to her own vulnerabilities, but it does not appear that this happened.

33.10 On the 26/10/2016 Mike failed to attend Court for his breach hearing and a warrant without bail was issued for him.

34. <u>November and December 2016</u>

34.1 On the 01/11/2016 the IDVA Service closed Shelly's case as they had had no reply to their letter and could not make contact with her.

34.2 A member of the public reported to Police on the 4/11/2016 that Shelly was attending his house daily asking for money. The NPT officer made contact with the reporting person, who was willing to provide a statement which was obtained to support Shelly's breach of the CPN.

34.3 On the 08/11/2016 a member of the public reported to Police that Shelly was knocking on her brother's door asking for money. An NPT officer attended and obtained statements. Shelly was reported for breaching her CPN.

34.4 A member of the public reported to Police on the 11/11/2016 that Shelly was attending her house every night asking for money. An officer made contact with the reporting person and informed her that Shelly had been reported for breaching her CPN, a CBO application had been made and Shelly was due to attend Court. Shelly was spoken to and denied asking neighbours for money.

34.5 On the 24/11/2016 a member of the public reported to Police seeing Shelly knocking on doors. A further member of the public reported that Shelly had knocked on her door asking for money. Police made several attempts to speak to the original reporting person, to no effect. The second reporting person did not wish to provide a statement.

34.6 On the 05/12/2016, Mike appeared at Court for breach of his Post Sentence Supervision (PSS) and entered a guilty plea and was sentenced to fourteen days imprisonment. He entered a not guilty plea for the allegation of assault against Shelly from the 29/09/2016. Shelly attended Court in support of Mike, but the CPS

advised there was an independent witness in the case and therefore the trial was listed for the 16/01/2017.

34.7 On the 13/12/2016, there was a further remand hearing listed for Mike via video link and a member of the public reported to Police that Shelly had attended at her mother-in-law's house asking for money. Police attended and obtained a statement of complaint. Shelly was reported for summons regarding the breach of her CPN, but the matter was withdrawn as a conviction was secured for an offence of theft which took place on the 14/12/2016 (explored below) and a 2 year Criminal Behaviour Order was later granted on the 07/04/2017.

34.8 On the 14/12/2016 a member of the public also reported to Police that Shelly was begging for money at an old people's complex. One resident had given Shelly £5 to go and buy cigarettes for her, but she had not returned. An officer made contact with the reporting person, but they did not wish to make a statement in respect of the matter. A PPN was submitted for the reporting person. Evidence was also being gathered in respect of Shelly's breach of her CPN.

34.9 A member of the public working as a carer reported to Police on the 14/12/2016 that Shelly had stolen a meal that had been delivered to the victim's home by Meals on Wheels. Shelly was arrested, charged and found guilty of theft on the 29/3/2017 and subsequently sentenced.

34.10 On the 19/12/2016 a care worker reported to Police the theft of tobacco from a client by Shelly. Shelly was arrested for this on the 9/1/2017, denied the offence but was charged.

35. <u>January 2017</u>

35.1 During January 2017, despite the provision of travel warrants by NPS because of expressed financial difficulties, Mike continued to miss appointments and a warning letter was sent on the 12/01/2017. Mike also failed to attend a 26/1/2017 appointment on the ground of ill health, getting Shelly to phone his Offender Manager on his behalf.

35.2 On the 20/1/2017, after an established pattern since October 2016 of Shelly attending her GP practice every two weeks for her diazepam prescription, Shelly presented early. This was refused by the GP.

35.3 On the same day three members of the public reported to Police that Shelly was knocking on doors and asking for money. Police attended and spoke to each member of the public and Shelly was reported by summons for breaching her CPN. ASB referrals were also submitted and PPN's for the victims.

35.4 On the 22/01/2017, a member of the public contacted the Police to report that Shelly was asking people for money, alleging that she had approached her ten-year-old daughter asking if she had any money for Shelly to give to Mike. A police officer spoke to the reporting person, who did not want her daughter to provide a statement, but wanted Shelly spoken to. Shelly denied the allegations, made no disclosure against Mike and was warned about her behaviour.

35.5 Mike attended NPS on the 30/1/2017 having rearranged his appointment, reporting that he did not have money to attend, despite Shelly reporting over the phone that the reason he had been unable to attend was because he was unwell. Mike was advised that all future calls needed to be made by him. The Offender Manager noted that Mike's presentation seemed unusual, but because they had only recently been allocated his case, they could not determine whether this was out of the ordinary for him.

35.6 Mike was described as mumbling something derogatory towards the Offender Manager and / or NPS, but when questioned on what he had said, he refused to clarify. The Offender Manager also noted that he attempted to control the appointment, for example telling them which parts should be written down. The Offender Manager queried whether Mike was under the influence, which he denied, although Mike admitted he might drink later. It was clarified that Mike had received a first warning letter on his PSS and it was observed that he did not seem worried about this, not presenting as caring too much about being on probation, further evidenced by having been recalled when on licence and later breached on this PSS.

35.7 During the interview Mike admitted that he remained in a relationship with Shelly and spent time at her property, reporting that he had his own house too. Mike described himself as the person who protected Shelly as she was disabled, had no family around and was bullied by others in the neighbourhood. Another

appointment was arranged for the 6/2/2017 and the Offender Manager confirmed she would make a home visit to the address in the coming weeks.

36. <u>February 2017</u>

36.1 On the 06/02/2017, Mike phoned the NPS asking to re-schedule his appointment, which was arranged for the 9/2/2017.

36.2 A member of the public contacted the Police on the 9/2/207 at the request of Shelly, who stated that her partner Mike 'keeps hitting her'. The reporting person stated that Shelly had what looked like old bruises and scars. Police attended and Shelly invited officers into the house, where Mike was asleep on the sofa. They stated they'd had a minor verbal argument a few hours ago but had now made up. Shelly stated that she had argued with several people in the street lately and believed the call was malicious. Mike was taken to a friend's house for the night. The reporting person was spoken to and confirmed the original report but refused to provide a statement.

36.3 A PPN was submitted and Shelly was risk assessed as high, but not referred to MARAC.

36.4 On the 09/02/2017 Mike failed to attend the NPS and a final warning letter was sent, with the next appointment identified as a home visit on the 15/2/2017; subsequently rearranged for the 20/2/17.

36.5 An arrest warrant was issued for Shelly on the 17/2/2017 when she did not attend Court in respect of the December theft offence. Shelly was subsequently arrested and conveyed to court on the 18/2/2017; the matter not concluding until April 2017.

36.6 On the 20/02/2017 Shelly called 999 asking for the Police. The number was contacted back, and Shelly stated that everything was fine, and she didn't want the Police now. Police attended and both she and Mike were intoxicated and did not disclose any offences. Whilst officers were at the address Shelly pulled an old scab off her forehead causing it to bleed. Shelly had no new visible injuries and was conveyed to her father's address for the night. As on previous occasions, a PPN was submitted and Shelly risk assessed as high. The PPN was shared with the IDVA service and on this occasion, Adult Services, but it was not referred to MARAC.

36.7 Mike was due to attend the NPS on the 20/02/2017, but Shelly phoned stating he could not attend. Mike then came on the phone and explained that he didn't have money for a bus. The Offender Manager agreed to visit to him at Shelly's address on the 21/2/2017.

36.8 On the same date Shelly attended her GP's for a medication review. Shelly presented with a black eye and swelling and a scratch mark to the forehead. The GP documented that Shelly 'denies being assaulted and persists with the story that the dog pulled her over'. Diazepam was re-issued.

36.9 On the 21/02/2017 a member of the public contacted the Police stating that Shelly was knocking on the reporting person's father's door asking for money. They did not want the police to attend the home address. Police attended the area to look for Shelly, with a negative response, and a neighbour was spoken to who saw Shelly knocking the door and challenged her. No witness would provide a statement.

36.10 On the same day the Offender Manager undertook a home visit to Mike at Shelly's address. Mike reported that Shelly was out walking the dog. The property was observed to be in a poor condition and Mike advised that he intended to re-decorate. Mike informed the Offender Manager that he still had his own property but spends a lot of time at Shelly's as well. Mike admitted that whilst intoxicated he had tripped and fallen, hitting his head on the bottom stair, which was (partly) why he couldn't attend the office.

36.11 Mike admitted that he was drinking more than he would like, and appeared willing to re-engage with Drug Aid for support, the Offender Manager noting that if Mike followed through on this, she would ensure appointments with NPS were held on the same day to help with compliance given his limited finances. It was also agreed that future appointments would be held on a Monday, as that was when Mike received benefits. A discussion took place around finances, Mike agreeing that it was possible for him to set aside £5 each week to travel to appointments and avoid being breached.

36.12 The Offender Manager made clear that should Mike continue to fail to attend appointments he would be breached on PSS for the second time, which would likely result in a further fourteen-day period in custody.

36.13 On the 22nd and 23rd of February 2017 the IDVA Service managed to make contact with Shelly via phone, but their support was declined.

37. March and April 2017

37.1 On the 15/03/2017, following supervision with their line manager, the NPS Offender Manager contacted Mike to advise that a three way meeting would be arranged between him, the Offender Manager and their Team Manager in response to his non-compliance and to establish his motivation to improve his attendance levels.

37.2 On the 17/03/2017 Mike failed to attend NPS again and a warning letter was sent with an appointment for the 28/3/2017, which Mike also tried to rearrange. After some resistance Mike attended as agreed, saying he had borrowed money from a friend. A final warning letter was sent with his next appointment for the 31/3/2017, which he did not attend.

