Rhondda Cynon Taf

COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Georgina'

Date of death: May 2023

Final Version

March 2026

Chair and Author: Carol Ellwood-Clarke (QPM)
Supported by: Ged McManus

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Family Tribute

'It's really hard to put in enough words to purely give my mam the credit she truly deserves, 46 whole years my mam endured nothing but hurt and trauma, she was let down by the people who really should have been her saviour. Regardless of everything my mam went through in her short life she gave more empathy and compassion to every single person that crossed her path regardless of their situation or background. She was the life and soul and anyone who was a part of her life would also agree that they were lucky to be a part of her life. She always said she didn't achieve much in her lifetime but one thing she was always proud of was being a mum and being a nanna. She absolutely loved being around me and her grandson and would find any given opportunity to be there. Mam was a free spirit, she had the driest sense of humour which majority of the time did get her in to trouble, yet she would always thrive to walk in to a room and put a smile on at least one persons face. Losing mam in the circumstance I did has been the most painful experience I've ever had to endure and although the person who is responsible for her death is behind bars for 17 years I have to live with a life sentence. There will never be enough punishment that'll be acceptable to me, every day I wake up and thrive on being the parent my mam would be proud of, there's never a moment where I don't think of her and wonder what she would be doing, she's missed out on so much including gaining two granddaughters, she would also be smitten to know that we used a name for her newest granddaughter, that she always loved, she finally got her little 'Dolly'. I hope wherever she is, that she's finally at peace and living a life she always deserved, she may have left this world in the most undignified way but I'll always carry her name and her story with the dignity she deserves. To the world she's just another statistic but to me she was my whole world.
'Love you to the moon and back again mam'

1. INTRODUCTION

1.1 Rhondda Cynon Taf Community Safety Partnership and the Domestic Homicide Review Panel offer their sincere condolences to Georgina's family.

1.2 This report of a Domestic Homicide Review (DHR)[1] examines how agencies responded to, and supported, Georgina, prior to her murder in May 2023. The review has been completed following the Home Office Domestic Homicide Review statutory guidance (2016).[2]

1.3 Georgina was alcohol dependant and known to agencies for her alcohol dependency, mental health, suicidal ideation, and as a victim of domestic abuse in previous relationships. During the review time period, Georgina had been in a relationship with a male called John. Georgina was a victim of domestic abuse within that relationship. John was convicted of assaulting Georgina, for which he received a custodial sentence. Georgina was not in a relationship with John at the time of her murder.

1.4 Georgina and Gary grew up in the Neath Port Talbot area of South Wales and knew one another from secondary school. They had been in a relationship as teenagers. In 2019, Georgina and Gary renewed their relationship, having met via social media: this relationship was described as being 'on and off'. At the start of their relationship, Georgina was living in the Rhondda Cynon Taf area. Gary lived in a privately rented property in Neath Port Talbot.

1.5 During Georgina's relationship with Gary, she was a victim of domestic abuse. The abuse was perpetrated by Gary and consisted of physical and financial abuse, as well as coercive and controlling behaviour.

1.6 In May 2023, the police received a report of concern for a female reported to be at the home address of Gary. Upon arrival of the police, Georgina was found, deceased. Gary was arrested and later charged with the murder of Georgina. A Home Office post-mortem determined that the cause of Georgina's death was: pressure to the neck by a ligature with blunt force injuries to the head and face.

1.7 In January 2024, Gary was found guilty of the murder of Georgina and sentenced to a mandatory life sentence, with a minimum tariff set at 17.5 years. In sentencing Gary, the judge stated that Gary had: 'brutally murdered a very vulnerable woman in her 40s, with whom you were in a

[1] Section 4 of this report sets out, in more detail, the purpose of a DHR and the terms of reference the review panel adopted.

[2] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

relationship. You did so firstly by inflicting various facial and other injuries on her... you then strangled her to death. It must have been a terrifying way for her to die, and she would have suffered not just physically but psychologically'. The judge further stated that Gary had 'acted with cold, callous self-interest throughout, and was impassive while listening to the victim impact statement read out in court'.

1.8 In addition to agency involvement, the review will also: examine the past to identify any relevant background or trail of abuse; whether support was accessed within the community; and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.9 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.10 It is not the purpose of this DHR to enquire into how Georgina died: this is determined through other processes.

1.11 Following the trial, the senior coroner reviewed the case. A decision was made to close the case, as the death had been dealt with at Crown Court.

2. TIMESCALES

2.1 On 10 May 2023, South Wales Police notified Cwm Taf Community Safety Partnership of the death of Georgina. Consultation was conducted with panel members, via e-mail, and it was agreed that the criteria for a Domestic Homicide Review were met. A letter was returned to South Wales Police on the 16 June 2023, outlining this decision but querying Georgina's residency at the time of her death.

After a period of uncertainty surrounding Georgina's residency, Cwm Taf Community Safety Partnership agreed to conduct the Domestic Homicide Review, and the Home Office was notified on 2 February 2024.

2.2 The first meeting of the Review Panel took place on 17 July 2024. There was a delay in the review starting due to the criminal investigation.

2.3 The DHR covers the period from 1 August 2019 to May 2023. The start date was chosen by the Review Panel to capture relevant information within the period of Georgina and Gary's relationship. All agencies were asked to consider and analyse any significant contacts prior to these dates, and these have been included within the review, where relevant.

2.4 The Domestic Homicide Review was presented to Cwm Taf Morgannwg Safeguarding Board Meeting on 17 June 2025 and Cwm Taf Morgannwg Community Safety Partnership on 26 June 2025 and concluded on 4th July 2025 when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Until the report is published, it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The report uses pseudonyms for the victim, perpetrator, and significant others: these were chosen by the family.

3.3 This table shows the age and ethnicity of the subjects of the review. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	Ethnicity
Georgina	Victim	46	White British Female
Gary	Perpetrator	48	White British Male
Significant Other			
John	Previous partner of Georgina	55	White British Male

4. TERMS OF REFERENCE

4.1 The purpose of a DHR 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 those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;

- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

- contribute to a better understanding of the nature of domestic violence and abuse; and

- highlight good practice.
(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7)

4.2 Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[3] did your agency identify for Georgina, and what was your response?

2. What knowledge was your agency aware of that indicated Gary and/or John might be a perpetrator of domestic abuse, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Gary and/or John?

3. How did your agency assess the level of risk faced by Georgina? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

[3] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

4. How effective was inter-agency information sharing and co-operation in response to the subjects of this review, and was information shared with those agencies who needed it? N.B. Please also consider cross-border information sharing.

5. How did your agency respond to any mental health issues, substance misuse, and/or self-neglect when engaging with Georgina and Gary?

6. What services did your agency provide for Georgina and/or Gary; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?

7. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions?

8. Were the subjects of the review signposted to other agencies, and how accessible were these services to the subjects? Were there any barriers that may have prevented access and/or engagement with services?

9. Were single and multi-agency policies and procedures, including the MARAC, followed? Are the procedures embedded in practice, and were any gaps identified?

10. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to COVID-19.

11. What knowledge did family, friends, and employers have of any incidents of domestic abuse, including coercive control, and did they know what to do with that knowledge?

12. Were there any examples of outstanding or innovative practice arising from this review?

13. What learning has emerged for your agency, and how has this been or how will this be embedded into practice?

14. Does this learning appear in other Domestic Homicide Reviews commissioned by Rhondda Cynon Taf Community Safety Partnership?

5. METHOD

5.1 On 9 April 2024, Carol Ellwood-Clarke was appointed as the Independent Chair and Author. The Chair was supported in the role by Ged McManus. There was a delay in the review commencing due to the ongoing criminal investigation and the availability of the Chair.

5.2 The first meeting of the DHR panel determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce Individual Management Reviews (IMRs):[4] the other agencies were asked to produce short reports.

5.3 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified, and auxiliary information was sought.

5.4 The DHR was complex and involved a significant amount of information being gathered during the review phase: across a range of agencies and cross-boundary areas – including Rhondda Cynon Taf, Neath Port Talbot, and Vale of Glamorgan. There were over 20 agencies involved in the review, producing a detailed combined chronology. The police had over 300 records of information held on their databases for Georgina alone. The majority of the information gathered, related to Georgina. Very little information was known about Gary.

5.5 During the review timescale, Georgina had been in a relationship with John. Georgina was not in this relationship at the time of her murder, and John was not involved in the murder of Georgina. The Review Panel agreed to only include information – in relation to Georgina and John's relationship – which referenced domestic abuse, alcohol and substance use, risk factors, and criminal behaviour. The Review Panel agreed that agencies would not undertake extensive research of John's records, as consent had not been obtained.

5.6 The Review Panel discussed the most appropriate way in which to analyse and report on the collective information – taking cognisance of the Home

[4] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

Office Statutory Guidance. The Review Panel reviewed all the information provided and made a decision to analyse only those significant events that fell within the Terms of Reference, and it would provide a summary of the remaining contacts, both within and prior to the review timescales.

5.7 The Chair wrote to Gary to invite him to contribute to the review. The letter was delivered by Gary's Prison Offender Manager, who explained the content of the letter and the review process. Gary initially agreed to speak to the Chair; however, on the date and time of the arranged meeting, he declined to attend the meeting.

5.8 During the gathering of information, Swansea Bay University Health Board informed the review that they required the written consent of Gary prior to accessing his health records. The Chair arranged for a letter and consent form to be delivered to Gary by his Prison Offender Manager. Gary provided written consent; however, despite repeated attempts by the panel member from Swansea Bay University Health Board, Gary's health records were unable to be sourced.

5.9 The Chair wrote to John to invite him to contribute to the review. The letter was delivered by John's Prison Offender Manager, who explained the content of the letter and the review process. John agreed to speak to the Chair, and information from this contact is captured in the report, where relevant.

Practitioners

5.10 In November 2024, the Chair spoke to frontline staff from South Wales Police and a support officer from Trivallis (housing provider) who had worked directly with Georgina – to gather further information to inform the review. These contacts were held via Microsoft Teams. Practitioners provided valuable information that has been included within the report, where relevant.

5.11 Thereafter, a draft overview report was produced: this was discussed and refined at panel meetings before being agreed.

5.12 The draft report was shared with Georgina's family and their respective Victim Support Homicide Worker. Georgina's family were invited to make any additional contributions or corrections. Following access to the draft report, Georgina's daughter expressed her view that the report

demonstrated that agencies had lacked any form of empathy towards her mother during their contacts prior to her mother's death.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS, AND THE WIDER COMMUNITY

6.1 The Chair was introduced to Georgina's family by their respective Victim Support Homicide Workers. Georgina's mother and daughters agreed to speak to the Chair and participate in the review process.

6.2 The Chair spoke to Georgina's eldest daughter via Microsoft Teams, and she provided the Chair with valuable information about her mother, which has been captured in the report, where relevant. The Terms of Reference were discussed and shared with Georgina's daughter, along with a copy of the Home Office leaflet.

6.3 As the review progressed, the Chair was informed by the Victim Support Homicide Worker that due to personal reasons, Georgina's mother would not be able to contribute to the review. The Victim Support Homicide Worker provided Georgina's mother with regular updates on the review process, including information held within the draft report.

6.4 The Chair attempted to speak to Georgina's youngest daughter; however, at the time of this contact, she had left Wales and was believed to be living in another country. The Chair contacted the Victim Support Homicide Worker, who had been allocated the case during the criminal investigation, to seek assistance; however, all attempts at contact by both the Chair and Victim Support Homicide Worker were unsuccessful. Georgina's family were not in contact with the daughter to aid communication.

Landlady

6.5 The Chair spoke to Gary's landlady, who provided the Chair with information in relation to Gary's tenancy and relationship with Georgina. Information from this contact has been captured in the report, where relevant.

Employer

6.6 Georgina was not in employment during the review time period.

7. CONTRIBUTORS TO THE REVIEW

7.1 This table show the agencies who provided information to the review.

Agency	IMR	Chronology
Adult Services – Rhondda Cynon Taf	·	·
Barod	·	·
Citizens Advice Bureau	·	·
Cwm Taf Morgannwg University Health Board (CTMUHB)	·	·
Housing Solutions – Vale of Glamorgan	·	·
New Pathways	·	·
Outreach and Recovery Team (Adult Community Mental Health Services)	·	·
South Wales Police	·	·
South Wales Victim Focus	·	·
Swansea Bay University Health Board (SBUHB)	·	·
Trivallis	·	·
Welsh Ambulance Service NHS Trust (WAST)	·	·
British Transport Police	Summary Report	·
Domestic Abuse Service – Rhondda Cynon Taf	Summary Report	·
Children's Social Care – Rhondda Cynon Taf	Summary Report	
Adult and Children's Social Care – Neath Port Talbot	Summary Report	
Department for Work and Pensions (DWP)	Summary Report	
IDVA Service – Rhondda Cynon Taf	Summary Report	
National Centre for Domestic Violence (NCDV)	Summary Report	
Probation Service	Summary Report	

7.2 The IMRs contained a declaration of independence by their authors, and the style and content of the material indicated an open and self-analytical approach, together with a willingness to learn. All the authors explained that they had no management of the case nor direct managerial responsibility for the staff involved with this case.

7.3 Below is a summary of contributors to the review.

7.3.1 **Adult Services**

Adult Social Care Services in Rhondda Cynon Taf work with adults who need care, support, or protection in order to live safely and independently in their own homes, within their local communities, while enjoying a fulfilled life.

7.3.2 **Barod**

Barod is a voluntary sector agency providing support, information, and advocacy to those who are vulnerable and marginalised as the result of their own or someone else's drug and/or alcohol use, in order to improve their physical, social, and emotional well–being. Furthermore, Barod aims to improve individuals', communities', and society's understanding and awareness of the relationship between drug/alcohol use, vulnerability and exclusion, in order to overcome barriers that perpetuate the cycle. Barod offers support in the forms of one-to-one psychosocial support, brief interventions, and groupwork, whilst following a harm-reduction way of working.

7.3.3 **Citizens Advice Bureau**

A charity that provides free impartial independent advice on issues such as debt, welfare benefits, and employment.

7.3.4 **Cwm Taf Morgannwg University Health Board (CTMUHB)**

Cwm Taf Morgannwg University Health Board provides all primary and secondary services to all people living within the designated area.