37.3 Mike attended NPS on the 03/04/2017 under the influence, but not heavily intoxicated enough that he could not be understood. Mike said he had consumed two flagons (3L each) of cider with Shelly and another friend before his appointment. Mike reported drinking approximately two-three litres himself, which he advised was a reduction on his usual amount. Mike declined to engage with Dyfodol, a local project providing support to people with drug and alcohol issues, to reduce his drinking, stating that he had done it on his own before and would so again, stating that he would not commit himself to getting sober until his order had finished and he moved to Scotland to live with his brother.

37.4 The Offender Manager noted in their recordings that Mike was doing just enough to avoid being breached, was consistently phoning to ask to re-arrange appointments and had little interest in engaging with support to address his alcohol use, stating that his level of drinking was not bad for him. Breach proceedings were instigated on the 4/4/2017.

37.5 On the 07/04/2017 Shelly was sentenced to a Community Order of twelve months with a Rehabilitation Activity Requirement (fifteen days) for an offence of Theft which occurred in December 2016.

37.6 On the 10/04/2017 Mike failed to attend NPS, but no action was taken as he was already in breach. On the same day, Shelly contacted the police to allege that her purse had been stolen by a friend in town. The purse contained money and a post office card. Shelly was spoken to and it was ascertained that she had left a bag containing her purse near some bins, and that when she went back the bag was gone. There was no evidence to support her allegation of theft and there was no usage of the Post Office card.

37.7 A member of the public reported to Police on the 11/4/2017 concerns about personal and insulting comments being made on the Police Facebook page about Shelly. Police updated the Niche OEL that the press office had been spoken to and were aware of the issues.

37.8 CRC's induction with Shelly was rescheduled within timescales on the 11/4/2017 as paperwork had not been received from the Court. The induction session rescheduled for the 19/4/2017 did not go ahead at Shelly's request, but the reasons for this were not recorded.

37.9 In discussion with his Offender Manager on the 12/4/2017, Mike claimed his and Shelly's relationship had calmed down and that whilst they will still have verbal arguments, this does not escalate as Shelly will walk out and spend some time at her father's, returning later when the situation has calmed down. Mike was advised that if there was any indication from Police that there were ongoing issues or callouts, he would not be allowed to stay at the property and would be required under the PSS to return to staying full-time at his own address.

37.10 On the 17/04/2017 a member of the public reported there was a domestic in progress at Shelly's house. Police attended and Shelly and Mike were present. They denied any incident had taken place, Shelly stating that she had been shouting at the dog and they had been moving furniture around. A PPN was submitted in view of the couple's history and Shelly was assessed as high risk, the PPN shared with the IDVA service, but not referred to MARAC.

37.11 On the 19/04/2017 the IDVA Service made contact with Shelly via phone, who declined support stating "we get on great".

37.12 On the 24/04/2017 Shelly's CRC induction was completed and she signed to confirm her understanding of the Order.

38. May 2017

38.1 A member of the public contacted the Police on the 5/5/2017 to report a domestic. Police attended and Shelly and Mike were both present and intoxicated. The house was observed to be very cluttered, with no lighting. They both denied arguing and Shelly was seen to have a mark on her lip, which she stated occurred when she fell over the dog. Mike was wanted on warrant and was subsequently arrested. Shelly made no complaint. A PPN was submitted and Shelly risk assessed as high, which was shared with the IDVA service but not referred to MARAC.

38.2 Shelly attended the GP to continue treatment for nasal vestibulitis on the same day and was noted to have rib strain allegedly caused by being pulled downstairs by her dog eleven days previously.

38.3 On the 08/05/2017 the IDVA Service made contact with Shelly via phone, who declined support. Shelly also asked to re-arrange her CRC appointment, but the reason given for this was not recorded.

38.4 On the 22/05/2017 a member of the public contacted the Police to state that their daughter had seen Shelly go to the toilet in the street. Police made attempts to contact the reporting person to no avail. No ASB forms were submitted, as the incident could not be substantiated. On the same day, Shelly attended CRC for her Rehabilitative Alcohol Requirement (RAR) and disclosed feeling stressed. A referral to agencies for support was discussed with Shelly but declined.

38.5 A member of the public contacted the Police on the 23/5/2017 to report that Shelly had knocked on her door twice asking for a takeaway phone number. When she refused to give her the number, Shelly had sworn at her and Shelly was now knocking other doors in the street. Police attended and Shelly explained she couldn't get a signal on her phone and wanted someone to order a Chinese for her. Shelly was spoken to and warned about knocking on people's doors.

38.6 On the 26/05/2017 Shelly attended the GP practice and fell asleep in the surgery. The GP records report that Shelly was more dishevelled than usual and was described as having slurred speech and a swelling/injury to her fingers. An A&E assessment was advised. Shelly requested further diazepam, but this was declined.

38.7 On the 30/05/2017 Mike failed to attend his NPS appointment. A warning letter was sent with his next appointment for the 6/6/2017. It is unclear from the recordings whether this took place or not.

39. <u>June 2017</u>

39.1 There was a phone call between the Offender Manager and Mike on the 14/6/2017, via Shelly's mobile phone, as there was no other number for him. Mike reported he had no money to attend his NPS appointment and denied residing with Shelly, as he knew he was not permitted to, advising that he was staying with a friend because of ongoing problems with his flat.

39.2 Mike attended NPS on the 19/06/2017 having missed his previous appointment. He offered no real explanation for this, only that he wished to complete his final few weeks without any further issues as he then planned to move to Scotland with his brother. Mike was reluctant to provide much in the way of detail. He confirmed that he was clear that he was not permitted to reside with Shelly whilst under probation supervision. Mike reported that he would stop drinking when he moves to live with his brother, as he will not tolerate it.

39.3 Shelly attended CRC on the 19/06/2017 under the influence of alcohol and reporting to be upset about family matters. She accepted a referral to an alcohol service.

39.4 On the 26/06/2017 Mike attended the NPS as planned and appeared relatively sober/lucid and they discussed the circumstances for his termination assessment to be completed. Mike was insistent that he had not been in a relationship with Shelly since the last time he had been released from prison and stated that this was because he wasn't allowed to live there. Mike was reporting drinking five-six cans a day, less than previously, but his Offender Manager recorded they were unclear how genuine a picture this was given his long-standing difficulties. The Self-Assessment Questionnaire was completed, with Mike stating that he would "definitely not' offend again, as he was 'finished with prison. Spent half my life in there and it's time to move on. I can't afford to lose my brother". The final termination assessment was completed, but no date for the last appointment was shown on the system and no further entry recorded detailing if Mike attended the appointment or not.

39.5 On the same day Shelly attended the GP, and was reported to be intoxicated, swearing and difficult to understand and reported to be upset at the anniversary of her grandmother's death. Shelly requested diazepam, which was re-issued despite her poor presentation and intoxicated appearance.

40. July 2017

40.1 On the 03/07/2017, Shelly disclosed being stabbed by a male (not Mike) to her CRC worker and was encouraged to seek further medical treatment. Shelly contacted the Police on the 6/7/2017 to report that a male was at her house and she wanted him removed. The phone went dead. Shelly contacted the Police again to say she had been assaulted by a friend of her partner. Police attended and both parties were spoken to. There had been a verbal dispute over bus times. No assault had taken place and Mike's friend was conveyed home by officers.

40.2 On the 7/7/2017 Shelly contacted the police to report that she had been stabbed in the leg by a male who had left the premises. Police attended and ascertained that there had been five persons at the house when an argument started between Shelly and a male over ten pounds and diazepam tablets which he wanted off her, which had led him to stab Shelly to the top of her leg, causing a two inch laceration. An ambulance was called and on arrival blood was "pouring" from Shelly's wound. Shelly did not want ambulance staff to cannulate her, and staff dressed the wound and conveyed her to hospital. The ambulance crew documented that a routine enquiry regarding domestic abuse was not undertaken because Shelly was not alone, which was in accordance with WAST policies and procedures.

40.3 At 13:02 hours Shelly was admitted to Accident & Emergency via ambulance from home, accompanied by her partner. Shelly reported being punched the previous night to the face and stabbed in the leg that morning by an 'assailant' when Shelly was unable to supply diazepam. Shelly had a two-inch wound to the inner aspect of her right thigh and swelling and bruising to her right eye was observed. The wound was sutured, and Shelly given antibiotics. Police attended A&E to take statements from Shelly and her partner, and records were taken for evidence. Shelly was discharged home with advice that her sutures should be removed in ten days.

40.4 It was recorded on the Niche OEL by the Scenes of Crime Officer that the home premises were in a poor state, with rubbish, dog excrement and furniture stacked in the living room.

40.5 Shelly's attacker was subsequently arrested and charged with causing GBH and received a two-year prison sentence.

40.6 On the 17/07/2017 Shelly contacted the GP practice to request that her appointment for suture removal was made later in the day. The GP surgery was unable to facilitate the request and documents that the background noise sounded like Shelly was in a pub. Shelly was advised to attend A&E for suture removal, Shelly reporting that she would remove them herself.

40.7 A neighbour of Shelly contacted the Police on the 19/7/2017 to report concerns that Shelly's dog had been left alone and was barking and howling. The RSPCA was contacted and stated they would be attending and would contact the Police if they required any assistance.

40.8 On the 21/07/2017 the GP records note a muscle hernia near Shelly's suture site from the stab wound. It is not clear who removed Shelly'S sutures and when.

40.9 Shelly attended CRC on the 24/7/2017 and was sober, advising that she was actively engaging with Police regarding the assault that occurred. Shelly confirmed that the incident occurred because she could not get a prescription for diazepam, and the man who had attacked her had demanded some as he had not been prescribed his Subutex, saying that he had grabbed the knife and stabbed her leg. Shelly reported no issues since and that she has not allowed associates into the house since.

41. <u>August and September 2017</u>

41.1 There was unplanned contact from Shelly on the 3/8/2017 with CRC, reporting that she had been stopped by a security guard whilst shopping and he had advised her that she should not be anywhere near the shopping area due to her CBO. Shelly was advised to go across to the Court building and enquire whether they have a record of anything on their system.

41.2 On the 21/08/2017 Shelly reported a significant reduction in alcohol use to her CRC worker and positive engagement with her GP and prescribed medication. Shelly confirmed she was aware of her CBO conditions, a copy of which was provided to her.

41.3 Shelly rang the GP practice six times on the 22/8/2017 to request her diazepam, a script was sent to a pharmacy nearer to her home where she can pick it up. The GP records notes Shelly'S increased requests and orders for diazepam, with fourteen days of her previous prescription still left to run. The GP advised that prescription

should last four weeks, and that Shelly should not attempt to order them before they are due.

41.4 On the 6/9/2017 Shelly attended CRC unplanned and stated that she felt as though the Police were harassing her. Shelly's contact details were requested but she stated that she was having a new phone. Further appointment arranged.

41.5 Shelly attended the GP practice on the 11/09/2017 to report that she had contacted a solicitor about her repeat prescriptions and that she is recording conversations with the surgery. On the same day Shelly complained to CRC that the Police continue to stop and search her, which she was unhappy about. Shelly advised her to seek legal advice and make a complaint to Police headquarters.

42. <u>October 2017</u>

42.1 On the 09/10/2017, a member of the public contacted the Police to report that Shelly was urinating and defecating in public. Police attended, but there was no evidence to support this. Shelly and Mike were given suitable advice and ASB referrals were also submitted.

42.2 A member of the public reported to Police on the 15/10/2017 that Shelly had come to his house and asked his wife to change her statement, as she was due to attend Court as a witness against Shelly. Shelly had also tried to sell them tobacco. Police attended and spoke with the informant and his wife, but they would not provide statements as no threats were made and they were not intimidated.

42.3 On the 16/10/2017 a care worker contacted the Police to report that Shelly had been at the sheltered accommodation complex despite being banned, asking for money. Shelly was subsequently reported to be covered in blood and looked like she had been beaten up. Shelly was arrested for breaching her CBO, charged and subsequently fined £80 at Court. When the risk assessment was undertaken with Shelly in custody and she was asked whether she had any injuries or ailments, it is recorded that she disclosed eczema related marks that were being managed by the GP. There is nothing in the police records describing Shelly as being covered in blood.

42.4 On the 18/10/2017 Adult Services recorded a MASH referral to Environmental Health, but nothing is recommended about a discussion with Shelly about her safety.

42.5 Shelly received a Court fine on the 19/10/2018 for Breach of her CBO.

42.6 A member of the public contacted the Police on the 20/10/2017 to report concerns for her Aunt who suffered with dementia, as Shelly was attending her house asking for money. The reporting person was spoken to and stated that her Aunt did not wish to make a complaint, but she wished for Shelly to be spoken to and warned not to attend the address. Shelly was spoken to and denied the allegation. Shelly was warned about her conduct and a PPN was submitted for the victim.

42.7 On the 23/10/2017 Shelly contacted the Police to report that a male known to her had stolen her mobile phone and cash. A statement was obtained, and the male was arrested; he denied the theft. The matter was eventually no further actioned due to a lack of evidence.

42.8 Shelly did not attend her CRC appointment on the 25/10/2017.

43. <u>November 2017</u>

43.1 On the 01/11/2017 a member of the public reported to Police that there were several males and females drinking alcohol and causing a nuisance in the local church grounds. Police attended and Shelly was one of the five persons present. All were advised regarding their conduct and moved on. ASB referrals were submitted.

43.2 Three days later Shelly claimed that her diazepam had been flushed down the toilet and she was issued seven more by her GP. On the 13/11/2017 Shelly was back at the GP's reporting that she had tripped over a shoelace, fallen downstairs and had pain to her left lower ribs. More diazepam was requested, but the GP records that Shelly needs to reduce her intake and issued twenty-four tablets instead of twenty-eight; it is unclear what support was offered to assist Shelly to do this.

43.3 On the 14/11/2017 a member of the public reported to Police that Shelly had been asking her for money and she had given her £1. The reporting person was spoken to and did not wish to make a complaint or provide a statement and Shelly was not spoken to about this.

43.4 On the 16/11/2017, Adult Services processed the PPN from the Police highlighting Shelly's drinking and their serious concern regarding home conditions and Shelly's health, as for information only.

43.5 On the 24/11/2017 Shelly requested further diazepam from her GP, which was declined because her prescription was not due until the 10/12/17.

44. <u>December 2017</u>

44.1 A member of the public reports to Police on the 4/12/2017 that Shelly was begging for £2. A statement was obtained from the reporting person and Shelly was arrested. On the same day Shelly attended her GP and was prescribed 5 mgs of diazepam to be taken at night. Twenty-two diazepam tablets were issued.

44.2 On the 05/12/2017 a member of the public reported to Police that Shelly had knocked on her door asking for money. She was concerned for Shelly as she said she was going to walk to town, and she looked awful. Police spoke to the reporting person, who did not wish to provide a statement. Shelly was spoken to and denied knocking doors. Shelly appeared to be well and stated she was watching TV with her partner and having a drink. A PPN detailing Shelly's vulnerabilities was submitted and shared with Adult Services.

44.3 On the 06/12/2017 a member of staff from a local support service for older people reported concerns to Police for a resident as Shelly had attended the complex she was banned from. Police spoke to the reporting person and the resident and their reports were conflicting. The neighbour was spoken to and stated she could not recall if Shelly had attended or not.

44.4 A member of the public reported to Police on the 7/12/2017 that he had helped Shelly out by giving her some money, and now she was asking all the time and had called at his address twenty times that week. An officer attended and ascertained that the reporting person had loaned Shelly money the previous week but had been repaid in full. The reporting person did not wish to make a complaint.

44.5 On the 09/12/2017 Shelly contacted the police to allege that someone was trying to set her house on fire and stated that he had dropped a cigarette onto her blanket. Police attended and spoke to both Shelly and Mike, who had been drinking. Shelly

stated that Mike had accidentally dropped his cigarette on the floor and no damage had been caused. No offences were disclosed.

44.6 A member of the public reported to Police on the 11/12/2017 that Shelly had been seen at his brother's house the previous day asking for money. Police spoke to the reporting person's brother and a statement was obtained from him.

44.7 On the 15/12/2017 two similar but separate reports were received by the Police and Shelly was arrested on the 16/12/2017 for the breach of her CBO and charged on the 17/12/2017.

44.8 On the 15/12/2017 Shelly contacted the Police via 999 and could be heard saying she would kill him and calling a male name. Police attended and it appeared that Shelly had been arguing with her father (who had since left), who was unhappy that Shelly was asking people for money. Shelly was irate with the officers but did not disclose any assaults. 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.

44.9 On the 18/12/2017 a professional contacted the Police to report that on the 15/12/2017 Shelly was found at the old people's complex she was banned from. On the 18/12/2017 Shelly attended Court for Breach of her CBO and three other breaches. The order was terminated, and a new Suspended Sentence imposed with no requirements. Shelly did not attend her planned CRC appointment.

44.10 On the 19/12/2017 Adult Services received the PPN concerning the incident on the 15/12/2017.

44.11 A member of the public reported to Police on the 20/12/2017 that Shelly had jumped out in front of her car and asked for £3. She was knocking people's doors and stopping delivery drivers. The NPT were informed for awareness and for sharing with their dedicated patrols.

44.12 On the 26/12/2017 a member of the public reported that Shelly had attended at her house and gone through her pockets looking for money. Shelly was subsequently arrested on suspicion of attempted burglary and breach of her CBO. She was later charged with the offences.

44.13 Shelly attended her GP on the 27/12/2017 with inflammation and a small cut to the external ear. Shelly requested more diazepam and twenty-one tablets were issued, which it was felt should last until the 24/01/18.

44.14 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.

45. <u>January and February 2018</u>

45.1 The Prison's Health Assessment, recorded on the 3/1/2018, identified that Shelly had a low platelet count and an abnormal liver function test which did not settle. Shelly was identified as Hepatitis C positive and had one positive blood test for Hepatitis B but had not had this repeated to confirm active infection. Shelly's blood results also demonstrated liver damage, which was not unexpected given her alcohol misuse levels. Further investigations and a referral to Hepatology were recommended on discharge, along with screening and vaccination of household contacts. 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.

44.2 On the 08/02/2018 Shelly was released from custody and reported immediately to Probation where a full induction was carried out. Upon release, Shelly reverts to her previous begging behaviour immediately.

44.3 By the 10/02/2018 Shelly had been arrested for attending the old people's complex she had been banned from previously and for begging; breaching her CBO. On the 12/02/2018 Shelly appeared via cells at Court and was charged with a new offence of breach of her CBO. A not guilty plea was entered, and the case was adjourned for trial on the 27/03/2018. Shelly was remanded in custody to the same Prison for a further bail hearing on the 20/02/2018; where she was granted bail with conditions not to approach directly or indirectly residents at the old people's complex.