7.3.5 **Housing Solutions – Vale of Glamorgan**

The Vale of Glamorgan Council (Cyngor Bro Morgannwg) is the local governing body for the Vale of Glamorgan: a county borough in South Wales, United Kingdom. It is responsible for providing local services and facilities to the residents of the area, including Education, Social Services, Waste Management, Housing, Planning and Development, Transportation and Roads, Leisure and Culture, and Environmental Health.

Vale Domestic Abuse Services (VDAS) is a specialist service commissioned by the Vale of Glamorgan Council via their HSG Service to provide support, advice, and accommodation to victims of domestic abuse. They have 17

units of accommodation in the Vale of Glamorgan, consisting of a Refuge, a Second Stage Refuge, and dispersed units.

7.3.6 **New Pathways**

New Pathways provides a range of support for victims of rape, sexual abuse, and assault. This includes advocacy support from Independent Sexual Violence Advisers (ISVAs), assessment and support from Sexual Violence Support Workers, and counselling.

7.3.7 **Outreach and Recovery Team (Adult Community Mental Health Services)**

Adult Community Mental Health Services provides support for individuals suffering with mental health issues/drug and alcohol issues from the areas of Bridgend, Rhondda Cynon Taff (RCT), and Merthyr Tydfil. The Adult Community Mental Health Services comprises of a number of teams that span across primary and secondary care. Primary care services are offered in each locality where assessment, signposting, and short-term intervention is available for patients referred by their registered GP. Secondary care involves Community Mental Health Teams (CMHT) for each locality offering assessment, monitoring, and longer-term intervention, as well as two Outreach and Recovery Teams offering recovery-based intensive support to individuals with serious and enduring mental illness. Local Community Drug and Alcohol Teams (CDAT) sit under secondary care services and receive referrals from DASPA (Drug and Alcohol Single Point of Access). CDAT are a specialist service who offer a harm reduction approach, which includes working towards abstinence when appropriate.

7.3.8 **South Wales Police**

South Wales Police provides a policing service to 1.3 million people, which equates to 42% of the population of Wales, with around 49% of the total recorded crime in Wales occurring in its force area.

The Force is developing ever closer partnerships to protect vulnerable people through multi-agency hubs. The Force has also introduced a tri-service centre with two Fire and Rescue Services and the Wales Ambulance Service Trust. The Force works collaboratively within policing and in conjunction with statutory and non-statutory partners to deliver a criminal justice and public protection service to the communities of South Wales.

The force area includes 64 of the 100 most deprived communities in Wales and is a diverse region, featuring rural, coastal, and urban policing challenges, including the two most populated cities in Wales – Swansea and the capital city, Cardiff, which attracts over 18 million visitors per year and is home to over 94,000 students.

7.3.9 **South Wales Victim Focus**

South Wales Victim Focus is funded by the South Wales Office Police and Crime Commissioner to provide support to the victims and witnesses of crime. Victim Focus is a multi-crime service that supports victims of all nature of crime. They receive the vast majority of referrals from South Wales Police, but also through referral pathways for self-referral or 3rd party agency referrals. They support standard risk victims of domestic abuse.

7.3.10 **Swansea Bay University Health Board (SBUHB)**

Swansea Bay University Health Board (SBUHB) is the local health board of NHS Wales for Swansea and Neath Port Talbot, in the south-west of Wales.

7.3.11 **Trivallis**

Trivallis is a housing association owned by its tenants – providing safe, secure, and affordable homes.

7.3.12 **Welsh Ambulance Service NHS Trust (WAST)**

Welsh Ambulance Services University NHS Trust is a clinically focused organisation providing high quality care and service across Wales. The services include:

- Blue Light 999 emergency response (EMS), including call taking, remote clinical consultation, see and treat, and if necessary, conveyance to an appropriate hospital or alternative treating facility.

- Non-Emergency Patient Transport Service (NEPTS): taking patients to and from hospital appointments and transferring them between hospitals and treatment facilities.

- NHS 111 Wales provides 24-hour health advice and information. Its 111 service also supports the front-end call handling and triage element of the GP out-of-hours service across Wales

999 call handlers deal with more than half a million calls every year: 24/7, and 365 days of the year.

Attends more than 250,000 emergency calls a year, over 50,000 urgent calls and, transports over 1.3 million non-emergency patients to over 200 treatment centres throughout Wales and England.

WAST employs almost 3,400 staff, operating from 90 ambulance stations, three contact centres, four regional offices, and four vehicle workshops.

7.3.13 **British Transport Police**

They police Britain's railways, providing a service to rail operators, their staff, and passengers across the country. They also police the London Underground, Docklands Light Railway, the Midland Metro tram system, Croydon Tramlink, Tyne and Wear Metro, Glasgow Subway, and IFS cloud cable car.

7.3.14 **Domestic Abuse Service – Rhondda Cynon Taf**

The team consists of dedicated individuals who are passionate about supporting individuals affected by domestic abuse and sexual violence. They each bring with them a diverse range of skills, knowledge, and experiences; however, what unites us is a shared passion to achieve our vision.

7.3.15 **Children's Social Care – Rhondda Cynon Taf**

Offers a wide range of support from information, advice, and early help to responding as part of their legal duties to when a child may be at risk of harm.

7.3.16 **Adult and Children's Social Care – Neath Port Talbot**

Supports people to stay independent and maintain choice and control over their lives.

7.3.17 **Department for Work and Pensions (DWP)**

The Department for Work and Pensions (DWP) is responsible for welfare, pensions, and child maintenance policy. As the United Kingdom's biggest public service department, it administers the State Pension and a range of working age, disability, and ill-health benefits to around 20 million claimants and customers.

7.3.18 **IDVA Service – Rhondda Cynon Taf**

The IDVA service provides advice, information, and support to people experiencing domestic abuse, primarily those assessed as high risk. The service is non-gender specific and works towards improving safety for

individuals to remain at home or alternatively support to move/source refuge provision. The IDVA service also offers support and information to victims/survivors when going through the court/criminal justice process and can offer advice and referrals/signpost to relevant specialist services as appropriate.

7.3.19 **National Centre for Domestic Violence (NCDV**)

The National Centre for Domestic Violence was established in 2003 – to help survivors of domestic violence and abuse obtain protection against an abuser, as well as offering services to the police, Probation Service, domestic abuse agency workers, the legal profession, and judiciary. They specialise in providing free, fast, and effective support to survivors of domestic abuse, usually by helping individuals obtain injunctions from their local county court. This free service is provided to everybody, regardless of their financial circumstances, sexual orientation, race, gender, age, political, religious belief, or otherwise.

7.3.20 **Probation Service**

The Probation Service is a statutory criminal justice agency that supervises all offenders (in the community) subject to statutory supervision.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the Review Panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Charlie Arthur	Chief Executive	Domestic Abuse Service, Rhondda Cynon Taf County Borough Council
Beth Aynsley[5]	Protecting Vulnerable Person Manager	South Wales Police
Elise Bacchetta	Business Coordinator	Cwm Taf Morgannwg Safeguarding Board
Gary Black	Head of Community Safety Partnership	Rhondda Cynon Taf
Carla Blackshaw[6]	Health/Clinical Nurse Specialist for Safeguarding	Cwm Taf Morgannwg University Health Board
David Butt	Senior Investigating Officer	South Wales Police
Carol Ellwood-Clarke	Independent Chair and Author	
Cheryl Emery	Service Manager	Housing, Rhondda Cynon Taf County Borough Council
Deb Farrar	Statutory Review Manager	South Wales Police
Chris Frey-Davies	Principle Officer	Children & Adults, Neath Port Talbot
Rachel Gronow	Housing and Domestic Abuse Service Manager	Rhondda Cynon Taf County Borough Council
David Harris	Senior Safeguarding Specialist	Welsh Ambulance Service NHS Trust
Menna Holcombe	Team Leader	Outreach and Recovery Team
Kate Hollinshead	Team Leader	Housing Solutions and Supporting People, Vale of Glamorgan

[5] Replaced by Deb Farrar following secondment to Welsh Government.
[6] Observing for professional development.

Lara Jackson[7]	Ambulance Technician	Welsh Ambulance Service NHS Trust
Nicola Jones	Senior Nurse	Cwm Taf Morgannwg University Health Board
Beth May	Head of Safeguarding Care and Support	Adult Services, Rhondda Cynon Taf County Borough Council
Ged McManus	Independent Reviewer	
Laura Morris[8]	Safeguarding Lead Nurse	Swansea Bay University Health Board
Emma Richards	Head of Delivery	Probation Service
Nicola Richards	Engagement and Intervention Service Manager	Barod
Derek Streek	Interim Head of Sustaining and Managing Tenancies	Trivallis
Katherine Thomas	Deputy Head of Safeguarding	Swansea Bay, University Health Board

8.2 The Chair of Rhondda Cynon Taf Community Safety Partnership was satisfied that the Panel Chair/Author was independent. In turn, the Panel Chair believed that there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met seven times. The circumstances of Georgina's death were considered in detail, with matters freely and robustly considered, to ensure all possible learning could be obtained. Panel meetings were held virtually. Outside of the meetings, the Chair's queries were answered promptly via email or telephone call, and in full.

[7] Observing for professional development.
[8] Observing for professional development.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 set out the requirements for review Chairs and Authors.

9.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not South Wales) in 2017, after 30 years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to safeguarding and family liaison. In addition, she is an Associate Trainer for SafeLives.[9]

9.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not South Wales). He served for over 30 years in different police services in England. Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

9.4 Between them, they have undertaken the following types of reviews: child serious case reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. In addition, they have undertaken accredited training for DHR Chairs, provided by AAFDA. Both have been awarded a certificate in chairing DHRs from the Open College Network, London.

[9] https://safelives.org.uk/

10. PARALLEL REVIEWS

10.1 HM Coroner for Swansea and Neath Port Talbot opened and adjourned an inquest. The Chair notified His Majesty's Coroner that a DHR was being undertaken. An inquest was not held because the senior coroner determined that the death had been dealt with at Crown Court.

10.2 South Wales Police completed a criminal investigation following Georgina's death. Gary was charged with the murder of Georgina. Following a Crown Court hearing, Gary was found guilty of the murder of Georgina and sentenced to life imprisonment with a minimum term of 17.5 years.

10.3 Georgina had received contact with adult safeguarding services and therefore a referral for an Adult Practice Review (APR) could have been considered in this case. There was no historical information to suggest at the time that the DHR notification was submitted or in subsequent agency communication to progress the DHR that this was fully recognised or actively considered. The DHR covered all aspects of vulnerability and members of the APR panel were on the DHR panel.

10.4 The review was not aware of any other investigations that have taken place since Georgina's death.

10.5 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DHR process. There has been no indication from any agency involved in the review that the circumstances of the case have engaged their disciplinary processes.

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include “over fifties” or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this

provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].

- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.[10]

Georgina

11.3 Georgina had regular contact with her GP throughout the review period. These contacts took place via telephone and face to face. Georgina was prescribed diazepam,[11] and there was evidence in GP records of regular reviews of the prescribing of the medication, in particular at times when Georgina requested additional medication due to loss or theft. Georgina also had periods of engagement with mental health services. In 2020, Georgina was diagnosed with post-traumatic stress disorder (PTSD).[12]

11.4 As a teenager, Georgina was involved in a motorbike accident. She required surgery and metal implements being inserted into her legs. The injury affected Georgina's mobility, and she was described as often having falls due to unsteadiness.

11.5 Georgina had alcohol dependency and received support from Barod. Georgina was offered Pabrinex[13] injections to minimise her alcohol use. These were administered by the Community Drug and Alcohol Team. Georgina was often reported as being under the influence of alcohol during contact with agencies. Georgina's support worker from Trivallis informed

[10] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.
[11] https://www.nhs.uk/medicines/diazepam/
[12] https://www.nhs.uk/mental-health/conditions/post-traumatic-stress-disorder-ptsd/overview/
[13] https://www.medicines.org.uk/emc/product/1426/pil#gref

the Chair that Georgina used alcohol as a means of self-medicating to cope with trauma in her life.

11.6 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act. It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Social Services and Well-Being (Wales) Act 2014 (care and support) assessment is completed.

11.7 Towards the end of 2019, Georgina spent a period of time in hospital for alcohol detox. A cognitive assessment was undertaken: the outcome was suggestive of cognitive difficulties that were likely to be having a negative impact on Georgina's ability to manage activities of daily living. The assessment was shared with Georgina's GP as part of her discharge information. There is no evidence of any further cognitive assessment or follow-up taking place. This is analysed further in Section 14.

11.8 Georgina was not in employment. Georgina was in receipt of Personal Independence Payment (PIP). The details within Georgina's PIP claim were alcohol, substance misuse, depression, anxiety, and post-traumatic stress disorder.

11.9 The Review Panel considered the information gathered within this section and determined that whilst this identified that Georgina had a 'mental impairment', this did not identify Georgina as 'disabled' – as defined within Section 6 of the Act.

Intersectionality:

11.10 By considering intersectionality, we can see that women who face domestic abuse, alcohol or drug abuse, and other challenges, are not experiencing these issues in isolation but rather as part of a broader, interconnected web of social and personal factors

11.11 **Mental Health:**

Mental health issues often intersect with substance abuse, and women facing domestic violence may be more prone to developing conditions such as anxiety, depression, or post-traumatic stress disorder (PTSD). These conditions can make it more challenging to break free from cycles of abuse or addiction, especially when combined with systemic barriers like lack of mental health resources.

11.12 **Gender and Domestic Abuse:**

Domestic abuse disproportionately affects women, with societal expectations of gender roles often placing women in more vulnerable positions. Women may face additional barriers in seeking help, such as the fear of not being believed, the stigma associated with being abused, or the limited access to resources. Social and cultural factors, including gender norms, might dictate the extent to which a woman can leave or seek help from abusive situations, affecting her ability to escape.

11.13 **Alcohol and Drug Use:**

Alcohol and drug use often intersect with experiences of domestic abuse. In many cases, substance use may be both a coping mechanism for trauma and an exacerbating factor in abusive relationships. Women who face domestic abuse may use substances to numb the pain or escape from the stress and fear of abuse. However, the use of substances can also make it harder for women to leave an abusive partner, either due to impaired judgment or dependence.

Gary

11.14 The Review Panel was unable to access Gary's GP records; therefore, health information from these records was not available for the review.

11.15 Gary was not known to mental health or drug and alcohol services as an adult.

John

11.16 The Review Panel did not have access to any health records for John.

11.17 Information held by Probation documented that John was alcohol dependent and was having weekly contact with Dyfodol.[14] Probation had discussed with John, opportunities of attending a rehabilitation centre to address his alcohol use.