44.4 A member of the public contacted the Police on the 21/2/2018 to report that Shelly had been in the street screaming that she knew who the 'grass' was and that she had lied.

44.5 Police received a 999 call from Mike on the 27/2/2018 who reported that Shelly had been drinking and fallen down the stairs. He requested that Police attend, and the emergency medical despatcher reported that Mike also sounded like he had been drinking. The WAST ambulance crew documented that Shelly had a laceration to her nose and became aggressive. Shelly refused spinal immobilisation and the crew were unable to undertake all the clinical observations they felt were necessary. Shelly was conveyed to hospital, with Mike in attendance.

44.6 Hospital records indicate that Shelly had sustained a large laceration to the middle of her forehead, and Shelly was described as intoxicated, aggressive and un-cooperative with treatment. Shelly was recorded as suffering with anxiety and depression and being alcohol and diazepam dependant. A CT scan of her brain and facial bones was undertaken, and a nasal fracture was seen. The radiologist also notes a possible fracture to her C6 vertebrae. Due to Shelly being unable to tolerate the medical examination, further scanning was recommended to rule this out.

44.7 A PPN was submitted by the Police due to the condition of the home, but Shelly refused consent to share the information with partner agencies.

44.8 On the 28/02/2018 Shelly attended CRC from hospital covered in blood, stating that she had fallen down the stairs in the house and Mike called her an ambulance. Shelly denied being drunk at the time but smelt heavily of alcohol. 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.

45. <u>March and April 2018</u>

45.1 A member of the public contacted the Police on the 3/3/2018 to report that Shelly had just pushed her way into a flat at the old people's complex. Shelly was arrested and pleaded guilty for the breach of her bail conditions and was remanded to Prison on the 5/3/2018, 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 dependant. 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.

45.2 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. On the 27/3/2018, Shelly appeared in Court and was found guilty and received 8 weeks imprisonment.

45.3 On the 25/04/2018 Shelly tested positive for Hep C and the risks of untreated infection and risks to her partner were explained to her before her release from Prison on the 4/5/2018, where a full induction was completed with her by CRC.

46. <u>May 2018</u>

46.1 On the 04/05/2018 Shelly was released from prison. Shelly attended CRC on the 8/5/2018 as planned, reporting that her relationship with Mike had ended and as such she was consuming less alcohol. Shelly was advised to attend the Department of Work and Pensions (DWP) to address her benefits.

46.2 On the 09/05/2018 Shelly attended her GP requesting diazepam and a fit note, advising incorrectly that she was prescribed diazepam in prison. The GP offered to contact the prison to query this, and no prescription was ultimately provided.

46.3 Shelly contacted CRC on the 24/05/2018 to advise that she could not attend due to not having any money, and it was agreed that a bus warrant would be issued to her for the following week.

46.4 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. Mike was released from custody at 05.25 hours, with no further action taken.

46.5 A PPN was submitted and the occurrence risk assessed as medium by the submitting officer and tasked to the PPU as a medium risk task. A secondary risk assessment was not conducted on this incident by the PPU, as Shelly was deceased by the time the task was opened.

46.6 May 2018 Police received a chaotic 999 call from a male caller, subsequently identified as a neighbour, stating that he was ringing for a female (Shelly) as Mike could not wake her and Mike keeps saying, 'she's gone, she's gone.' The call taker correctly recorded that the patient was not conscious and whilst it is not known whether Shelly was breathing, he recorded a no answer to this question. The call taker asked if there is any way he can be provided with a contact number for the address to provide Basic Life Support instruction. The neighbour clarified that he has been woken and is not sure of the circumstances. Mike then spoke to the call taker and stated that he found Shelly that morning and started to get distressed when the call taker suggested he performs Basic Life Support, replying that Shelly is cold, blue and stiff. The call taker was told that "He has tried to help her for an hour, he feels that she is beyond help, just send someone".

46.7 The ambulance crew arrived on scene at 06:41, where the Police were already in attendance. The responding crew noted that Shelly was lying on the sofa in the living room, not breathing and there was no pulse evident and there were clear signs of hypostasis and rigor mortis. The crew documented that they observed a laceration and swelling to Shelly's right eyebrow/eyelid, with evidence of bleeding. There was also some noticeable bruising to the abdomen and arms. Recognition of Life Extinct called at 06:47.

47. Analysis

The analysis has been grouped under four thematic headings.

48. Analysis: Victim Characteristics

48.1 Shelly's step-mother believes that the breakup of Shelly'S parents' marriage had a significant effect on Shelly and she never really got over it. Shelly's step-mother described Shelly as the girl who had everything, but it wasn't enough. Shelly's step-mother described Shelly as helpful, polite and very generous – noting that as a young woman she was attractive and well presented.

48.2 Shelly's mother died from Cirrhosis of the liver and it is the Panel's view that a pattern of inter-generational alcohol misuse had emerged by the time Shelly was a

young adult. In research completed by Olsen, 75% of people defined as self-neglecting experienced one or more traumatic life experiences such as physical or sexual abuse as a child and problems with mental illness or alcoholism, compared with fewer than 25% of controls (s.6.9; Olsen et al., 2007).

48.3 In February 2009 following a violent hammer attack carried out by two former friends, Shelly was left blind in one eye and was registered disabled. Family visited her every day in hospital and encouraged her to get help for her alcohol misuse, however within a few days of being discharged Shelly was drinking again. Shelly's step-mother was able to see this incident as the trigger for a further decline in Shelly's presentation and believed Shelly used diazepam to block out the pain she was suffering in her life.

48.4 Shelly claimed benefits for her disability and did not work, which meant a lot of money was being spent on alcohol; particularly as family members were also paying bills for her at times. Family recalled that if Shelly got an idea in her head, she could also become difficult and abusive and would often phone the home repeatedly trying to goad her father or step-mother. Shelly's father would try and apply some boundaries with Shelly, such as no more financial support until she spoke to them properly, but Shelly's step-mother admitted that she found this hard to enforce and she struggled not to respond when Shelly contacted her, even when verbally abusive.

48.5 Shelly and Mike met in 2012 and Mike made a very good first impression with the family, presenting as polite and well dressed. Family thought things between them seemed alright for around two to three years, but then Shelly started to present with injuries. Unbeknown to the family, Mike had a history of controlling and violent behaviours in his relationship history. Following the start of her relationship with Mike, Shelly kept her family increasingly at arm's length and would not allow them to visit her home. From that point on contact was usually precipitated by a crisis and although Shelly and her father had enjoyed a very close and loving relationship, they had become estranged in the months prior to her death because her father disapproved of what Shelly was doing and felt powerless to intervene. Shelly's step-mother and Shelly's father rarely saw Mike and he never visited their home. In many respects he operated under the radar and could go for months without being seen, and when they did meet him, he would not talk to them.

48.6 Shelly usually blamed her pet dog for any injuries, 'I fell over the dog or down the stairs.' Shelly's step-mother believed that over the years Mike's gradual erosion of Shelly's confidence and self-respect led her to believe she was lucky to have him and she went from a being a strong, opinionated woman to a shell of herself, who looked lost and dishevelled in the weeks leading to her death. Shelly's step-mother felt that the physical deterioration in Shelly attracted negative attention and further damaged her confidence. Shelly's step-mother also suspected Mike was guilty of sexual violence against Shelly and found this very painful to think about.

48.7 The family believed that Mike would kill Shelly one day and recalled only two occasions when Shelly was honest that Mike had hit her (one involving an injury to her ear). Shelly would usually blame the dog for tripping her up or would claim she had fallen down the stairs. The family knew that Shelly loved her dog and believed that Mike was cruel to it because of that. The family have heard rumours that the dog was killed by Mike, but have no evidence for this. The family recalled that Shelly would always defend Mike and that when Mike was challenged by Shelly's father about what he was doing to her, he would say nothing in his defence, as Shelly could always be relied upon to defend him.

48.8 Alcohol had a very bad effect on Shelly, and she would drink to extreme excess frequently, often becoming aggressive and abusive. Shelly would often be incapable of taking care of herself and was very vulnerable. Shelly lost several of her teeth due to alcohol misuse but would not attend appointments with the dentist to try and sort it out. As time went by, her hygiene also deteriorated, particularly after her grandmother died in 2014, as before then Shelly would go to her home for baths and something to eat. Shelly's step-mother believes alcohol was at the root of many of Shelly's problems and family tried very hard to get her to seek help. Shelly's step-mother reported that she tried to get Shelly 'sectioned' once and had the paperwork to proceed, but Shelly resumed drinking and the Unit would not accept her.

48.9 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.

48.10 Shelly was a frequent attender at the GP surgery, where the primary care team had developed a relationship with her and her family since childhood; which may go

some way to explaining the apparent tolerance of her at times challenging behaviour towards surgery staff. It would have been quite apparent to the professionals who met Shelly that she drank excessively and 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.

48.11 Despite Shelly being a frequent attender at her GP surgery, which arguably presented greater opportunities to engage her more effectively, this was not the case and there was no obvious consideration of Shelly's mental health or treatment options other than diazepam, although health records describe anxiety, depression and Shelly's grief at the loss of her grandmother; leading to various missed opportunities to offer help and support to Shelly.

48.12 When referred to alcohol services, Shelly was, in the main, resistant to receiving help and in response, the support services were not sufficiently proactive or persistent in their efforts to engage her. Shelly often refused referrals to support services, declined to attend appointments or did not comply with treatment. Shelly could at times give the appearance of being interested in addressing her alcohol misuse, but there was in truth no real evidence that she was genuinely motivated to make any significant changes to her drinking and little evidence that some agencies actively discussed or pursued this with her. Shelly could not be said to have disengaged from services that she never actually engaged with in the first place, because she was in reality non-compliant, which increased her risk because no-one person or agency really had an accurate picture of what was happening to her.

48.13 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. Ultimately Shelly's father was there for her, but Shelly would often reject his attempts at help. Shelly's father tried on several occasions to get Shelly to see sense about Mike, or to warn Mike to leave her alone, but Shelly would not listen and would threaten her father with the Police.

48.14 Family have highlighted that when they had contact with Shelly they would try and ensure that she ate in front of them, as they believed that any food, they gave her would be taken off her by Mike. In addition, information that came to light following

Shelly's death, suggests that she may not have co-ordinated benefits payments for herself upon release from prison, which would support the Panel's view that Shelly was struggling to co-ordinate even the most basic of self-care skills; namely ensuring she had enough money to be able to eat.

48.15 There is no doubt that Shelly's family recognised she was a victim of domestic abuse, was alcohol dependant and vulnerable, and they tried to assist her with this, but had become increasingly frustrated with her lack of motivation to address her problems and the way that this would manifest itself in her behaviour. Shelly's step-mother said that Shelly idolised her grandmother and she provided Shelly with a 'sanctuary' to run to. When Shelly's grandmother died, this had a very bad effect on Shelly, which was a trigger for a further deterioration.

48.16 Shelly's step-mother believed that Shelly genuinely loved Mike and Shelly believed that he loved her in return. As an illustration, even though Mike might have only just done something abusive to her, Shelly would still put him first and her step-mother recalled bringing Shelly back home from the hospital after Mike had injured her ear and offering to buy her curry and chips to cheer her up; Shelly immediately asking if she would buy some for Mike too.

48.17 Towards the end of her life, Shelly's step-mother and father saw Shelly out in all weathers looking 'dreadful' and would try and encourage her to go to their home, but she was always reluctant to do so. Shelly's step-mother said Shelly was seen begging Christmas Day 2017 in the local square and her father approached her and tried to encourage her to return home with him, but she refused. Shelly's step-mother believes Mike was forcing Shelly to beg, or she would be beaten, something which Shelly had disclosed to a few people. This had been reported to Shelly's father and triggered a visit from him Christmas time 2017 to Shelly's home, to warn Mike to stop hitting Shelly. Shelly ultimately defended Mike, which damaged her relationship with her father. There is certainly some evidence that Shelly's repeated and increasingly bold begging within the community may have been prompted by poverty, hunger and fear and there is one report of Shelly asking a child for money for Mike (investigated by Police, but denied by Shelly), which would support the view that she was becoming increasingly exploited in her relationship.

48.18 Shelly's step-mother described family members as feeling sorry for Shelly when her mother died, and they would often support her financially. This appeared to have the unintended consequence of making Shelly less self-reliant and more dependent on others and that this, combined with her alcohol misuse, made Shelly highly vulnerable to exploitation by others. Shelly's family recall an incident when she

phoned them from a pub, asking for the deeds to her house because a man that Mike knew wanted to buy it from her for £10,000; significantly under its value. Fortunately, the family were able to prevent this from happening.

48.19 Evan Stark (2007), described a typology of behaviour in coercive control, identifying four key components: violence, intimidation (including threats, surveillance, degradation, withholding money), isolation and control. The Panel found ample evidence that Shelly was being coercively controlled by Mike, as she had suffered repeated acts of assault, threats, humiliation and intimidation - designed to harm, punish and frighten her; all of which had a serious effect on her. It is also clear from her increasingly frequent begging that Shelly's access to money was clearly compromised. 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, making it harder for her to leave the relationship. Clearly this situation did not happen overnight, and the Review Panel are persuaded that Mike would have likely known the serious effect this was having on Shelly.

48.20 To compound the challenges facing Shelly, she had also become increasingly isolated from her family as her relationship with Mike continued and it appeared to the Panel that Mike had tried and succeeded in getting Shelly to cut contact with family and friends so that she was easier for him to control and the avenues for her to access support had been closed off.

48.21 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. Neighbours also reported on occasions overhearing Shelly asking people to leave her home and described times when she would be seen outside in inclement weather with her dog, appearing reluctant to return home. 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.

48.22 Shelly was arguably self-neglecting and presented to her family, professionals and the community as increasingly unkempt, unclean, underweight and injured as a result of assaults. People who seriously self-neglect are often at high risk of

sustaining serious harm and self-neglect has featured in a significant number of Serious Case Reviews in England and Adult Practice Reviews in Wales. In the view of the Review Panel, Shelly presented with all the following self-neglect indicators:

- Lack of self-care, including hygiene, nutrition, hydration and health.
- Lack of care of one's environment, including squalor and hoarding.
- A refusal of services which would mitigate the risk of harm (Braye, Orr and Preston Shoot, 2015: 2).

48.23 Shelly's home conditions were also uncomfortable at best and unfit for human habitation and a health hazard at worst. The RSPCA had removed her pet dog because of them and would not agree his return until the situation had improved. Shelly also experienced periods without electricity or heating. The home conditions identified by those agencies that had seem them were described as unacceptable and suggestive of hoarding behaviours, although Environmental Health never assessed this because as already noted, a joint visit with the Police never took place.

49. Analysis: Practitioner Perceptions

49.1 Outsiders looking in at Shelly'S situation were often left feeling that she was not motivated to change and had made a life-style choice to remain in her adverse situation, but given that coercive control has been referred to as 'intimate terrorism' (Elmhirst 2019), leaving its victim hostage-like in the damage it inflicts on their self-respect, freedom, autonomy and sense of self, as well as to their physical and emotional well-being; Shelly was in reality exhibiting all the classic signs of someone suffering from the effects of coercive control.

49.2 Upon receipt of various PPNs raising concerns about Shelly'S situation, the Adult Services Safeguarding Co-ordinator recalls discussing Shelly's situation with a police colleague (not supported by contemporaneous records on the system), but this did not result in any action in response because of what she perceived as inflexibility in the view of multi-agency partners towards Shelly, operationally unhelpful procedures regarding mental capacity, and insufficient time when dealing with cases to fully reflect on the outcomes trying to be achieved. These are personal observations, but the comments made would support the Panel's view that at times the practitioners and agencies meeting Shelly and Mike demonstrated a lack of professional curiosity.

49.3 Various professionals had concerns about Shelly's alcohol use and her GP was also aware that she was misusing diazepam. 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 Shelly by her GP to mitigate the risk to the health, safety and well-being in light of these dependencies. There is also no evidence of referral onto other services with expertise in drug and alcohol dependency, although it is known that alcohol services can provide support and skills which can be used to improve other negative situations in a person's life, for example, by "reducing vulnerability factors, motivational interviewing and drug refusal training" (Mason, 2017: p.38). In addition, despite her high usage and frequent requests for early prescriptions, no apparent consideration was given to the thought that Shelly could be supplying her own diazepam to others; be it of her own volition or because she was being exploited and intimidated into doing so.

49.4 In addition, because Shelly had likely come to depend on alcohol and medication as a coping mechanism, perhaps to block out what was happening to her, the Review Panel thought it important to consider how this might have contributed to her additional needs and presented barriers to her ability and willingness to recognise or report abusive behaviour.

49.5 The Review Panel also identified that practitioner's working directly with Shelly and Mike frequently accepted what they were told and witnessed at face value, despite observing behaviours and hearing explanations that were suspicious and / or inaccurate and which would have warranted further investigation and challenge. As an example, the RSPCA had information about Shelly'S circumstances that was suggestive of domestic abuse and had also been inside her home and were aware of the conditions – but did not conclude that this was something that warranted further discussion with partners tasked with safeguarding adults.

49.6 In addition, despite being repeatedly told that he was not permitted to reside at Shelly'S address, it is clear from agency records that Mike was spending a significant amount of time at Shelly's and was to all intents and purposes, back living with her. This arrangement was unintentionally condoned when Mike's Offender Manager arranged and undertook a visit to him at Shelly's address, but did not arrange to visit him at his nominated address; which may have provided clear evidence that Mike was not genuinely residing there and was in breach of his conditions.

49.7 On arrival at prison, Shelly's weight was recorded as very low. However, following her admission, her weight gain over a short period of time was significant. Shelly's step-mother commented that being in Prison appeared to help Shelly, as she would

stop drinking and put on weight. When she was released in 2017, Shelly's family reported that she came to their home looking clean and healthy, but within a short time she had lost a lot of weight and started to look unwell again.

49.8 The reasons for the sudden weight change do not appear to have been explored with Shelly by the Prison or her GP and following Shelly's release from Prison in February 2018, a discharge letter to the GP recommended a referral to a Hepatologist to further investigate and manage a positive Hepatitis B and C diagnosis. This referral was not made, which the GP could not offer an explanation for and by the time of her death, Shelly had lost a further significant amount of weight.

49.9 The prioritisation of the need to fund her and, most likely, Mike's alcohol consumption, could quite reasonably have contributed towards Shelly's low body mass index (BMI) and declining health; albeit no medical enquiries to establish whether she had any alcohol related physical health problems were ever undertaken, despite her undernutrition, reported poor balance / unsteadiness and observable disorientation, confusion and questionable mild memory loss. This is questionable in so far as the combined effect of Shelly's diazepam and alcohol use might also go some way to explaining her presentation.