11.18 All subjects of the review are white British. There is nothing in agency records that indicated that any subjects of the review lacked capacity,[15] in

[14] https://dyfodoltraining.com/about/

[15] The Mental Capacity Act 2005 established the following principles:
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".
Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".
Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".
Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.
Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".

accordance with the Mental Capacity Act 2005. Professionals applied the principle of Mental Capacity Act 2005:

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

Research

11.19 The panel acknowledged that domestic abuse is a gendered crime, with women being more likely to be victims than men. In November 2023, the Office for National Statistics published the following data – 'Domestic abuse in England and Wales overview':[16]

- The Crime Survey for England and Wales estimated that 2.1 million people aged 16 years and over (1.4 million women and 751,000 men) experienced domestic abuse in the year ending March 2023.
- There was no significant change in the prevalence of domestic abuse experienced in the last year compared with the previous year.
- The police recorded 889,918 domestic abuse-related crimes (excluding Devon and Cornwall) in the year ending March 2023: a similar number to the previous year.
- There were 51,288 domestic abuse-related prosecutions in England and Wales for the year ending March 2023, compared with 53,207 in the year ending March 2022.

Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".

(Mental Capacity Act Guidance, Social Care Institute for Excellence)

[16] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2023

12. DISSEMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process:

- Georgina's family
- Rhondda Cynon Taf Community Safety Partnership
- Cwm Taf Morgannwg Safeguarding Board
- Area Planning Boards
- All agencies that contributed to the review
- South Wales Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, CHRONOLOGY AND OVERVIEW

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the subjects of the review and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies.

The Review Panel wanted to highlight that there was very limited information held by agencies about Gary. Gary was not engaged with, or being supported by, any agency. Therefore, the majority of the information, provided to the review, related to Georgina. As detailed at 5.4 – 5.6, this section does not contain every contact within the period of this review.

13.1 Georgina

13.1.1 At the age of 14, Georgina was sexually abused by a family member, and she was placed into care. Georgina did not have an extensive family and had limited family contact after this time.

13.1.2 Georgina was described by her family as a happy person who always made time for others and was happy to help anyone. Georgina completed a college course on plastering and worked in that trade for a while but then became a carer, working for various domiciliary care companies for nearly nine years.

13.1.3 Georgina's daughter stated that life as a child with her mum was fun, and they were always out and about or doing things at home. She recalled one time when Georgina arranged for a bouncy castle in the lounge of the house they were living in.

13.1.4 After 2007/2008, Georgina had no contact with her daughters due to their respective father's seeking custody through court proceedings and preventing any contact with Georgina. In addition, Georgina's youngest daughter had moved abroad with her father.

13.1.5 Georgina's eldest daughter regained contact with Georgina after she left her father's house at the age of 17. Georgina's daughter described how they went on to have a mutually supportive relationship, speaking frequently.

13.2 Gary

13.2.1 Gary has no previous convictions or intelligence in relation to domestic abuse held within the United Kingdom.

13.2.2 Gary had previously lived abroad. Information supplied through Interpol, established that Gary was known for a minor traffic violation in 2012. There were no other convictions or intelligence held, including domestic abuse.

13.2.3 At the start of the review timescales, Gary had been employed as an operating assistant within a charitable medical facility. Gary's employment was understood to have ended by early 2021.

13.3 John

13.3.1 John has a significant pattern of violent, racist, and aggressive offending behaviour: this includes 72 convictions for 138 offences relating to offences against the person, public order offences, and offences relating to courts/police/prison.

13.4 Georgina and Gary's relationship

13.4.1 Georgina and Gary had previously been in a relationship as teenagers. In August 2019, Georgina and Gary renewed their relationship, having met via social media: this relationship was described as being 'on and off' over the review time period.

13.4.2 Georgina's caseworker at Trivallis told the Chair that the relationship was 'very fast moving'. Georgina's daughter told the Chair that in 2020, not long after the relationship resumed, they became engaged; however, by the following year, the relationship ended.

13.5 Events prior to the review timescales

13.5.1 On 23 October 2018, Georgina was convicted for an assault under Section 20 Offences against the Person Act 1861 – unlawful wounding or inflicting grievous bodily harm (GBH) without intent. This conviction was not related to Gary or John. Georgina was made subject to a 12-month community order, supervised by the Community Rehabilitation Company (CRC).

Events within the Terms of Reference

13.6 August 2019 onwards

13.6.1 Throughout this period, Georgina was in regular (often daily) contact with a support officer from Trivallis, the Community Rehabilitation Company, the Community Drug and Alcohol Team, and caseworker from Barod. At times, Georgina was under the influence of alcohol, which resulted in appointments being missed or not progressed.

13.6.2 On 15 August, Georgina made an application under the Domestic Violence Disclosure Scheme[17] – for information on Gary.

13.6.3 On 25 September, a housing review meeting was held about Georgina, with Trivallis, the police, Barod, and the Community Rehabilitation Company in attendance. The meeting discussed that Georgina was at risk of eviction and the options to support her in sustaining her tenancy. A tenancy enforcement order was implemented.

13.6.4 On 9 October, Georgina was referred for inpatient detox.

13.6.5 On 10 October, Georgina telephoned her support worker from Trivallis, asking for the postcode for a hospital. Georgina was whispering during the call, stating that she was in the bathroom and that her partner (believed to be Gary) had shouted at her. Georgina was advised to protect herself and ask Gary to leave if things escalated.

13.6.6 On 19 October, Georgina was taken to inpatient detox. Georgina informed staff that she had fallen down the stairs the previous week and sustained a bruise to her lower back, as well as experiencing black outs. Georgina was seen to have a black eye. Georgina became agitated when showing staff her eye, stating: 'Gary didn't do it, I tripped over my dressing gown'. Georgina further stated that Gary was worried that people would think that he had done this to her. The injuries were explored with Georgina, and she stated that she had accessed a Clare's Law, which came back clear of information and that Gary needed anger management for his verbal aggression. When asked by staff, Georgina stated that Gary did not hit her.

[17] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet

Georgina's detox admission was meant to be for a 7-day period; however, Georgina suffered seizures that caused a head injury which required stitches, and she had to stay a further week in hospital for a safe withdrawal. The discharge date was set for 3 December.

13.6.7 On 22 October, Georgina's community order ended.

13.6.8 On 26 November, Georgina telephoned her Barod caseworker and stated that Gary was not happy that she would be staying in hospital an extra week. Georgina asked the Barod caseworker to telephone Gary to explain why she needed to stay in hospital. The caseworker telephoned Gary, and it was documented that he challenged the decision for Georgina to remain in hospital, that he felt that Georgina was not being looked after, and that he wanted her home. Gary stated that he struggled to support Georgina, and he was provided with information on Barod's 'Concerned Other'[18] support service.

13.6.9 Whilst in detox, a clinical psychologist completed a cognitive test with Georgina. The outcome of the assessment was suggestive of cognitive difficulties, which were likely to be having a negative impact on Georgina's ability to manage activities of daily living. The information was sent to Georgina's GP.

13.6.10 On 2 December, Georgina was discharged from detox. Georgina was collected by Gary. Barod and Trivallis were not aware that Georgina had been discharged a day earlier.

The below information was gathered by the Chair during the completion of the review.

13.6.11 The support worker from Trivallis informed the Chair that Georgina had later told her that Gary had presented her with a bottle of port when he collected her from detox, as he 'did not like her sober'.

13.7 2020

13.7.1 On 6 January, Georgina informed her support worker from Trivallis that she was no longer in a relationship with Gary, as he had been too controlling.

[18] https://barod.cymru/wp-content/uploads/2021/06/Concerned-Others-Information-for-Professionals.pdf

13.7.2 On 12 January, the police received an abandoned 999 call from Gary's address. A male and female were heard arguing during the call. The police attended at the address, and Georgina stated that they had both been drinking alcohol and had had an argument. Georgina had started to record the incident on her mobile phone, and Gary had pushed her onto the bed. Gary had returned to the room with a metal bar, which he raised towards Georgina. Gary was arrested by the police. Georgina provided a statement but stated that she did not want to substantiate the allegation and did not support a prosecution or attend court. Georgina did not give consent for her phone to be examined. Gary was interviewed by the police and later released from custody without charge. A Public Protection Notice (PPN) was completed and risk assessed as high. A referral was made to MARAC. This was the first reported incident of domestic abuse to the police.

13.7.3 On 13 January, the case was allocated to an IDVA. The IDVA telephoned Georgina and arranged to see her on 15 January.

13.7.4 On 15 January, Georgina attended the meeting with the IDVA. Georgina was supported at this meeting by her support worker from Trivallis. Georgina was reported to be heavily intoxicated during the meeting but shared information about financial abuse within her relationship with Gary, including that she had sent Gary money whilst she had been in hospital and that he had withheld her medication.

13.7.5 On 28 January, the MARAC referral was discussed at the daily discussion meetings and placed on the agenda for the MARAC meeting on 6 February.

13.7.6 By the end of January, it was documented that Georgina was consuming alcohol at a significant level and had missed appointments in relation to relapse support work. There was no evidence of referral or signposting to other agencies.

13.7.7 On 6 February, the case was heard at MARAC. It was documented that Georgina was in another relationship.

13.7.8 On 11 February, Georgina's case was closed with Barod, as she had not been engaging with the service.

13.7.9 By the end of February, Georgina was understood to be back in a relationship with Gary. Georgina had missed an appointment with the IDVA. Georgina had attended an appointment with her GP and reported

that she was pregnant. Gary had accompanied Georgina to the GP appointment. Records documented that Georgina stated: 'This is the opportunity to get her life on track and her and Gary to have some stability. She acknowledged that she had contacted the police when Gary was intoxicated, and he did frighten her but they are now "back on track". This will be Garys first child, and she wants to give him the opportunity to become a dad'. Referrals were made to Children's Social Care.

13.7.10 On 9 March, Georgina attended a face-to-face meeting with the IDVA. Georgina stated that she was reducing her alcohol intake and that she had an appointment for a scan.

13.7.11 On 11 March, Georgina attended an appointment for a scan. Gary was present. The scan confirmed that Georgina was not pregnant.

13.7.12 On 24 March, the support worker from Trivallis telephoned Georgina and advised that due to the COVID-19 restrictions, she could only have telephone contact with Gary.

13.7.13 On 9 April, a dietician sent a letter to Georgina's GP: this was following a telephone consultation with Georgina, which stated that Georgina reported feeling unsafe in her current address and that she had issues with stalking. Details of who this related to were not recorded.

13.7.14 On 4 May, Georgina telephoned her support worker from Trivallis and reported that she had been staying at Gary's address and had awoken to find part of her hair shaved off. Georgina explained that she had recently spoken with Gary about getting hair extensions. Georgina stated that she was waiting for Gary to return and then she was going to ask him to take her home. Later that day, Georgina contacted her support worker and stated that she was back at her property and had paid Gary money for the petrol to take her home and money for some 'weed'.[19] Georgina stated that the relationship was over.

13.7.15 On 21 May, the support worker from Trivallis contacted the IDVA and reported that Georgina was spending time staying with Gary, and he was reportedly self-harming by cutting with a blade until he collapses, and that Georgina was then 'expected' to look after him. Concerns were also shared that Georgina was supporting Gary financially, and he was questioning where her money was going.

[19] Weed is a slang term for cannabis: a drug that comes from the cannabis plant.

13.7.16 On 21 May, Georgina contacted the police and reported that she had been assaulted by a female friend. The matter was finalised on 22 June, as all attempts to contact Georgina had been unsuccessful.

13.7.17 On 22 May, the IDVA telephoned Georgina and completed an initial assessment. A DASH and an individual safety and support plan were completed. The DASH score was 13, which detailed that the risk remained high. The IDVA emailed the support worker at Trivallis and stated that they had considered a referral to MARAC but that this was not going to occur because the risk factors had not changed. The decision not to refer to MARAC was supported by a team leader. This is analysed further at Term 9.

13.7.18 On 30 May, Georgina attended at hospital with a head injury reported to have occurred three weeks earlier and a potential new head injury caused by a neighbour (not a subject of this review). An Ask and Act Domestic Abuse Assessment was completed by a staff nurse. Georgina was not seen by the hospital-based Independent Domestic Violence Advisor (IDVA) due to the admission taking place on a weekend. A referral for IDVA support and an Adult Protection Referral were completed. Georgina was also provided with information leaflets.

13.7.19 On 5 June, two social workers attended at Georgina's home to see her in response to the Adult Protection Referral and to undertake an enquiry under Section 126 Social Services and Well-Being (Wales) Act 2014.[20] Georgina was not at home. A further visit was undertaken on 11 June, when Georgina was seen. Georgina agreed for a referral to Barod. The Section 126 enquiry closed because it was determined that Georgina was not an adult at risk but may have other needs for care and support services, which were being addressed.

13.7.20 On 23 June, the police received a call from the support worker at Trivallis, who reported that Georgina had left a voicemail four days earlier in which Georgina was 'thanking them for all their help and that she couldn't live the way she was anymore'. The support worker had been unable to contact Georgina. The police saw Georgina, and she stated that she was not suicidal and had had an argument with her neighbours and been to stay with her boyfriend.

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20 https://www.legislation.gov.uk/anaw/2014/4/notes/division/2/70#:~:text=Section%20126%20%E2%80%93%20Adults%20at%20risk&text=363.An%20adult%20at%20risk,a%20result%20of%20those%20needs.

13.7.21 On 26 June, the caseworker from Barod telephoned the support worker at Trivallis and reported that during a telephone call with Georgina, she stated that Gary had pushed her down the stairs 'the other week'. The information was shared with the IDVA three days later.

13.7.22 On 1 July, Georgina's case with the IDVA was subject of case discussion and overview. It was agreed to close the case because there was no meaningful engagement from Georgina, the IDVA was not providing any real level of service, Georgina remained in her relationship with Gary, and she was engaged with other agencies.

13.7.23 On 17 July, Georgina contacted the police and reported that she had been assaulted by a female friend. Georgina did not support any progression of criminal action.

13.7.24 On 27 July, the IDVA received a text message from Georgina, stating: 'I desperately need help please ring me'. Attempts to contact Georgina were unsuccessful, and the IDVA contacted the police to complete a welfare check. Georgina was found at Gary's address and spoken to alone. Georgina denied sending the text message and knowing the recipient. Georgina stated that she did not need help and did not wish to report any concerns to the police.