49.10 It is clear that opportunities to explore domestic abuse and her substance misuse levels with Shelly were missed on numerous occasions, highlighting that in reality, no agency was more meaningfully engaged with her than any other and none were exercising sufficient ownership; leading the Review Panel to conclude that some practitioners appeared to have become 'fatigued' by the scale and nature of the challenges faced in trying to work with Shelly and Mike. Consequently, risk assessment and risk management processes did not operate consistently or effectively in Shelly's case and the level of risk Shelly was subject to was often poorly understood and did not take account of all relevant agency and family information.

50. Analysis: Effectiveness of Multi-Agency Working

50.1 During the period under review, the Police attended 126 incidents involving Shelly. Many were domestic related calls, most made by neighbours after hearing shouting and arguing coming from Shelly's address and on occasions, witnessing assaults. There were also numerous calls in relation to Shelly'S begging and a Criminal Behaviour Order was issued to her in April 2017 as a result.

50.2 South Wales Police's IMR identified that, in the main, positive action was taken by them in response to domestic incidents, in the form of arrests when assaults had

taken place and 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. The police IMR also highlighted a missed opportunity in August 2015 to pursue a conviction against Mike, when after making a rare disclosure to officers of assault by Mike, Shelly was returned to the home briefly for Mike to be arrested and Shelly immediately changed her mind.

50.3 It was noted by the Panel that in view of the limited contact between Shelly and her family, they may not have been fully aware of the actions taken by the police and did not appear to know that evidence based prosecutions had taken place in Shelly's case. However, as Shelly's family have 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. As previously noted, on such occasion's officers arrested Mike for breach of the peace or removed him from the address to an alternative location, as The Crime and Security Act 2010 stated that violence or the threat of violence was required before a Domestic Violence Protection Notice (DVPN) could be issued and a Domestic Violence Protection Order (DVPO) granted.

50.4 The result of the now defunct internal police process implemented in response to the high volume of referrals to MARAC, was that for a significant period of time 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. The Police's position in this respect was not challenged by partner agencies until the MARAC Steering Group did so, which resulted in an immediate reversal of the process.

50.5 By the time of the last domestic incident between Shelly and Mike, the high-risk marker for Shelly had dropped off the police system as there had been no domestic abuse incidents reported for twelve months. The national guidance advises that markers should drop off after twelve months if there are no further incidents. The attending officer submitted a PPN and graded this as medium. The attending officer's risk assessment is based on the presenting circumstances, completion of the DASH, warning markers and additional information known about the individuals involved; they are not in a position to conduct an in depth risk assessment with a full

consideration of the history - this happens as part of a secondary risk assessment undertaken by risk assessors in the PPU. The risk assessors prioritise PPNs based on the risk allocated by attending officers and therefore high-risk cases will be opened first. A secondary risk assessment was not conducted on the final domestic abuse incident by the PPU as Shelly was deceased by the time the task was opened, but had this not been the case this risk assessment would have had a wider focus and would likely have raised the risk to high.

50.6 Shelly's vulnerabilities were recognised by the Police and information was shared with partner agencies via PPNs. In the main, PPNs were submitted appropriately by the Police and on those occasions where they had not been submitted but could have been, this was usually because on attendance the incident did not appear as first reported and no domestic incident was evident. PPNs, 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. The Panel has identified that referrals to Drug Aid documented in 2016 for Shelly are not recorded on Drug Aid's system, which they have no explanation for, but which suggests that some efforts made to access Shelly the necessary help were falling through the net.

50.7 Between the 12/6/2015 and 8/5/2017, in response to PPNs, 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 options, support and recovery, and advocacy. The service will collaborate with other agencies to increase the possibility for engagement, but in Shelly's case, it was unaware of other agency involvement other than that of the Police.

50.8 Shelly often reported that her injuries were as a result of falls, usually reproaching the family dog as the cause. Shelly rarely disclosed the truth about the abuse she was suffering at the hands of Mike and would always retract a disclosure, and when asked if she required support usually declined this. This is unsurprising, as victims of controlling or coercive behaviour may not recognise themselves as such and Shelly's repeated denials that she was in a domestically violent relationship, despite clear evidence to the contrary, were not understood or challenged by agencies and appears to have hindered appropriate intervention, support and progress.

50.9 Although there is no documented evidence that Shelly was asked directly by her GP whether she was the victim of abuse and there is 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.

50.10 In the wider health services, there was no documented evidence of questioning around domestic abuse and no assessment or identification of risk when Shelly was attended by WAST or presented at A&E, despite having injuries consistent with physical abuse and despite staff being alerted to the number of previous A&E presentations through access to electronic systems. Shelly was not discussed at 'Frequent Flyer' meetings either, where her vulnerabilities could have been discussed and consideration given to a bespoke management plan focussing on mitigating further harm.

50.11 Not surprisingly the research evidence shows that controlling relationships have an adverse impact on mental health (Barter, C.,McCarry, M., Berridge, D. and Evans, K. 2009) which is a risk factor for being a victim of coercive control i.e. they are mutually reinforcing. The findings of domestic homicide and serious case reviews highlight that domestic abuse, mental health issues and drug and alcohol problems feature significantly in cases where women or children are killed (Brandon et al., 2010; Robinson et al., 2018), and substance use was a factor in around half of domestic homicides in the United Kingdom (Home Office, 2016). There is little evidence that the agencies working with Shelly were sufficiently alert to this in their dealings with her and understanding of her situation and as established in Shelly'S case and within the research data, coercive control is a significant predictor of domestic homicide.

50.12 Panel 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. As an example, Adult Safeguarding received four PPNs from South Wales Police between the 18.10.2017 and 19.12.2017, and during the review it became apparent to the Panel that Adult Services had processed some of the PPNs 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.

50.13 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 it took the Panel

some time to identify what had happened in response because of inadequate record keeping and staff absences. The Environmental Health Officer subsequently reported that whilst a visit was arranged with the Police, they did not hear back from the Police Officer and did not follow this up with them or relevant senior staff. The 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.

50.14 As noted previously, Mike's Offender Manager arranged and undertook a visit to him at Shelly's address (which he was not permitted to reside at), but did not arrange to visit him at his nominated address to check that he was genuinely residing there - accepting at face value what they were being told by a service user demonstrating very limited levels of compliance.

50.15 There were various missed opportunities in the management of this case to engage Shelly in meaningful interventions and whilst Shelly was in a custodial setting for example, a safe and secure environment, prison visits were not undertaken. Whilst it is not common practice for prison visits to take place by an Offender Manager, it is good practice and when Shelly was in the prison environment, away from Mike and sober, she was possibly in a better position to respond to interventions designed to address her abusive relationship and alcohol misuse. Whilst the Prison managed Shelly's alcohol detoxification and undertook a health screening with her, there is no documented evidence that they explored domestic abuse directly with Shelly.

50.16 Several multi-agency meetings were held in relation to Shelly in the time period under review; including MARAC's, Quality of Life and ASB meetings. The minutes produced of these meetings were very limited in content and it was difficult to conclude whether there was a full discussion of the complexities of the case, which was not recorded, or no discussion took place. In either scenario, the action plans did not reflect that options for joint working were considered or utilised by the agencies present, and did not demonstrate robust agendas, comprehensive information-sharing, discussion, risk analysis, a focus on vulnerability or SMART action planning. Additionally, key agencies appeared to be missing from the MARAC despite having relevant information that would have increased knowledge.

50.17 It would appear that many of the agencies viewed Shelly's risk level through the narrow lens of their own organisation's input and it was responded to episodically as a result, not as an evolving process that needed to be kept under review by agencies

working together to consider key or new risks. As a result, Panel noted that some agencies, like the RSPCA, assumed that other agencies had primacy or held more information than they did about Shelly or Mike and therefore had greater insight and more ownership for taking the safeguarding lead. In addition, a Senior Nurse who contributed to the Review acknowledged that when Police are present with a patient who has been assaulted, it is unlikely that emergency staff will question around domestic abuse, in the belief that this will be dealt with by Police colleagues.

50.18 It should have been apparent to the agencies that met Shelly that she had multiple complex needs as a result of the abuse she suffered and her chaotic, self-neglecting behaviours. Despite the fact that a number of agencies had involvement with Shelly and Mike and were aware of the history of domestic abuse and alcohol misuse, they did not consistently or effectively share information in respect of them and generally operated in isolation from each other, resulting in the absence of practitioner or agency 'oversight' for the case and very limited opportunities for coordination of a multi-agency response to what was happening.

50.19 The Review 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.

51. Analysis: Understanding and Implementing the Law

51.1 At the time of writing this report, there were a range of existing orders that could be used in domestic abuse cases, including Non-Molestation Orders, Occupation Orders, Restraining Orders and Domestic Violence Protection Orders (DVPO's). Who could apply for them, the conditions that could be attached to them and the consequences of breach varied widely. In addition, there was no single order that was equally accessible across the criminal, family and civil courts, which led to confusion for domestic abuse victims and practitioners and created problems with enforcement.

51.2 It is not therefore surprising that when the Home Office reviewed the use of DVPNs and DVPOs one year after their rollout in 2014, it found that there was some confusion in police forces over the types of abusive behaviour covered by the orders, because the statute stated that a necessary precondition of issuing a DVPN was that the perpetrator had "been violent towards, or had threatened violence towards" the

person for whose protection the notice was intended. In addition, police, practitioners and organisations representing victims advised the Home Office that the effectiveness of the DVPO was limited due to its length, just fourteen – twenty-eight days, and the absence of criminal sanctions if the order was breached. The Domestic Abuse Bill 2019 has sought to address the challenges associated with DVPNs and DVPOs, through the explicit inclusion of abuse other than violence or the threat of violence.

51.3 The Review Panel also concluded that the legal frameworks available to protect individuals like Shelly were not always considered or used when they could have been. The Social Services and Well-being Act (2014) provides the statutory objectives of Safeguarding Boards, which in relation to adults is:

a) *"To protect adults within its area who –*

(i). Have needs for care and support (whether or not a local authority is meeting any

of those needs), and

(ii). Are experiencing, or are at risk of, abuse or neglect, and

b) To prevent those adults within its area

i. from becoming at risk of abuse or

ii. neglect" (S.135 (2)).

51.4 Abuse is defined as "a violation of an individual's human and civil rights by another person or persons which results in significant harm," and it is recognised that it can happen anywhere. An 'Adult At Risk' is a person aged 18 years or older and may include people with mental health problems, particularly when their situation is complicated by additional factors such as physical frailty, chronic illness, sensory impairment, challenging behaviour, lack of mental capacity, social and emotional problems, poverty, homelessness or substance misuse.

51.5 As Shelly spent a significant amount of her time intoxicated, and when sober was preoccupied by her need for alcohol and diazepam, the Review Panel would argue this drove her decision-making and suggests her addiction was impacting on her ability to reason. In addition, the Review Panel was persuaded that Shelly's capacity was also likely affected by the fact she was being coercively controlled by Mike; and at various points in her life she was arguably subject to all of the factors that can impact on whether someone would be defined as an 'Adult at Risk'.

51.6 Despite the Social Services and Well-being Act (2014) identifying people with substance misuse problems as possibly needing care and support, there is little guidance in applying this legislation, or the equally relevant Mental Capacity Act (2005) to this group of people. Helpfully for practitioners in England, The Care Act (2014) identifies alcohol and drug users as people who fall within its remit (s.92, para 5), and statutory guidance supporting the Care Act identifies self-neglect as a form of neglect and the guidance also states that someone does not need to lack capacity to be regarded as vulnerable.

51.7 There is nothing similar in the SSWB(W) 2014 Act or anything that specifically states that drugs and alcohol users are to fall within the Welsh Act's remit, but there is a presumption that they do from the definitions of 'adult' and 'wellbeing'. The Regulations to the Welsh Act specifically include drugs and alcohol users as eligible if their need arises from their use of drugs and alcohol: Para 3(a): The Care and Support (Eligibility) (Wales) Regulations 2015
http://www.legislation.gov.uk/wsi/2015/1578/pdfs/wsi_20151578_mi.pdf

There is no definition of vulnerable in the Welsh Act or in its Regulations, but there is a definition of capacity – Para 197(5) of the Act: A reference in this Act to a person having, or lacking capacity in relation to a matter is to be interpreted as a reference to a person having, or lacking, capacity within the meaning of the Mental Capacity Act (MCA) 2005. The legal aspects of the MCA 2005 are complex and it is not always obvious how it applies to people with alcohol misuse problems and it does not specifically address mental capacity in the context of alcohol misuse, something which the Department for Constitutional Affairs (2007) identified as an omission.

51.8 The MCA 2005 Code of Practice recognises that mental capacity can fluctuate and is time and decision-specific, which is particularly relevant to those with chronic alcohol problems. In the MCA 2005 Code of Practice the symptoms of alcohol use are listed as a potential 'impairment of the brain or mind' which can be a cause of lack of capacity (Department for Constitutional Affairs, 2007). When not heavily intoxicated, Shelly was capable of specific decisions and it appeared to the Review Panel that professionals had reached a view that Shelly met the first principle in the MCA 2005 and had capacity unless proven otherwise. Braye et al. (2011) has proposed that decisional and executive capacity can be impaired by alcohol misuse and there is plenty of evidence that Shelly's executive capacity was impaired, as she was rarely in a fit state to make it to an appointment that she may have previously decided to attend; her heavy alcohol use and chaotic circumstances limiting her ability to follow through on actions.

51.9 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. In Shelly's case her mental capacity was always assumed, despite an alcohol and diazepam consumption level that would have suggested evidence to the contrary. Shelly's capacity was never formally assessed or appropriately addressed, and her GP recalled that she consistently refused any offers of help and he considered her to have the capacity to make unwise decisions. Adult Safeguarding had also reached a conclusion on more than one occasion that Shelly had capacity, which was based on a superficial informal assessment that did not properly consider the degree of harm that she was subject to.

52. Conclusions

52.1 Mike killed Shelly, but there were several factors that clearly complicated and exacerbated the factors that led to the tragic outcome that Shelly's family had sadly come to believe was inevitable. The analysis of the four thematic headings referenced in the analysis section, have identified the below main issues and conclusions, from which the detailing of lessons learnt will be explored in the next section.

52.2 Victim Characteristics:

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

52.3 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.

52.4 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.
- 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.

52.5 **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.

53. Lessons to be Learnt

53.1 Lessons to be Learnt: Victim Characteristics

53.2 Shelly suffered several significant and traumatic events in her life, including experiencing adverse childhood experiences following the breakup of her parents' 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, which triggered the start of an unhealthy lifelong relationship with alcohol and a dependence on diazepam that led to a marked and steady deterioration in her physical and emotional well-being.

53.3 In addition, as a result of the violence and coercive control she was being subjected to, Shelly had become subordinate to Mike and was entirely dependent on him, as she had become isolated from sources of support, increasingly exploited and incapable of asserting her independence. Whilst Mike chose to present himself to the NPS and likely others, as Shelly's protector, it is clear from the review that Mike exploited her vulnerabilities in order to maintain control, which was not readily recognised by agencies and used to inform their involvement with Shelly. In addition, the assaults perpetrated on Shelly by associates, and the reasons she provided for why they had occurred, were also suggestive of someone experiencing exploitation at the hands of others.

53.4 More robust clinical input would also have been beneficial in assessing Shelly's physical and emotional well-being, as symptoms such as her weight loss, could have been picked up and indicated the extent of her alcohol and diazepam consumption, undernutrition and self-neglect. Heavy drinkers often under-report their alcohol

intake, so accurate assessments are vital, as establishing the risk associated with alcohol is often contingent upon accurately assessing the levels and patterns of consumption.

53.5 A key issue for practitioners and agencies is that clients with complex needs, at high risk of serious harm or death, and with fluctuating capacity due to alcohol misuse, are often resistant to, or do not engage with services. Shelly repeatedly refused care from services and was not motivated to make or attend prearranged appointments to address her alcohol addiction, and, in truth, her chaotic lifestyle made the likelihood of her being able to follow through on actions highly unlikely. Shelly's case has highlighted the inability of support services to intervene and stop what was happening, Shelly requiring input from a flexible alcohol treatment provision that could provide assertive outreach in and outside of normal working hours because of her complex needs.

53.6 The Review Panel also concluded that some frontline practitioners seemed unsure at what point Shelly's alcohol misuse was severe enough to warrant safeguarding concerns on the grounds of vulnerability to harm, exploitation or self-neglect. As with concerns of abuse and neglect by others, a multi-agency approach to protection and risk mitigation is crucial, and positively, Cwm Taf Morgannwg Safeguarding Board has sought to address the guidance gap for practitioners and developed a robust framework that will enable them to work together in a co-ordinated and consistent way, which offers the best chance of long-term positive outcomes for the person concerned. In the absence of All Wales guidance, the Review Panel would encourage Cwm Taf Morgannwg Safeguarding Board to agree and sign off the Multi-Agency Staff Guidance & Protocol for the Management of Cases of Serious Self-Neglect as a matter of urgency.

54. Lessons to be Learnt: Practitioner Perceptions

54.1 Whilst Shelly's presenting appearance and behaviours were highly suggestive of someone in distress and living under duress, this did not, interestingly, positively contribute to other people's sense of this, and does not appear to have prompted any real consideration by agencies of what the daily lived experience for Shelly must have been like; albeit there was a recognition that her circumstances were concerning. Consequently, Shelly's repeated begging within the community was consistently responded to as an anti-social behaviour matter and, outside of brief enquiries by the police, did not lead agencies to investigate the drivers for this; which may have enabled a conversation with Shelly about the level of exploitation in

her relationship, the level of substance misuse in existence and the impact this was having on her health and well-being.

54.2 Although Shelly could present as unresponsive and at times challenging in her response to those efforts made to try and provide her with assistance, as her situation became more desperate and she undoubtedly became more challenging in her interactions with others, the Review Panel has questioned whether it is possible that Shelly may have elicited a less inquisitive and sympathetic response from those around her; as there is limited evidence that the complexity of the situation she was in was recognised or understood by agencies. The Review Panel has identified numerous examples where opportunities to explore Shelly's lived experience with her were not taken advantage of by practitioners; such as during private consultations with her or of through the absence of visits to Shelly at home to assess her situation as intended / directed, and of missed opportunities by practitioners to visit Shelly in the prison environment.

54.3 Despite presenting with significant substance misuse indictors, this did not trigger assessment and treatment options for Shelly. The Review Panel would have anticipated given Shelly's risky poly substance misuse, that some medically supervised efforts to try and reduce her usage would have been attempted in the community, but this did not happen; the Health Board recognising that Policy to better inform prescribing practices is required in response. In addition, and as noted earlier in the report, whilst the Prison managed Shelly's alcohol detoxification and undertook a health screening with her, there is no evidence that they explored domestic abuse directly with Shelly.