13.7.25 On 29 July, Georgina attended an appointment with the Community Drug and Alcohol Team. Gary was present during the meeting. Georgina stated that she had been in a relationship with Gary for the past few months and that he was very supportive and would be managing her appointments, ensuring she attended because he drove.

13.7.26 On 4 August, Georgina reported (to the caseworker at Barod) threatening, controlling and coercive behaviour from Gary. Gary was not taking her to appointments with the Community Drug and Alcohol Team, after being given money to do so. Gary was calling her names, putting her down, and losing his temper when alone with her. Georgina reported that he had held her prisoner at his house a few months previously, where police were called but no charges made.

13.7.27 On 5 August, Georgina attended an appointment with the Community Drug and Alcohol Team. Gary accompanied Georgina. During the appointment, Gary attempted to look at Georgina's chart. When Georgina asked for the chart to be hidden, Gary stormed out of the room. Georgina then showed

the worker a bruise on her arm and stated that Gary had done this. Georgina also stated that Gary had charged her money to bring her to the appointment.

13.7.28 On 10 August, the Community Drug and Alcohol Team submitted an A1 safeguarding referral to the Multi Agency Safeguarding Hub (MASH) in response to the contact with Georgina on 5 August. The Community Drug and Alcohol Team determined that a MARAC referral was required but that this needed Georgina's consent before it could be submitted. A MARAC referral was not submitted.

13.7.29 On 13 August, Georgina disclosed further domestic abuse to the caseworker at Barod, including financial, physical abuse, withholding of prescribed medication, and controlling behaviour from Gary. Georgina declined a referral to Women's Aid or MARAC and stated that she was waiting for money that Gary owed her.

13.7.30 On 17 August, Georgina's mother contacted the caseworker at Barod and the Community Drug and Alcohol Team. She expressed concerns about Georgina's relationship with Gary. Gary was described as being controlling, taking Georgina's money, and threatening her with a curtain pole.

13.7.31 On 18 August, Georgina was informed that a safeguarding referral had been made to the Local Authority Designated Officer (LADO)[21] by Barod, due to Gary's employment within a private hospital. Georgina expressed concerns over the following days regarding the consequences of this, and that the risk of her safety would escalate. This included, in one day, the Barod caseworker receiving in excess of 30 contacts from Georgina, and Georgina asking the caseworker to telephone Gary and tell him that there was a requirement for potential routine drug testing in his employment. This request from Georgina was made to remove any link for the safeguarding referral being made.

13.7.32 On 25 August, a Professional Adults Safeguarding Meeting (PASM) was held in relation to Gary, due to his employment. A further meeting held in January 2021, determined that Gary was no longer in employment.

13.7.33 On 25 August, Georgina's mother contacted WAST and expressed concerns for Georgina, as she had been unable to contact her. An ambulance

[21] https://www.safeguarding.wales/en/chi-i/chi-i-c5/c5-p2/#:~:text=Local%20Authority%20Designated%20Officer%20(LADO,Officer%20for%20Safeguarding%20(DOS

attended at Gary's address, and Gary and Georgina were spoken to. Georgina refused assessment and stated that she was 'happy in the relationship'. Georgina expressed frustration with her mother's activity.

13.7.34 On 27 August, the police received concerns from the support worker at Trivallis regarding Georgina's relationship with Gary. The police spoke to Georgina at her address. She denied the concerns, describing them as 'ridiculous'.

13.7.35 On 7 September, Georgina informed the caseworker at Barod that the relationship with Gary was over. Two days later, Georgina informed the Community Drug and Alcohol Team that she was still in a relationship with Gary.

13.7.36 On 23 September, Georgina's support worker from Trivallis closed the case. The decision had been made because the support needed was in relation to drug and alcohol use, which was being provided by Barod and the Community Drug and Alcohol Team.

13.7.37 On 31 October, Georgina attended at hospital with an arm and head injury. Georgina initially stated that it had been caused by her partner, Gary, and then later stated it had been a neighbour.

13.7.38 On 4 November, Georgina was admitted to hospital following a report that she had been assaulted. Georgina sustained the loss of three front teeth, two black eyes, bruising to her torso, and a swollen and heavily bruised right arm. Georgina was admitted to hospital for 10 days and underwent surgery. There was some variation of Georgina's account as to how the injuries were sustained. Georgina denied that she had been assaulted by Gary. Enquiries later established that it was likely that two separate incidents had occurred, including an assault by unknown males and a fall downstairs. Upon discharge, Georgina was reported to be living with Gary.

13.7.39 Over the following weeks, Georgina had several telephone calls with the caseworker at Barod. Georgina informed the caseworker that the calls were on loud speaker so that Gary could hear what was being said.

13.7.40 On 15 December, the IDVA team received a PPN for the incident from 25 August, following concerns expressed by Georgina's mother. The case was referred to MARAC.

13.8 2021

13.8.1 On 7 January, the case was listed at MARAC for 'information only'.

13.8.2 In January, Georgina had contact with health professionals following pain and reoccurring problems due to an injury sustained in November. During these contacts, Georgina was reported to be under the influence of alcohol.

13.8.3 By the end of January, Georgina was no longer engaging with the Community Drug and Alcohol Team, and, despite repeated attempts to contact her over the following months, the case was eventually closed in April.

13.8.4 On 4 February, Georgina informed the caseworker at Barod that she was continuing to live with Gary and no longer needed support. Georgina declined any follow-on relapse prevention support from Barod, and the case was closed.

13.8.5 In May, Georgina had further contact with health professionals in relation to continuing problems with her shoulder injury from November 2020.

13.8.6 In June and September, Georgina contacted the police on three occasions and reported that she had been assaulted by a male whom she had invited into her house. On each occasion, it was documented that the men were homeless. Each incident related to a separate male. Georgina did not support a prosecution.

13.8.7 On 22 September, Georgina reported that John had threatened to kill her. Georgina described John as a friend. Georgina stated that the threat was not genuine, and she did not want to pursue a complaint. The police spoke to John and gave him advice.

13.8.8 Throughout September and October, Georgina was in contact with the police, reporting repeated incidents of unknown people banging on her door.

13.8.9 On 1 October, a GP completed an A1 safeguarding referral that was sent to the MASH on 5 October. The information was basic, and further information was requested. The information stated that Georgina had attended at the GP surgery with a scalp laceration and stated that she had been physically and sexually assaulted. The referral expressed concerns

that Georgina was putting herself at risk. The case was allocated to an officer from the Rape Investigation Team the same day – to make contact with Georgina. This was achieved on 8 October. Georgina stated that she had been physically assaulted by John, who had grabbed her to the throat and tried to strangle her. Georgina described a separate incident, with another male, of sexual assault.

13.8.10 Over the following months, the police made repeated attempts to contact Georgina, including arranging appointments to see Georgina to progress gathering her evidence in relation to the sexual assault. All of the attempts were unsuccessful. Georgina cancelled appointments or, when spoken to by the police, was described as incoherent due to alcohol consumption; therefore, evidence could not be gathered. On 6 December, the police submitted a PPN for Georgina. In February 2022, the case was closed by the police. No further action was taken. Georgina had not provided a statement.

13.8.11 Following the submission of the safeguarding referral, the case was allocated to an Independent Sexual Violence Advocate (ISVA). The ISVA attempted to make contact over the following months, with one successful contact being completed; however, this call was terminated by Georgina.

13.8.12 On 29 October, Georgina was discussed in a monthly Problem Solving Group meeting attended by the police, local authority, and Trivallis. The plan at this stage was to respond to the repeated calls of people knocking on her door and anti-social behaviour.

13.8.13 At the end of December, Georgina contacted the police and reported that she had been sexually assaulted by a male. Georgina stated that she did not know who the male was. Georgina was unable to provide a description of the male. The police had several contacts with Georgina to progress identification of the male and pursue a criminal investigation.

13.9 2022

13.9.1 At the beginning of January, Georgina had contact with health professionals in relation to the sexual assault. Georgina had contact with the Crisis Team, during which she stated that a previous partner had taken £24,000 out of her bank account. A referral was made to New Pathways, and a Wales Applied Risk Research Network (WARRN)[22] was completed.

[22] The Wales Applied Risk Research Network (WARRN) is a risk assessment process for mental health service users in Wales that helps to reduce the risk of suicide and physical harm to others.

13.9.2 On 13 January, Georgina self-referred to Barod. The case was closed the following month because engagement with Georgina was not established.

13.9.3 On 25 January, Georgina attended a bank and reported that she was a victim of financial abuse and being targeted by the community. The bank reported the concerns to the Domestic Abuse Service, who made contact with Georgina and Trivallis. Georgina informed the Domestic Abuse Service that she had reported the financial matters to the police. There is no record that this matter was reported to the police.

13.9.4 Throughout February, there was evidence of agencies sharing information and working together to respond to concerns for Georgina around her vulnerabilities, mental health, alcohol use, missed medical appointments, and anti-social behaviour. Referrals were made to the Citizen's Advice Bureau for support in relation to seeking alternative accommodation. At times, agencies' contact with Georgina was inconsistent and often unsuccessful. The Citizens Advice Bureau closed their case at the beginning of March.

13.9.5 On 16 February, Georgina was assaulted by a male friend. Georgina received medical treatment. The male was arrested by the police and denied assaulting Georgina. Georgina did not support a prosecution, and no further action was taken.

13.9.6 On 26 February, Georgina contacted the police and reported she had been threatened by John. The police spoke to Georgina. She described John as a friend, who had been 'sofa surfing' at her property. John was taken from the property.

13.9.7 On 5 March, John assaulted Georgina. Georgina was taken to hospital by the police and received treatment for facial injuries sustained in the assault.

13.9.8 On 10 March, John was arrested. John denied assaulting Georgina and stated that they were not in an intimate relationship. The case was referred to the Crown Prosecution Service, who determined that no further action would be taken in relation to the assault.

13.9.9 In March 2022, a referral for Georgina was made by a service manager for Substance Misuse and Mental Health to the Taf Ely Problem Solving Group.

The police created a Plan on a Page (POP), in relation to Georgina, which detailed a multi-agency approach to respond to issues of alcohol, substance use, and anti-social behaviour surrounding her current accommodation. The POP was managed by a designated Neighbourhood Police Officer and Police Community Support Officer (PCSO). Over the following months, there was detailed evidence of the multi-agency work and contact with Georgina in response to the POP.

13.9.10 On 21 March, John was recalled to prison.

13.9.11 On 6 April, Georgina was visited by a social worker (Community Mental Health Team) and a worker from Drug and Alcohol Team to undertake a Care and Treatment Plan assessment. Georgina reported that she had consumed alcohol prior to the visit. Georgina requested support in relation to her alcohol use, and she was referred to the Community Drug and Alcohol Team and closed to the Community Mental Health Team.

13.9.12 By the end of May, the POP documented that Georgina was engaging with agencies and that calls for service from the police had significantly reduced. Georgina was reported to have a good relationship with the police.

13.9.13 On 9 June, the police were informed by Probation that John was due to be released from prison and that he harboured 'ill feelings' towards Georgina, whom he blamed for his recall. Georgina was seen on two occasions by the police and advised of John's release.

13.9.14 On 17 and 20 June, the police received reports that Georgina had been seen lying in the road, intoxicated. Georgina had reported that she had been assaulted by a neighbour. Over the following weeks, further reports were received that related to incidents between Georgina and neighbours, often involving alcohol and anti-social behaviour. Georgina's engagement with the Community Drug and Alcohol Team had reduced, and her case was closed at the end of July.

13.9.15 On 23 June, John was released from custody on Post-sentence Supervision. John's case was escalated to MAPPA Level 2.

13.9.16 On 22 July, Georgina contacted the police and reported that she had been sexually assaulted by a male. The male was arrested. The investigation into this matter was still ongoing at the time of Georgina's death.

13.9.17 On 16 August, John was deregistered from MAPPA Level 2, as the risk management plan was responding to the presenting risks.

13.9.18 On 18 August, Georgina's GP made a referral to primary mental health services due to Georgina experiencing flashbacks and night terrors following reports of the assault in June.

13.9.19 On 7 September, following a Local Primary Care Initial Assessment being completed, Georgina was referred to MIND for counselling to support her with historical trauma.

13.9.20 By the end of September, the POP was closed.

13.9.21 On 30 October, the police received a report that Georgina was being targeted by a group of teenagers. Georgina was seen by a PCSO, and a PPN was submitted. The PPN contained information that John was at the address during the visit, that Georgina had a black eye (caused by Gary), and that she was going 'back and forwards' to Gary, who was described as an ex-boyfriend.

13.9.22 On 3 November, Georgina was discussed as part of the GP weekly meetings. These meeting are in place to review cases. Safeguarding cases are also included in these discussions.

13.9.23 On 6 November, a PCSO attended at Georgina's address as part of a routine patrol. Georgina informed them that John, whom she described as a friend, was hiding in the bedroom, and she did not want him there. John was removed from the property. A PPN was submitted and shared with Adult Services.

13.9.24 On 14 November, the police received two calls – one from a member of the public and another from Georgina – reporting an incident at Georgina's property. Georgina stated that John was outside her address and was being aggressive and kicking the door. Officers attended at the address and spoke to Georgina and a friend. Details of the friend were not recorded.

13.9.25 On 25 November, the police received two calls relating to Georgina. In both calls, Georgina was reported to be intoxicated. One of the calls described how Georgina had been seen 'rolling on the floor'. A PCSO attended at Georgina's address and spoke to her. Georgina was in the company of an adult male who Georgina asked the PCSO to remove. A PPN was submitted and shared with Adult Services.

13.9.26 On 4 December, Georgina contacted the police (via 999) and reported that John had entered her property and threatened to kill her. John was taken from the property by the police. Georgina and John stated that they were not in a relationship. A PPN was submitted and shared with Adult Services.

13.9.27 On 8 December, Georgina contacted the police and reported that John had assaulted her and stolen her bank card and property. Georgina was seen by the police. Georgina denied anything had occurred. John was not at the address. A PPN was submitted but not shared, as consent was not provided.

13.9.28 On 9 December, Georgina contacted the ambulance service via 999. Georgina reported that she had been assaulted and had barricaded herself in her house. The ambulance service passed the call to the police, who attended and spoke to Georgina; however, she denied that she had been assaulted. A PPN was submitted but not shared, as consent was not provided.

13.9.29 On 16 December, the police and Probation attended at John's current address (hotel) to move him to his own accommodation; however, he was not at the address.

13.9.30 On 20 and 22 December, Georgina contacted the police and reported that John had been banging on her door. In response to the second incident, the police made enquiries with work men who were working opposite the address: none of whom had seen any incidents at the property. On both occasions, Georgina stated that John was an old school friend.

13.9.31 On 24 December, Georgina reported that she had been assaulted by John. When the police attended and spoke to Georgina, she denied that John had been at her property or that she had been assaulted.

13.9.32 On 25 December, the police received an abandoned 999 call from Georgina. The police attended at her property. The police forced entry, and Georgina was found inside with serious facial injuries, including lacerations. Georgina stated that John had caused the injuries. John was present in the property and was arrested by the police. A PPN was submitted, and the case was referred to MARAC. John was charged with assaulting Georgina and remanded into custody.

13.10 2023

13.10.1 On 1 January, WAST received five calls from Georgina, requesting their attendance. When WAST attended, Georgina stated that she had made the calls to pretend that she was ill so that her neighbour would leave her alone.

13.10.2 On 1 January, Georgina contacted the police and reported harassment via text messages from Gary, whom she described as her ex-partner. The police attended and reviewed the messages. They determined that they were more of a conversation rather than abuse. A PPN was submitted. A secondary risk assessment was undertaken on 18 January, which determined the risk as medium. The PPN was not shared because consent had not been provided.

13.10.3 On 3 January, an IDVA contacted Georgina and discussed the availability of refuge spaces. The following day, Georgina moved into a refuge in the Vale of Glamorgan and was supported by the IDVA with transportation.

13.10.4 On 5 January, a MARAC meeting was held.

13.10.5 On 11 January, Georgina left the refuge to stay with Gary for a few days. Georgina described Gary as her partner. This was one of several 'stays' that Georgina reported to staff at the refuge over the following weeks.

13.10.6 Between 14 and 17 January, Georgina was spoken to by staff at the refuge regarding alcohol use and interaction with other residents.

13.10.7 On 26 January, a MARAC meeting was held in Vale of Glamorgan, following transfer from Rhondda Cynon Taf.

13.10.8 On 31 January, staff at the refuge spoke to Georgina about her relationship with Gary. Staff encouraged Georgina to apply for disclosure under the Domestic Violence Disclosure Scheme. Georgina stated that Gary could be controlling at times, but people change and that she had known him since she had been a teenager.

13.10.9 On 9 February, Georgina was admitted onto a waiting list for inpatient detox.

13.10.10 On 10 February, Georgina was involved in an altercation with a resident in the refuge. Over the following four days, further incidents occurred in the refuge, and Georgina was evicted. Georgina went to stay with Gary. The

refuge sought to find alternative accommodation for Georgina. Georgina declined alternative refuge space, as it was too far away from Gary. The refuge supported Georgina to present as homeless to Vale of Glamorgan Housing.

13.10.11 On 16 February, Georgina was placed in temporary hotel accommodation.

13.10.12 At the beginning of March, the police and refuge received several calls from members of the public, reporting concerns for Georgina due to her being under the influence of alcohol.

13.10.13 On 7 March, Georgina was evicted from the temporary accommodation, and Vale of Glamorgan had ended their involvement under the Housing (Wales) Act.[23] Georgina was supported with financial costs to move to Gary's address.

13.10.14 During March, Georgina was in contact with Victim Support, following a referral for the assault by John on 25 December.

13.10.15 On 3 May, Georgina had contact with British Transport Police after she had been found under the influence of alcohol and was deemed unsafe to travel. Georgina was taken to Gary's address.

13.10.16 On a date in May, the police attended at Gary's address and found Georgina deceased. Gary was arrested by the police and later charged with Georgina's murder.

[23] https://www.legislation.gov.uk/anaw/2014/7/contents

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Term 1

What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Georgina, and what was your response?

14.1.1 Georgina had been a victim of domestic abuse in relationships prior to the review time period. The males in those relationships are not the subjects of this review.

14.1.2 Within the scope of this review, Georgina had two relationships. The first and main relationship was with Gary. The relationship was described by agencies and families as being 'fast moving' and 'on and off'. The police responded to seven incidents between Georgina and Gary, between August 2019 and January 2021. In addition, the police received third-party reports from family and professionals following disclosures of domestic abuse made by Georgina.

14.1.3 The police responded to 11 incidents of domestic abuse between Georgina and John. The first incident was in September 2021, when, at that time, Georgina referred to John as being a friend. There were no further reports until the end of February leading into March 2022, when Georgina reported being assaulted by John. This resulted in John being recalled to prison.

14.1.4 Between November and December 2022, there were eight reports made by Georgina about John, which culminated in Georgina being seriously assaulted by John on Christmas Day. This incident was responded to as domestic abuse, risk assessed as high and referred to MARAC. John was arrested and convicted for the assault, for which he received a custodial sentence.

14.1.5 Georgina and John maintained to professionals that they were not, and had never been, in an 'intimate relationship. Information gathered by the police from neighbours, described Georgina and John's relationship as 'boyfriend and girlfriend'. John told the Chair that his relationship with

Georgina was 'on and off' over the 2.5 years that they were together. John described the relationship as 'intimate'.

14.1.6 As a result of the assault, Georgina was moved out of the area and placed in a refuge. It was at this point that Georgina's relationship with Gary appeared to intensify. Georgina was spending time away from the refuge, staying with Gary. By early March 2023, following Georgina's eviction from the refuge and temporary accommodation, she was supported with financial costs to move into Gary's property. Whilst Georgina still had a tenancy with Trivallis, she did not return to live there.

14.1.7 From March 2023 onwards, Georgina had limited contact with agencies. In addition, Georgina's daughter told the Chair that in the months prior to her mother's murder, the contact between them had reduced significantly.

14.1.8 At the start of Georgina's relationship with Gary (August 2019), she was encouraged by the Community Rehabilitation Company to request information about Gary under the Domestic Violence Disclosure Scheme. Gary was not known to the police as a domestic abuse perpetrator at that time, and the police held no other information that they could share with Georgina.

14.1.9 The Review Panel discussed how Georgina may have interpreted the lack of information. Whilst not knowing what Georgina's understanding was, based on the Review Panel's professional opinion, they concluded that Georgina may have been reassured about there being no information held by the police, particularly if there had been no domestic abuse at that time. However, she could also have felt 'isolated' by such a lack of disclosure, in that the abuse was only happening to her because it appeared that no one else had reported previous abuse to the police.

14.1.10 By the end of 2019, Georgina was starting to inform professionals about Gary's controlling behaviour. In October 2019, during an inpatient admission, Georgina was seen with bruising. It was noted that Georgina was 'quick' in stating that the injuries had not been caused by Gary. Further concerns were noted when Georgina's admission was extended, and Georgina asked a caseworker from Barod to telephone Gary and explain the circumstances of her continued admission, as she told professionals that Gary was not happy that she was staying in hospital.

14.1.11 In January 2020, Gary assaulted Georgina. This was the first report of physical violence. Gary was arrested. The case was referred to MARAC. At this point, Georgina stated that the relationship had ended. However, by the end of February, the relationship had resumed, and Georgina reported that she was pregnant. Georgina stated to professionals: 'This

will be Garys first child, and she wants to give him the opportunity to become a dad'. A later scan revealed that Georgina was not pregnant.

14.1.12 Throughout Georgina and Gary's relationship, further concerns were identified about Gary. These concerns resulted from family and disclosures made by Georgina to professionals. The main concern was around Gary's control over Georgina.

14.1.13 The Review Panel analysed those concerns and agreed that as well as evidence of physical abuse, there were indicators of coercive and controlling behaviour. The following are some examples of those incidents:

- Georgina giving Gary money for petrol to take her to and from appointments.
- Georgina's money being used to pay for drugs and food.
- Gary having Georgina's PIN number for her bank card and taking her money.
- Georgina reporting that Gary had cut her hair to prevent her getting hair extensions.
- Georgina asking professionals to 'lie' to Gary about her engagement with services.
- Gary asking professionals to look at Georgina's health records.
- Georgina informing professionals that she had the phone on 'loud speaker' so that Gary could hear the conversation.
- Georgina being expected to look after Gary after he had self-harmed.
- Gary not taking Georgina to appointments.
- Georgina reporting that she had been locked in Garys flat.
- Georgina had shown professionals bruising caused by Gary.

14.1.14 The Review Panel also discussed the financial abuse perpetrated by Gary and, in doing so, took cognisance of the Wales Safeguarding Procedures[24] and the following definitions, as detailed by the UK charity Surviving Economic Abuse:[25]

Economic abuse is a legally recognised form of domestic abuse and is defined in the Domestic Abuse Act. It often occurs in the context of intimate partner violence and involves the control of a partner or ex-partner's money and finances, as well as the things that money can buy. Economic abuse can include exerting control over income, spending, bank accounts, bills, and borrowing. It can also include controlling access to and use of things like transport and technology, to allow an individual to work

[24] https://www.safeguarding.wales/en/
[25] https://survivingeconomicabuse.org/about-us/what-we-do/
Surviving Economic Abuse (SEA) is the only UK charity dedicated to raising awareness of economic abuse and transforming responses to it.

and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs.

Financial abuse is controlling finances, stealing money, or coercing someone into debt. Economic abuse and financial abuse involve similar behaviours, but it is helpful to think of financial abuse as a subcategory of economic abuse.

14.1.15 The Review Panel concluded that there was evidence that Georgina had been the victim of economic and financial abuse perpetrated by Gary.

14.1.16 The support worker from Trivallis told the Chair that Georgina was financially secure and received a significant amount of benefits. Georgina had savings – which she never used for day-to-day living because Georgina described these as being part of her safety planning and slush fund. Gary knew of Georgina's finances, and Georgina often spoke about how she had to pay for petrol money for Gary to come and pick her up and use her money to buy food and alcohol when they were together. At times, Georgina would return from visits to Gary, seeking help with food parcels. The support worker further stated that all Georgina wanted was a 'secure and loving relationship', and Georgina felt she had this from Gary.

14.1.17 The Review Panel also looked at agencies' contact and engagement with Georgina during 2023 and in the months prior to her murder. It was evident in the wealth of information provided by agencies that contact with Georgina had significantly reduced. Georgina was no longer 'open' to Barod and the Community Drug and Alcohol Team. Georgina had moved away from Rhondda Cynon Taf area and was living with Gary in Neath Port Talbot. Despite still having a tenancy, contact with her support worker from Trivallis had ceased.

14.1.18 Georgina's daughter told the Chair that in the months prior to her mother's murder, their contact had reduced significantly because it was difficult to have conversations, including face-to-face contact, with Georgina when she was living with Gary. Prior to this, they had seen each other every other week.

14.1.19 The Review Panel considered whether this identified that by Georgina moving to live with Gary, she had become isolated from her family and those agencies and professionals with whom she had previously known and engaged. The Review Panel concluded that this isolation was a further indicator of Gary's coercive and controlling behaviour.

14.1.20 Gary was not charged or convicted of any offences perpetrated towards Georgina prior to her murder.

14.1.21 The Review Panel concluded that the case identified learning around the knowledge of and responses to coercive control by professionals involved in this case. In identifying this learning point, the Review Panel acknowledged that amongst agencies there will be a continuous stream of staff turnover, and the requirement for training on domestic abuse, including coercive control, needs to be continuous – with ongoing support to embed the training into practice.

14.2 Term 2

What knowledge was your agency aware of that indicated Gary and/or John might be a perpetrator of domestic abuse, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Gary and/or John?

Gary

14.2.1 Gary was not known as a perpetrator of domestic abuse prior to his relationship with Georgina. Gary had no previous convictions. Gary had spent some time living abroad, and information supplied to the police identified that he had one previous conviction for road traffic offences. The knowledge that Gary was a perpetrator of domestic abuse was gathered by agencies throughout the review timescales.

14.2.2 In January 2020, Gary was arrested for assaulting Georgina. Gary was released from custody with no further action being taken. There was an opportunity at this point to have applied for a Domestic Violence Protection Notice,[26] which would have allowed the police to have applied to a magistrate court for a Domestic Violence Protection Order (DVPO).

14.2.3 A DVPN is an emergency non-molestation and eviction notice that is issued by the police to a perpetrator of domestic abuse. A DVPO can prevent a perpetrator from returning to a residence and from having contact with the victim for up to 28 days, which allows a victim a degree of breathing space to consider their options, with the help of a support agency.

14.2.4 The victim does not have to give their consent for a DVPN, but their views should be taken into consideration when an application is being considered.

[26] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

A DVPN is issued by a police superintendent if they have reasonable grounds for believing that:

'The perpetrator has been violent towards, or has threatened violence towards the victim,

And

The issue of the DVPN is necessary to protect that person from violence or a threat of violence by the perpetrator.'

14.2.5 With regards to necessity to prevent further violence / threat of violence, consideration should be given to:

- 'What the DVPN will seek to achieve and why this cannot be obtained by any other or less disruptive means, e.g. bail conditions not applicable or the perpetrator has accepted a formal Police caution;
- Whether the risk of harm is too great to allow the perpetrator to return to the address and therefore the sole use of a suitable risk management plan is not adequate;
- The only option to reduce risk of further violence or threat of violence is to remove P from the address and to continue to deny access to the perpetrator by issuing a DVPN.'

Officers should consider carefully whether the issue of a DVPN is necessary and proportionate to protect the victim.

14.2.6 Domestic Violence Protection Notices (DVPNs) and Domestic Violence Protection Orders (DVPOs) guidance,[27] states:

'DVPOs are a civil order that fills a "gap" in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions. It is important to note that bail with conditions and protective measures can be used simultaneously to build up greater protection for the victim'.

The use of the wording 'immediate aftermath' does not feature in the legislation.

[27] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

14.2.7 The Review Panel agreed that the consideration of applying for a DVPO is subjective and based on the evidence available for each case. There was no record that a DVPN/O was considered by the police.

14.2.8 The use of preventative orders was identified during a PEEL (Police effectiveness, efficiency and legitimacy) inspection published in May 2024[28] by His Majesty's Inspectorate of Constabulary and Fire and Rescue Service (HMICFRS), which identified that: 'The Force should increase its consideration and use of preventative orders to safeguarding vulnerable people in all appropriate cases'.

14.2.9 The police informed the Review Panel that they are committed to improving responses to victims of domestic abuse and continue to undertake the following actions:

- Delivering improvement workshops with officers based in investigation hubs looking at what we do and how to improve.
- Awareness raising of DVPNs and DVPOs and the inclusion of a rationale in each case to demonstrate if one has been considered and why no application was made.