54.4 In summary, the toxic relationship between Shelly's domestic abuse and self-neglect as a result of alcohol and prescription medication was poorly understood and 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. Consequently, in Shelly's case, her begging and criminal behaviour was primarily regarded by others as a personal choice, rather than a symptom of her vulnerability and exploitation.

55. Lessons to be Learnt: Effectiveness of Multi-Agency Working

55.1 The Panel identified that agencies had not responded effectively to the challenge presented by someone who resisted support, despite needing it, and because it is incumbent on agencies tasked with taking care of the most vulnerable, work is being done 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, providing an opportunity to offer support.

55.2 The Review Panel has identified that internal and multi-agency agency policy and procedures did not always operate consistently, leading Shelly to be spoken to in front of Mike on occasions when allegations were being investigated, or not being questioned about the cause of injuries despite clear indicators that abuse was present; and in respect of Shelly'S mental health and substance misuse levels, policy and procedures not being followed consistently resulted in barriers to her receiving appropriate assessment, care and treatment pathways and at the right time. From a criminal justice perspective this also resulted in MARAC meetings not taking place in an effort to manage risk and demand differently and home visits to Mike and breach proceedings by the NPS being initiated later than they could have been.

55.3 It is also important that agencies do not operate in silos and recognise that in the world of safeguarding, effective communication can and must exist between those agencies tasked with investigating and addressing abuse in all its forms. Shelly's case highlighted the relationship that often exists between human and animal abuse and in this case, these links were not made and the recognition of the responsibility to safeguard outside of the parameters of role were missed; there being no liaison between the RSPCA and its Adult safeguarding partners.

55.4 It is also crucial that agencies making and those receiving referrals have a shared understanding of how forms should be completed and how they will be processed in response. Otherwise vulnerable people needing services will fall through the gaps, the Panel having identified that referrals to Drug Aid in 2016 for Shelly (the service is no longer in existence) were not recorded on Drug Aid's system, and Adult Services had not acted on some referrals because they believed incorrectly that consent had not been provided and that they were being shared for information purposes only. In response, SW Police and Adult Services have engaged in a piece of work designed to clarify understanding and remove any potential barriers to people accessing support and services because of a difference in agency interpretation. Both agencies will also develop clear guidance for staff and officers to ensure that this is not happening.

55.5 Conversations have also taken place locally in the VAWDASV and Safeguarding fields about the efficacy of both the MASH daily Domestic Violence discussions and the MARAC process. Consequently, the Community Safety Partnership tasked the

MARAC Quality Assurance Group with addressing the question of whether either were sufficiently effective. The MARAC Quality Assurance Group concluded that improvements needed to be made to achieve better outcomes and both processes needed to re-focus on the fundamental aims of the MARAC; safeguarding victims, children, professionals and managing perpetrator behaviour.

55.6 Additionally, it was felt that earlier and more complete interventions at the daily discussions level might prevent the escalation of risk, reduce the volume of cases discussed at MARAC and identify earlier victims and perpetrators who are resistant to engaging with service provisions and therefore most at risk. The proposals being taken forward should enable the multi-agency network to identify and articulate risks more clearly, generate actions to mitigate each risk identified, share only information that is relevant and proportionate, create consistency of process through the MASH daily discussions into the MARAC and ensure that all necessary agencies attend and contribute to actions. The Review Panel were also assured that SWP have now recruited four additional risk assessors and implemented a daily triage of PPNs to address any delays such as those highlighted by the review.

55.7 The monthly QOL Meeting has now changed to a monthly PSG (Problem Solving Group) meeting, which will escalate matters to a quarterly QOL meeting (which reports to the Community Safety Partnership and Public Service Board). The purpose of the group is to identify the individuals, groups, locations and issues, which adversely impact on the quality of life of the communities within Northern BCU and increase demand on Police and partners. Each partner organisation contributes towards the delivery of the PSG outcomes; for South Wales Police these outcomes are hate crime, ASB, crime prevention and investigation, safeguarding and addressing vulnerability, public order, partnership working and third sector engagement.

55.8 As a result of this review, and to ensure a focus on vulnerability, a Protecting Vulnerable Persons Officer from the Public Protection Unit will now attend the monthly meetings. The group will discuss, identify and implement problem solving tactics to resolve them. The chair will identify specific actions to tackle the priorities identified, with an update to be provided at the next meeting. Where the problem has not been resolved within three months by the tactical practitioners, it will be escalated and included on the agenda for the quarterly QOL meeting.

55.9 Shelly's family recognised that Shelly refused to engage with services and would only accept support on her own terms but understood that some agencies and professionals knew what was happening to her. With hindsight, perhaps if agencies

had sought to engage with Shelly's family this might have resulted in a greater respective awareness of what was going on, a better understanding of Shelly's vulnerability, the cause of her service refusal and greater opportunity to develop risk management strategies.

55.10 In addition, had the quality of information sharing between agencies prior to Shelly's release from prison been effective, this may have prompted appropriate liaison between CRC and the resettlement service, Through the Gate; when consideration of the need to explore Shelly's social and environmental circumstances and benefits requirements could have taken place. In addition, it is possible that Shelly'S release from custody may have been recognised as increasing the risks she faced and multi-agency consideration could have been given to the potential for a false positive outlook by the professional network, and appropriate measures put in place to mitigate against any likely risks.

56. Lessons to be Learnt: Understanding and Implementing the Law

56.1 By the time of the last domestic incident between Shelly and Mike, in line with national guidance, the high-risk marker for Shelly had dropped off the police system as there had been no domestic abuse incidents reported for twelve months. Whilst the Police handled the last domestic abuse incident in line with national guidance, the Review Panel has speculated whether Shelly's absence from the area through serving prison sentences, had the unintended consequence of suggesting that tensions between the couple had reduced, when in reality the opportunity for domestic incidents to occur had been limited by their enforced separation.

56.2 The Domestic Abuse Bill 2019 introduces a new civil Domestic Abuse Protection Notice (DAPN) to provide immediate protection following a domestic abuse incident, and a new civil Domestic Abuse Protection Order (DAPO) to provide flexible, longer-term protection for victims. This will enable DAPNs and DAPOs to be used to protect victims from all forms of domestic abuse, including non-physical abuse like controlling or coercive behaviour; which will hopefully go some way towards resolving the problem with interpretation that existed and was expressed as practitioner and family frustration in Shelly's case.

56.3 Section 7 of the Social Services and Well-being Act Wales 2014 includes coercive control and details the local authority duty to make (or ask others to make) safeguarding enquiries and to determine what action is needed to protect 'an adult at risk' if there is 'reasonable cause to suspect' that an adult with health and social

care needs is experiencing coercive control (where their needs prevent them from protecting themselves). Whilst this can be particularly complex in situations where a person, like Shelly, may have impaired capacity to make a decision due to the impact of the abuse they are experiencing affecting their ability to weigh up the risks and benefits of that decision, Case law has indicated that:

> *A vulnerable adult who does not suffer from any kind of mental incapacity is, or is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other vitiating factors.* (Re: SA (Vulnerable adult with capacity: marriage) [2005] EWHC 2942 (Fam). Para 79)

56.4 In a Court of Protection judgement (A Local Authority v DL, RL & ML [2010] EWHC 2675) and a subsequent judgement heard by the Court of Appeal, it was agreed that 'inherent jurisdiction' could be used in such a circumstance. Local Authorities can therefore apply to the Court of Protection for relevant orders to protect people who are not able to make decisions due to the level of coercion and control being exercised over them, which the Panel have concluded would have been a suitable course of action in Shelly'S case had there been a better agency grasp of the adverse circumstances she was facing and understanding of the impact coercive control has on capacity.

56.5 Mental capacity can and does fluctuate, and despite indications that an assessment was needed, Shelly's capacity was never assessed or appropriately addressed. Agencies have a duty to safeguard adults, which can make finding the right balance between choice and protection challenging, but given no legal advice was ever sought in Shelly's case, this prevented a discussion on the possibility of Court of Protection proceedings and decisions being made in Shelly's best interests. Whilst this responsibility clearly requires that Authorised Officers (AO) in particular, who make applications to a magistrate's court for an Adult Protection and Support Order (APSO), need to be able to identify coercive control and its effects on vulnerable adults, the Panel would argue that any professional coming into contact with a vulnerable adult should be alert to the indicators of coercive control, and the additional vulnerability and personal damage it creates when it begins to manifest itself in the behaviour of victims. Legal training is clearly needed for practitioners on this, which will align with the Multi-Agency Staff Guidance & Protocol for the Management of Cases of Serious Self-Neglect

56.6 Shelly was a vulnerable adult, who was also 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 a substance misuser; which resulted in persistent barriers to Shelly receiving appropriate assessment, care and treatment pathways. Guidance and training 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.

56.7 Unlike the Care Act (2014), the SSWB (W) 2014 Act does not provide practitioners working within Wales with a definition of what self-neglect looks like and guidance on how to respond to it, which was a missed opportunity given how complex this work can be. Self-neglect is a relatively recent concept in the world of adult safeguarding and this, combined with the lack of clarity within legislation and guidance in Wales, appears in Shelly's case to have impacted on practitioner knowledge levels; with alcohol and diazepam misuse in Shelly's case being less readily identified as self-neglect compared to other symptoms and more of a 'lifestyle choice' rather than symptom and cause of other underlying issues. The Multi-Agency Staff Guidance & Protocol for the Management of Cases of Serious Self-Neglect developed by the Safeguarding Board should help to address this.

57. Recommendations

57.1 **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.

57.2 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.'

57.3 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

57.4 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.

57.5 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.

57.6 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

57.7 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.

57.8 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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