It was noted in the HMICFRS PEEL inspection that in the year ending 31 March 2023, South Wales Police recorded 30,157 domestic abuse related crimes, which equated to 23 domestic abuse related crimes per 1,000 population. This was higher than the rates across all Forces in England and Wales of 15.8 domestic abuse related crimes per 1,000 population. Of note, these figures are for all areas that South Wales Police covers.

14.2.10 The police provided the Review Panel with data in relation to applications for DVPOs and DVPNs since 2020. These figures showed a yearly increase in applications and authorisations. In addition, since May 2023, the police have appointed a member of staff who specifically oversees the orders process whilst assisting with the upskilling of staff and awareness raising in relation to DVPNs and DVPOs, and a Force Stalking Co-ordinator.

14.2.11 The police informed the Review Panel that the process to support the awareness of the prohibitive and protective orders has been recognised in another DHR, outside of Rhondda Cynon Taf (in an area covered by South Wales Police), and the learning from that DHR has been raised at a national level with the police, HM Courts, and Ministry of Justice.

[28] https://s3-eu-west-2.amazonaws.com/assets-hmicfrs.justiceinspectorates.gov.uk/uploads/peel-assessment-2023-25-south-wales.pdf

14.2.12 Other agencies' knowledge that Gary was a perpetrator of domestic abuse was gathered from disclosures made by Georgina, Georgina's mother, and information shared from PPNs and through the MARAC process.

John

14.2.13 During part of the review period, John was managed under the Wales Integrated Serious and Dangerous Offender Management (WISDOM) team. The aim of WISDOM is to reduce reoffending and the risk of serious harm via a multi-agency team comprising police, Probation, forensic psychological service, and other local partners working together. WISDOM works with offenders subject to community supervision, licence supervision, and those who are not on statutory supervision to reduce risk.

14.2.14 On 23 June 2022, John was released from custody on Post-sentence Supervision. John's case was escalated to MAPPA Level 2, and his risk was escalated to known adult and public accordingly – to very high. The Review Panel was informed that the intention was that MAPPA escalation would establish a more co-ordinated approach to his management and for agencies to work collaboratively to ensure public protection.

14.2.15 Further support was offered to manage John's offending, with collaborative working to manage his risk. In August 2022, John was deregistered from MAPPA Level 2 due to the risk management plan managing the risk at that time. John continued to have weekly contact with the police, Probation, and Dyfodol. It was noted in Probation records that John held entrenched negative views of women.

14.2.16 The Review Panel sought clarification as to whether Probation were notified by the Police, of incidents involving John, during 2022. In 2022, 'notifiable incidents' were sent to Probation via email; there was no record held by Probation as to whether these incidents had been received. The Review Panel were informed that there is now a robust process in place in receiving and responding to 'reportable incidents'; which are uploaded onto each person's record as they are received. Notification is sent to relevant staff and their Manager, via email. Responses to the 'reportable incidents' are tracked to ensure that they have been responded to effectively prior to being closed.

14.2.17 Both the DRIVE Project29 for high risk perpetrators of domestic abuse and the Driving Change Perpetrator Programme30 for medium and

[29] https://drivepartnership.org.uk/about-us/the-drive-project/

[30] https://www.cwmtafmorgannwgsafeguardingboard.co.uk/En/SafeguardingUpdates/ResourcesSGUpdates/DrivingChangeLeafletforProfessionals.pdf

standard risk perpetrators of domestic abuse are operational within the Cwm Taf Morgannwg region and were available to non-convicted perpetrators of domestic abuse.

14.2.18 To engage with Driving Change's programme of work, clients must demonstrate – A basic recognition that they are behaving in a violent and abusive way in their intimate relationships, including a level of commitment/motivation to change this. At the most basic level, capacity to accept full responsibility for their own behaviour and actions. A willingness and ability to commit to and engage in the personal work needed, including regular attendance of the programme. Every individual referred is assessed to determine both their suitability and readiness to engage in Driving Change's programme of work.

14.3 Term 3

How did your agency assess the level of risk faced by Georgina? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

14.3.1 The police used the DASH risk assessment tool when Georgina disclosed domestic abuse perpetrated by Gary. The first time this was used, which was in January 2020, the risk was assessed as high, and the case was referred to MARAC.

14.3.2 Georgina's relationship with John was not initially identified as being domestic abuse. This decision was influenced by Georgina and John repeatedly stating that they were not in an intimate relationship. However, following the serious assault in December 2022, a DASH was completed, risk assessed as high, and the case was referred to MARAC.

14.3.3 In mental health services in Cwm Taf Morgannwg, the WARRN risk assessment and risk management tool is used. Adult Services did not complete a formal risk assessment, in respect of Georgina, because her assessment was a 'screening' assessment to determine whether secondary mental health services were appropriate. The outcome of this assessment was that Georgina was accepted by the Community Drug and Alcohol Team.

14.3.4 As a result of the Section 126 enquiries made in June 2020, Georgina was deemed not to be an adult at risk under the Wales Safeguarding Procedures and Social Services and Wellbeing Act (Wales) 2014. Under s126(1) of the Act, it defines an adult at risk as an adult who:

1. Is experiencing or is at risk of abuse or neglect,
2. Has needs for care and support (whether or not the authority is meeting any of those needs), and
3. As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

14.3.5 The enquiry identified that Georgina was able to contact the police and therefore could take steps 'to protect herself against the abuse or neglect or the risk of it'. Professionals made decisions that Georgina was not an adult at risk in accordance with guidance contained within the Social Services and Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 6 – Handling Individual Cases to Protect Adults at Risk.[31] Once this determination was made, all future PPNs were forwarded to mental health and/or substance misuse services to offer support, and there was no further action under adult safeguarding processes except for the two occasions when the PPN escalation process was triggered. [See Term 9]

14.3.6 The Review Panel concluded that this was a missed opportunity to gather and analyse information known at this time in relation to reoccurring risks and vulnerabilities, including domestic abuse, alcohol use, and self-neglect. The Review Panel determined that this was a learning point for the review around the response to cases where there is an escalation of risk and concerns being raised by agencies. This is also analysed further in Term 4 and 9.

14.3.7 Health professionals completed the Ask and Act Domestic Abuse Assessment in order to identify risks posed to Georgina, and a referral for additional support was sent to the Health IDVA. The Health IDVA assessed the risks identified in the referral and reviewed the admission notes, which resulted in an A1 (Vulnerable Adults) referral being sent to Adult Services as well as notification to Georgina's GP, highlighting the risks posed and the action taken.

14.3.8 In November 2020, Health submitted an Adult Protection referral based on professional judgement. In addition, discussions were held with the trauma and orthopaedic (T&O) consultant due to the possibility of Georgina leaving the hospital against medical advice. This resulted in surgery being expedited to treat her injuries. During follow-up appointments, the consultant made attempts to see Georgina on her own.

[31] https://www.gov.wales/sites/default/files/publications/2019-06/volume-6-handling-individual-cases-to-protect-adults-at-risk.pdf

14.3.9 Georgina's GP also identified the risks posed to Georgina when she did not attend follow-up health appointments and therefore submitted an Adult Protection referral.

14.3.10 During Georgina's time under the care of the Community Drug and Alcohol Team, there was no formalised process for documenting risk. Consequently, risks associated with Georgina were recorded in her patient notes within the Functional Analysis of Care Environments (FACE) system, from August 2019 to November 2020. This has been identified as a single agency learning point.

14.3.11 In November 2020, a risk assessment was created using the WARRN Risk Formulation and Management Plan. However, several sections of this assessment were incomplete, and there was no evidence that identified risks were communicated to Georgina. Although there were efforts to manage risks, such as collaboration with other agencies involved with Georgina, a definitive management plan for ongoing risk of domestic abuse was absent.

14.3.12 In January 2022, the Community Drug and Alcohol Team completed a WARRN risk assessment that indicated a risk from others due to an alleged sexual assault. The risk management plan involved referring Georgina to an appropriate third-sector agency for support. However, there is no documentation indicating that these risks were discussed with Georgina, nor is there any record of her perspective regarding her risks.

14.3.13 The Review Panel was informed that whilst high caseloads within the Community Drug and Alcohol Team were considered, a clear process for identifying, managing, and sharing risks needed to be established. This area of learning is addressed in Term 13.

14.3.14 Risk assessments completed by Barod, considered the following areas:

- Substance Misuse and Harm Reduction
- Physical/Mental/Sexual Health
- Safeguarding Adults
- Safeguarding Children
- Domestic Abuse
- Relationships
- Offending Behaviour
- Housing/Finance/Other

A risk score of low, medium, or high is determined from exploring these categories.

14.3.15 In December 2019, the risk was assessed as medium, and then two months later, this was increased to high due to the domestic abuse incident with Gary. The risk remained as high over the following assessments, which resulted in a risk management plan being implemented to manage the risk. The risk management plans were reviewed and agreed by a line manager.

14.3.16 The Community Rehabilitation Company assessed Georgina as posing a risk of physical and emotional harm to the public, namely those individuals that she made acquaintances with, and that the risks of harm were greatest when Georgina was intoxicated or felt threatened by others. The Pre-sentence Report (PSR) and OASys risk assessment highlighted Georgina's history of childhood sexual abuse followed by domestic abuse in intimate relationships as an adult. These factors were considered in the risk assessments, particularly concerning her relationships and associations throughout her supervision period.

14.3.17 Georgina had regular supervision sessions with the Community Rehabilitation Company, where her behaviour, compliance with the community order, and overall well-being were monitored. The Review Panel was informed that the sessions provided opportunities to discuss Georgina's relationships, substance use, and any incidents or concerns that arose. During those appointments, risk assessments were conducted to evaluate potential threats to her safety and the safety of others.

14.4 Term 4

How effective was inter-agency information sharing and co-operation in response to the subjects of this review, and was information shared with those agencies who needed it? N.B. Please also consider cross-border information sharing.

14.4.1 Throughout the review time period, there was a high level of inter-agency information sharing between Barod, Trivallis, the Community Drug and Alcohol Team, the police, and domestic abuse services.

14.4.2 The police submitted multiple PPNs. On two occasions, this triggered the implementation of the PPN escalation process, which resulted in one multi-agency meeting being held (March 2022). This resulted in a six-month period of multi-agency meetings being held. The Plan on a Page (POP) plan included encouraging Georgina to engage with Barod, Trivallis, and the police. Following a reduction in calls, the POP was closed, as the aim of the plan was, at that point, deemed to have been successful. This was

the only period of intensive multi-agency meetings to manage the risks to Georgina.

14.4.3 The Review Panel was informed that PPNs that reference substance misuse are taken to the Joint Allocation Meeting (JAM). The meetings are split into geographical areas and have representatives from substance use services across a range of sectors. When the person named on the PPN is already open to a service, the PPN will be forwarded to that service(s). When the person is not known, it is usually actioned for Barod's Drug and Alcohol Single Point of Access (DASPA) to contact the person and offer a referral into the relevant substance use service. However, during sign off processes for the DHR it was identified that there were differing processes across the region responding to PPNs and discussions with the JAM. This point has been raised within the recommendations for the review.

14.4.4 When Barod became aware of Gary's employment, they shared safeguarding concerns with the Neath Port Talbot Safeguarding Team, whilst at the same time taking on responsibility for Georgina's safety and any increased risk to her due to the information sharing.

14.4.5 Probation notified the police of the impending release of John in June 2022. This notification was two days prior to John's release, and the police completed two visits to Georgina before John's release. However, the review has identified that no markers were placed on either Georgina or John's records to identify the potential risk that he posed to her at this time.

14.4.6 Adult Social Care informed the review that it had been noted in other practice reviews that inter-agency information sharing was hampered by the use of different systems. For example, PPNs forwarded to mental health or substance misuse services were consistently put forward for discussion at multi-agency decision-making meetings – Drug and Alcohol Single Point Access (DASPA) and Single Point of Entry (SPoE). However, the details of these discussions are not visible on the Welsh Community Care Information Request system (WCCIS). The Review Panel was informed that it had been the ambition that all health and social care records would be held on the same system; however, this did not take place.

14.4.7 The Review Panel was informed that WCCIS is being replaced in 2026, which will still only make visible health and social care records. The review was informed further that a Multi-Agency Safeguarding Tracker (MAST) has been developed in Neath Port Talbot, which joins disparate IT systems across the partnership to ensure an individual's interactions with individuals are visible for the purpose of safeguarding.

14.4.8 The Review Panel's overall analysis of the information sharing, concluded that despite the volume of information being shared, and evidence of joint working between Barod and Trivallis, an overall multi-agency response to the risks and vulnerabilities to Georgina was not taken, with the exception of the POP between March and October 2022. This is a learning point for the review.

14.5 Term 5

How did your agency respond to any mental health issues, substance misuse, and/or self-neglect when engaging with Georgina and Gary?

14.5.1 There was evidence seen by the Review Panel that Georgina had a number of traumatic events in her childhood and adult life. These included sexual abuse as a child and adult, being placed into care, physical injuries sustained in a motorcycling accident, the loss of her children, and domestic abuse. It was clear to the Review Panel that these events were a trigger for Georgina's alcohol and substance use.

14.5.2 The support worker from Trivallis informed the Chair that Georgina blocked out her past trauma and put up a barrier, choosing not to discuss her past in any detail. The support worker stated that Georgina used alcohol to self-medicate and whilst she presented as a strong woman, behind this mask, she was very vulnerable.

14.5.3 Georgina was assessed by a social worker from the Community Mental Health Team: the outcome was allocation to the Community Drug and Alcohol Team, and CMHT involvement was ended.

14.5.4 In March 2022, a referral for Georgina was made by a service manager for Substance Misuse and Mental Health to the Taf Ely Problem Solving Group. The referral was as a result of the PPN escalation process in place. [See Term 9]. The multi-agency group are part of the wider public safety agenda and is attended by the police, Housing, Health, and community safety partners; however, the attendance of Social Services is not consistently embedded into practice across the area.

14.5.5 There was evidence from meeting notes that a number of agencies were trying to support Georgina at that time, but that Georgina's engagement was variable. Social Services was involved throughout this process, and it was noted that during this timeframe there was a period of stability and significant reduction in concerns around anti-social behaviour being raised

for Georgina. Georgina was discussed monthly until October 2022. This is analysed further in Term 9.

14.5.6 The timeline demonstrated a number of occasions where Health identified and responded to issues such as mental health and substance misuse:

- GP referrals were made to mental health services and Community Drug and Alcohol Teams.
- Georgina was asked about her mental health and substance misuse at all Accident and Emergency admissions, with referrals to mental health services being made.
- Mental health and alcohol consumption was discussed during a number of follow-up appointments with Trauma and Orthopaedics.
- Pregnancy Advisory Service contacted mental health services to expedite an appointment due to urgent emerging concerns.

14.5.7 Within the review time period, 19 Adult at Risk PPNs were submitted by the police for Georgina in relation to concerns around her alcohol use, suspected drug use, mental health, vulnerability, and risk from others (non-domestic). Of those, 13 were shared with Adult Services. Those that were not shared were due to Georgina not providing consent.

14.5.8 At the start of the review period, Georgina was being supervised by the Community Rehabilitation Company. Georgina had been assessed as posing a risk of physical and emotional harm to the public, namely those individuals that she made acquaintances with, and that the risks of harm were greatest when Georgina was intoxicated or felt threatened by others. It was established by the CRC that Georgina had complex needs, including a history of significant trauma, substance misuse, and unstable relationships. The CRC made referrals to agencies, and Georgina was engaged with the Community Drug and Alcohol Team. This intervention aimed to help her manage her alcohol consumption, which was linked to her risk of harm to herself and others.

14.5.9 Georgina's daughter informed the Chair that she was aware of her mother's alcohol dependency, which she stated was a form of escape due to previous trauma. Georgina's daughter was aware that her mother was working with Barod. Georgina's daughter stated that her mother did not drink when she was visiting her daughter and grandchildren.

14.5.10 Georgina's daughter told the Chair about two incidents in 2019 and 2021, when she wanted her mother to move in with her so that she could support her in relation to reducing her alcohol use. Georgina's daughter stated that, on both occasions, she telephoned Children's Social Care to seek advice and was advised that if her mother moved into her address,

this may instigate child protection proceedings. Georgina's daughter stated that this dissuaded her from allowing her mother to move in; therefore, Georgina remained living independently. The Review Panel has not identified any records of these contacts with Children's Social Care.

14.5.11 John told the Chair that he and Georgina were both reliant on alcohol. John stated that he would drink up to eight cans of cider and a bottle of vodka during a day and that Georgina would also drink heavily.

14.5.12 The Review Panel was aware of a guidance document published by Alcohol Change UK – 'How to use legal powers to safeguard highly vulnerable dependent drinkers'[32] – that is available to support practitioners to work with alcohol dependency and agreed that there was information in this document that was of relevance for this case and the challenges faced by professionals seeking to engage with Georgina.

14.5.13 In addition, a fact sheet produced by Alcohol Change – 'Alcohol and Domestic Abuse'[33] – highlights the following links between alcohol and domestic abuse:

1. Drinking and domestic abuse often occur at the same time.
2. When alcohol is involved, abuse can become more severe.
3. Controlling access to alcohol can become part of the abuse.
4. People who experience domestic abuse may drink to try to cope.

14.5.14 Alcohol Change UK have produced a further document – 'The Blue Light Approach'[34] – which sets out a number of strategies and offers a fundamental positive message that change is possible. It contains:

- Tools for understanding why individuals may not engage.
- Risk assessment tools that are appropriate for drinkers.
- Harm reduction techniques that workers can use.
- Advice on crucial nutritional approaches that can reduce alcohol-related harm.
- Questions to help non-clinicians identify where individuals may be at risk of serious health problems.
- Management frameworks.
- Guidance on legal frameworks.

[32] https://alcoholchange.org.uk/publication/how-to-use-legal-powers-to-safeguard-highly-vulnerable-dependent-drinkers
[33] https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-and-domestic-abuse
[34] https://alcoholchange.org.uk/help-and-support/training/for-practitioners/blue-light-training/the-blue-light-project

The Blue Light Approach, documents: 'that, while we may not always be able to make someone change completely, we can help reduce harm and manage the risk they pose to themselves and others'.

14.5.15 Towards the end of 2019, a cognitive assessment was undertaken with Georgina. The assessment was completed whilst Georgina was in hospital on a detox programme. The assessment tool used is divided in to five domains: immediate memory, visuospatial, language, attention, and delayed memory. In the context of Georgina's case, the assessment was used to follow up with patients who had scored lower than expected on the ACE-III (a memory assessment) following completion of detoxification. Discharge summaries were sent to Georgina's GP and other keyworkers. Whilst in hospital, Georgina attended a memory group where she was given a handout containing relevant information on memory strategies and how they could be utilised, as well as memory aids in preparation for her discharge. The outcome of the assessment was suggestive of cognitive difficulties that were likely to be having a negative impact on Georgina's ability to manage activities of daily living. The Review Panel was informed that there were limitations to the assessment due to the responses from Georgina; however, Georgina was advised on aids that could benefit her cognitive ability, including the use of memory aids, making lists, and using a calendar.

14.5.16 The Review Panel acknowledged agencies' involvement with Georgina in responding to her mental health and alcohol use. The Review Panel considered whether the impact of alcohol dependency impacted on Georgina's capacity.

14.5.17 The Review Panel was informed that Cwm Taf Morgannwg Safeguarding Board have a 'Multi-Agency Staff Protocol for the Management of Cases of Serious Self-Neglect'[35] and offers a framework and escalation process for agencies, services, and professionals to work together in a co-ordinated and consistent way in order to reduce risk and intervene successfully with people. The aim of the protocol is to offer the best chance of long-term positive outcomes for the person concerned. The protocol details how a 'multi-agency planning meeting' should be held to develop a multi-agency plan to support the person. Where the risks remain high or critical and have not reduced with intervention, or, indeed, the assessed risks have increased, an escalation process is triggered, and the case would be referred to the Self-Neglect Partnership Panel (SNPP).

35 https://www.cwmtafmorgannwgsafeguardingboard.co.uk/En/Professionals/JointPoliciesandProcedures/A8SelfNeglectProtocolEndorsedJune2021.pdf

14.5.18 The Review Panel was informed that the typical cases referred to the SNPP are around issues of hoarding/poor housing repair/not undertaking personal care tasks, etc. In addition, the risk assessment tool, contained within the protocol, focuses on environmental factors – such as hoarding and fire risk, etc. – with alcohol and substance use seen as an exacerbating factor.

14.5.19 The protocol was not utilised on this case, and there was no evidence that it had been considered. The Review Panel agreed that this case identified an opportunity to review the protocol against the learning from this case and the availability of information to professionals working with individuals whose level of alcohol consumption gives rise for concern.

14.6 Term 6

What services did your agency provide for Georgina and/or Gary; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?

14.6.1 Gary was not in receipt of any services or in contact with any agency.

14.6.2 Georgina had extensive involvement with agencies responding to her alcohol use. Georgina's involvement with Barod was for support around her alcohol use. This included the use of psychosocial interventions, preparatory work for inpatient detox, and relapse prevention work. Georgina's engagement was, at times, sporadic, but the review heard that she had a good relationship with her caseworker.

14.6.3 The police responded to all calls made by Georgina. Where she reported criminal offences, the relevant individuals were arrested in line with her wishes. In addition, when Georgina wanted people removed from her property, this was actioned. Onward referrals were made to Adult Services, IDVA services, Barod, Trivallis, and SARC, and she was conveyed to hospital by the police on a number of occasions.

14.6.4 The Review Panel determined that the services offered to Georgina, at that time, were 'fit for purpose'. The Review Panel heard how agencies have now adopted a trauma-informed approach when engaging with individuals, which has been reflected in training delivery and policies and procedures.

14.7 Term 7

When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions?

14.7.1 There was evidence in the information shared to the review that agencies considered Georgina's wishes and feelings during contact. Appointments were arranged in accordance with her wishes – such as arranging for these to take place at her home and during the afternoon. Georgina was advised of options/choices and was allowed to make informed decisions.

14.7.2 It was noted that there were times when Georgina did not consent for information to be shared and referrals to be made.

14.7.3 The Community Mental Health Team scheduled four appointments to see Georgina, before she was finally seen. Appointments were made in accordance with Georgina's wishes – e.g., a home visit in an afternoon, as Georgina had stated that she stayed up late and slept poorly. However, during the assessment, it was noted that Georgina was under the influence of alcohol, stating that she had consumed alcohol prior to the visit.

14.7.4 Two WARRN risk assessments were completed within the timeframe relevant to this report (November 2020 and January 2022) – neither of which captured Georgina's views on risk formulation. In addition, there was no evidence that discussions had taken place with the safeguarding team to explore how Georgina could be supported in making an informed decision. This has been identified as an area of learning by the Adult Community Mental Health Services.

14.8 Term 8

Were the subjects of the review signposted to other agencies, and how accessible were these services to the subjects? Were there any barriers that may have prevented access and/or engagement with services?

14.8.1 The Review Panel recognised that Georgina had experienced significant trauma throughout her child and adult life and that this continued to have an impact on her. The support worker from Trivallis told the Chair, in detail, about how this trauma continued to impact Georgina.

14.8.2 The review has seen that Georgina was signposted and referred to other agencies, including Barod, sexual health clinic, mental health services, Community Drug and Alcohol Teams, pregnancy advisory services, and the

IDVA service. Whilst those services were accessible, the Review Panel felt that there were a number of factors that may have prevented agencies' ability to engage with Georgina.

14.8.3 The Review Panel identified the following elements of Georgina's life that may have impacted agencies' ability to maintain engagement with Georgina:

- Chaotic lifestyle.
- Capacity to understand and process information due to intoxication.
- Alcohol use.
- Consent not provided for onward referrals.

14.8.4 The Review Panel considered to what extent Georgina's alcohol use had an impact on Georgina's engagement with agencies and took account of a report by the Institute of Alcohol Studies[36] – 'Alcohol, domestic abuse and sexual assault' – which states:

'Alcohol has been found to be associated with victimisation, with research finding victims of domestic assault to have higher alcohol consumption than non-victims, and that the risk of violence increases with levels of consumption.

'There are many reasons why victims of domestic abuse may drink. Amongst those caught up in long-term domestic abuse, there is evidence that they may use alcohol to cope with the effect of domestic abuse. Indeed, one study found that women who suffered domestic abuse from their partners were twice as likely to drink after the abuse as their violent partner'.[37]

14.8.5 The Review Panel also considered a fact sheet published by Alcohol Change – 'Alcohol and Domestic Abuse':

The links between alcohol and domestic abuse

1. Drinking and domestic abuse often occur at the same time

Many abuse incidents occur when one or both people involved has been drinking, and alcohol is more commonly involved in more aggressive incidents.[38] It is not just being intoxicated that can increase risk; lack of

[36] https://www.ias.org.uk

[37] Galvani, S. 'Grasping the Nettle: alcohol and domestic violence'

[38] https://academic.oup.com/bjc/article/59/5/1035/5486457

access to alcohol can make someone irritable or angry which can, in turn, create a trigger point.

2. When alcohol is involved, abuse can become more severe

Alcohol can affect our self-control and decision-making and can reduce our ability to resolve conflict. Global evidence shows that alcohol use can increase the severity of a violent incident.[39] Home Office analysis of 33 intimate partner domestic homicides in 2014 – 15, found that 20 of these involved substance use.[40]

3. Controlling access to alcohol can become part of the abuse

A perpetrator may exert control over another person by withholding alcohol from them or preventing them from buying it. For someone who is dependent on alcohol, this could be extremely distressing and even dangerous, if they experience withdrawal symptoms.

4. People who experience domestic abuse may drink to try to cope

Living with domestic abuse can be extremely frightening, distressing, or exhausting. This can cause some people to drink alcohol to try to cope with the physical and mental health impacts of domestic abuse. Research shows that women who experience extensive physical and sexual violence are more than twice as likely to have a problem with alcohol than those with little experience of violence and abuse.[41]

Alcohol use can also leave someone more vulnerable to further abuse, especially if drinking prevents survivors from accessing support or makes their mental health worse.

14.8.6 The Review Panel discussed whether there were any indicators in this case that may have been a barrier to domestic abuse being reported. The Victim Support report – 'Survivor's Justice'[42] – contains the following information:

[39] https://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_intimate.pdf

[40] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

[41] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/the-nature-and-impact-of-domestic-abuse/

[42] https://www.victimsupport.org.uk/wp-content/uploads/documents/files/VS_Survivor%E2%80%99s%20justice.pdf

Barriers to reporting, as cited by Victim Support caseworkers

Barriers to reporting	Percentage of respondents citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear that they would not be believed or taken seriously	42%
Fear, dislike, or distrust of the Police/criminal justice system (CJS)	25%
Concern about their children and/or the involvement of social services	23%
Poor previous experience of the Police/CJS	22%
Abuse normalised, not understood, or believed to be deserved	15%
Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator	14%
Cultural or community concerns	9%
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

14.8.7 The Review Panel concluded that research supported the identification of barriers being present in Georgina's life. The Review Panel reflected on the information provided to the review that Georgina had told professionals that she 'wanted a secure and loving relationship'. The Review Panel also heard that Georgina used alcohol as a means of self-medication to deal with her past trauma. At times, when there were periods of stability in Georgina's life, she did reach out and engage with services. The Review Panel also recognised that once there was stability, those services were often withdrawn because it was deemed that she was responding and no longer in need of support.

14.9 Term 9

Were single and multi-agency policies and procedures, including the MARAC, followed? Are the procedures embedded in practice, and were any gaps identified?

14.9.1 Adult Services have an escalation process in place when an individual is the subject of repeated PPNs. The threshold for triggering escalation to the service manager for safeguarding, is three PPNs in a calendar month. This happened twice during the relevant period – in March and November 2022. The escalation process in March 2022, resulted in Georgina being discussed at the Taf Ely Problem Solving Group until October 2022, when she was removed from the group.

14.9.2 The following month, in November 2022, a further three PPNs were received. The response to the PPNs was that Georgina would be offered support from Barod, and the escalation policy was not triggered. Adult Services has identified this as a missed opportunity to consider a multi-agency meeting to assess whether a co-ordinated and proactive approach could have supported better outcomes for Georgina. The Review Panel determined that this was also a strategic learning point for the review.

14.9.3 In August 2020, a caseworker from Barod identified that Georgina was a victim of domestic abuse and that the risk was high and needed to be referred to MARAC. The caseworker contacted the Multi Agency Safeguarding Hub (MASH) to discuss the concerns and was advised that because Georgina had capacity and she was not deemed to be a vulnerable adult, then the case could not be referred to MARAC without Georgina's consent. This advice was inaccurate.

14.9.4 The Review Panel has been informed that this area of learning has already been addressed by Barod, with all staff having received training from SafeLives on DASH, Risk Identification Checklist, and MARAC processes.

14.9.5 In August 2020, during an appointment with the Community Drug and Alcohol Team, Georgina disclosed coercive and controlling behaviour by Gary. Whilst the worker completed a safeguarding referral to MASH, there was no documented evidence that they consulted with the safeguarding team for guidance on safeguarding Georgina. This area of learning has been addressed, and communication has been sent to reinforce the importance of documenting full details within records.

14.9.6 The case was heard at MARAC on three occasions during the review time period:

- February 2020, with Gary named as perpetrator
- January 2023, with John named as perpetrator
- January 2023, with John named as perpetrator.

The second MARAC in January 2023, was as a result of a MARAC-to-MARAC transfer because Georgina had moved into a refuge in the Vale of Glamorgan.

14.9.7 There were opportunities after the MARAC meeting in February 2020 for Georgina to have been referred back to MARAC; however, this did not occur.

14.9.8 In February 2020, during the MARAC, information was shared by Trivallis that Georgina was in another relationship. The minutes did not evidence any exploration of who this male was, and there was no action to undertake any further enquiries in relation to the male and any potential risk he might pose to Georgina.

14.9.9 The police identified a missed opportunity to refer Georgina back to MARAC in August 2020, after concerns had been raised by Georgina's mother and in response to the safeguarding referrals submitted by professionals to the MASH. Georgina was seen by the police in response to those concerns; however, Georgina's denial of the disclosures she had made to professionals, and concerns raised by her mother, was accepted by the police and not probed further.

14.9.10 In January 2021, the case was listed at MARAC as 'information only'. The Review Panel was informed that this system has been in place for a number of years and consists of a list titled 'Information Only' being sent to agencies, along with the case discussion list. The 'Information Only' list includes further incidents reported to the police involving victims/perpetrators that have been discussed in MARAC in the 12-month period and where the newer incidents are not deemed to be at a high level of risk to be heard at MARAC. The Review Panel was informed that it is agencies' responsibility to review the list and refer back into MARAC for a full discussion, should they identify further risks that need addressing.

14.9.11 During the MARAC in January 2023, the IDVA shared that Georgina was staying with Gary, whom she described as her boyfriend. An action was raised for the IDVA to discuss that Georgina apply for a Clare's Law disclosure; however, relevant information on previous incidents between Georgina and Gary were not researched and shared within the MARAC, and a previous Clare's Law had determined that there was no information to disclose.

14.9.12 The Review Panel discussed, in detail, the MARAC meetings held on this case. The Review Panel recognised that there are a significant number of cases heard at each MARAC meeting, and that this continues to be the case. Georgina's case was complex, and there were a significant number of agencies involved. The Review Panel felt that whilst agencies are represented at MARAC, in complex cases there is a need for those with specific knowledge on the case to be in attendance to inform the discussions and risk management.

14.9.13 The Review Panel agreed that this case identified the need for a multi-agency meeting to be held, to be attended by those professionals who knew and were working with Georgina to agree a co-ordinated response to work to manage the identified risks. The Review Panel agreed that this could be achieved by the MARAC raising an action for a multi-agency meeting to be held to respond to the risks identified.

14.9.14 The Review Panel was informed of Multi Agency Risk Assessment and Management (MARAM)[43] processes that have been adopted by some Safeguarding Boards as a multi-agency process designed to provide guidance to staff seeking to support individuals at risk to live autonomously and independently, whilst seeking to support them to manage, reduce, and mitigate any risks resulting from their lifestyle or behaviours.

14.9.15 In October 2022, Georgina told the police that Gary had given her a black eye. The details of this disclosure were contained within a PPN and not identified during supervisory and secondary risk assessment processes. This resulted in a crime report not being created and the matter not being investigated. The police have identified learning in relation to these matters.

14.9.16 WAST informed the review that clinical care was provided in all contacts, and targeted enquiry was performed on two occasions. On one occasion, it was identified that due to limited documentation, there was no record of discussion with Georgina about her social history and no enquiry to determine whether there was any domestic abuse risk. The Review Panel was informed that this area of learning has been identified in another DHR being undertaken in a different area and that recommendations and actions have been put in place to support the learning.

14.10 Term 10

Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to COVID-19.

14.10.1 It was acknowledged by the Review Panel that the timescales of the review covered the dates of the COVID-19 pandemic, which had resulted in new

[43] https://liverpoolsab.org/professionals/local-policies-and-procedures/

working arrangements for many agencies, particularly Health, due to Government restrictions.

14.10.2 Adult Services stated that there was no evidence that capacity or resources impacted on Adult Services' ability to screen PPNs or offer appointments to Georgina. Appointments were scheduled within expected timescales; these sometimes had to be rearranged because workers did not get a response from Georgina, but there was no undue delay with rescheduling.

14.10.3 Many of the appointments Georgina had with Barod took place via telephone. This was due to restrictions in place due to the COVID-19 pandemic. Normal practice would have been face-to-face meetings at Barod offices, community venues, or home visits. The latter restricted partners being present or having the ability to listen to consultations. This was difficult to manage during telephone contacts.

14.10.4 Health's response to the COVID-19 pandemic, impacted on training and the ability to provide extra services. Some of Georgina's attendance at Accident and Emergency took place over periods where senior staff may not always have been present in the department. Additionally, Cwm Taf Morgannwg did not have a Health IDVA in post until 2022.

14.10.5 Health appointments followed COVID-19 guidelines, and there were reduced face-to-face contacts. At times, Georgina's contact was difficult to maintain and required additional telephone and the attempted use of face-to-face contacts to try and achieve necessary contacts.

14.10.6 Safeguarding Level 3 Training for health professionals was paused from July 2020 and not reinstated until March 2022, which resulted in a decrease in staff compliance.

14.10.7 WAST informed the Review Panel that there were occasions where service demand resulted in organisational actions and escalation in line with their Clinical Safety Plan. The Review Panel has seen evidence that the police were contacted on occasion to respond to Georgina when an ambulance was not available.

14.11 Term 11

What knowledge did family, friends, and employers have of any incidents of domestic abuse, including coercive control, and did they know what to do with that knowledge?

14.11.1 Georgina's daughter told the Chair that Georgina had a number of relationships in which she was a victim of domestic abuse. Georgina stated that she supported her mother to end those relationships when necessary.

14.11.2 Georgina's daughter stated that she was aware that her mother had reconnected with Gary in 2019 and that she was initially happy about this. Georgina's daughter described how her mother had moved in with Gary at times throughout their relationship and that they had become engaged.

14.11.3 Georgina's daughter stated that one of the factors of Georgina moving in with Gary was because he had told Georgina that he could not afford his rent or to smoke cannabis, and that as Georgina had a reasonable income from benefits, that this would help him. Georgina's daughter stated that her mother had been living in a difficult situation at times and that the stability Gary apparently offered her, may have been attractive to her mother.

14.11.4 Georgina's daughter stated that in the six months prior to her death, communication with Georgina had been difficult, and meetings were less frequent. Georgina would often make arrangements to meet her daughter but then gave excuses for why she could not make it. Georgina's daughter went on to describe that although they spoke on the telephone, it was not always easy, and she recalled one incident when she was speaking to her mother when she heard Gary say to Georgina: 'Be quiet' I'm watching something'.

14.11.5 Georgina's daughter stated that, in hindsight, she thought that Gary's behaviour was controlling towards her mother.

14.11.6 There was information within agencies' records of Georgina's mother contacting services to report concerns over her daughter's relationship with Gary. Georgina's mother described how she felt that Gary controlled Georgina. On one occasion, when Georgina was seen by WAST in response to those concerns, Georgina expressed her frustration at ambulance staff about her mother, and she stated that she was happy in the relationship with Gary.

14.12 Term 12

Were there any examples of outstanding or innovative practice arising from this review?

14.12.1 The review has highlighted that there was extensive evidence of joint multi-agency working to respond to Georgina's risks and vulnerabilities. This included information sharing between agencies, both verbally and in

writing. There was evidence of joint visits amongst frontline practitioners to encourage Georgina to attend appointments and engage with professionals.

14.12.2 In speaking to the Chair, the PCSO and Neighbourhood Police Officer stated that they would see Georgina nearly every day, which included routine visits to her address to check on her safety.

14.12.3 Georgina's support worker from Trivallis spoke to the Chair about the good working relationship that they had with the caseworker from Barod and that, at times, they communicated daily to work together in supporting Georgina to access services.

14.13 Term 13

What learning has emerged for your agency, and how has this been or how will this be embedded into practice?

14.13.1 Adult Social Care – Rhondda Cynon Taf

- Use of 'Ask and Act' when the opportunity presents itself, particularly where individuals have a history of missed appointments and non-engagement.

Action taken to address this learning –

- Establishment of Domestic Abuse Champions across agencies has been recommended in an Adult Practice Review and will be implemented through an action plan linked to that review. This will result in upskilling practitioners to act in a consultative capacity to their colleagues, to raise awareness of how these issues can present in practice settings and to encourage a reflective analysis of the options available to support individuals and address risk.
- Development of an escalation process where information is received that indicates an individual may be at risk of domestic abuse, but there is no ongoing allocation to a worker or no role for Adult Services in relation to meeting their care and support needs.

14.13.2 Barod

- Completion of DASH and Risk Identification Checklist.
- MARAC referrals.

Action taken to address this learning –

- Training delivered by SafeLives (2023) covering DASH and RIC and referral criteria for MARAC.

14.13.3 Cwm Taf Morgannwg University Health Board

- Health IDVA was not employed during part of the review period.
- Suspension of safeguarding training due to COVID-19 pandemic.

Action taken to address this learning –

- Continue to embed VAWDASV training programme.
- Bespoke Training for Dietetics, T&O, and A&E departments
- Health documentation to be reviewed to include risk assessment for domestic abuse at triage in Accident and Emergency, and if successful, to consider expanding to other departments.
- Audit to review IDVA referrals following bespoke training packages.
- Produce a combined Health 7-minute briefing.

GP Surgery

- Level 3 Safeguarding Training requirement for GP revalidation.
- Weekly GP meeting to include safeguarding considerations.
- MASH Health to be contacted for advice and support for complex cases.

Action taken to address this learning –

- Designated safeguarding lead within the GP surgery.
- All GPs are IRIS trained.

14.13.4 Housing – Vale of Glamorgan

- Recording keeping.

Action taken to address this learning –

- A new database is being implemented to ensure more timely sharing of support plans and risk assessments between commissioned support providers and the Housing Department. This is due to be implemented by the end of 2025.
- Commissioned support providers will be required to complete and share risk assessments at the end of their involvement with the Housing Department to ensure that any risks are known and acted on, including domestic abuse services.

14.13.5 Outreach and Recovery Team (Adult Community Mental Health Services)

- Communication and recording regarding identified risks in compliance with legislation and policy.
- Strengthening the collaboration between the Community Drug and Alcohol Team, Crisis Resolution Team and Safeguarding Team, and external agencies.

- Improved co-ordination between primary and secondary care.
- Relapse prevention work post detox discharge.

Action taken to address this learning –

- Training – Promotion of compliance with relevant mandatory training and specifically Safeguarding Adults and Violence Against Women, Domestic Abuse and Sexual Violence across adult mental health services.
- Improved recording systems – Ongoing consultation to determine a patient recording system across mental health services in Cwm Taf Morgannwg Health Board to allow all teams to access same up-to-date information on patients, improving co-ordination and responsiveness.
- Regular communication and meetings – Implementation of weekly meetings between primary and secondary care teams as part of single point of entry to discuss and allocate complex patients.
- Risk Assessment – All patients assessed in the Community Drug and Alcohol Team to receive risk assessment as part of the FACE (patient recording system) Comprehensive Assessment. Patients where there is an identified additional mental health need or forensic risk, a full WARRN will be completed.
- Relapse prevention work – Post-detox follow-up includes an individualised care plan that is devised upon pre-detox depending on substance/life situation/patient goal.

14.13.6 South Wales Police

- In line with the sharing of PPNs, as per the Wales Safeguarding Procedures, officers and staff should request a strategy discussion/meeting with Adult Services and be cognisant of the concerns for and vulnerability of the individual and the identification of repeated reports of concern that require action on the part of services.
- Professional curiosity when responding to third-party concerns and submission of PPNs.
- Response to information shared at MARAC.
- Progression of criminal investigations and that all 'lines of enquiry' are progressed, including evidence-led prosecutions.

Action taken to address this learning –

- From August 2023 to May 2024, the Force delivered Operation Amddiffyn, a program of vulnerability and safeguarding upskilling for officers and staff, which included the importance of professional

curiosity. Continued messaging around this continues to be a priority.

- Learning from this review to be shared with MARAC Chairs as a reminder of the importance of considering risks outside of the relationship being discussed, with requirement for learning to be cascaded to all agencies via the Chair/Co-ordinator.
- In July 2024, South Wales Police launched a force-wide review of crime investigations to improve investigative standards; therefore, no recommendation is made in relation to this area.
- Production of case study with learning from this review, with specific focus on professional curiosity. This case study to be shared with SWP Learning and Development Department and the Strategic Public Protection & Safeguarding Command for inclusion in relevant professional development sessions/courses.
- The Strategic Public Protection & Safeguarding Department to examine Adults at Risk (AAR) as an area of focus and work with each of the local authority based AAR units to understand current practice around requesting multi-agency strategy discussions to ensure consistency and best practice across the force area. This work should seek to embed learning from this and other statutory reviews.

14.13.7 Victim Focus

- Professional curiosity when gathering background information rather than a reliance on information contained within the referral.

Action taken to address this learning –

- Learning disseminated through internal training sessions.

14.13.8 Welsh Ambulance Service NHS Trust

- Enhance understanding of Violence Against Women (and Girls), Domestic Abuse and Sexual Violence, and how themes intersect with domestic abuse.
- Promote increased recognition of times to undertake a targeted enquiry leading to opportunities for earlier intervention and support.

Action taken to address this learning –

- Create a '7-minute briefing'.
- Incorporate learning within 'Ask and Act' training.
- Promotion and completion of 'Ask and Act' training.
- Create a bespoke 'SWAY' training package on intersectionality, to be hosted and promoted on WAST Learning Zone.

14.14 Term 14

Does this learning appear in other Domestic Homicide Reviews commissioned by Rhondda Cynon Taf Community Safety Partnership?

14.14.1 Professionals' knowledge and training in relation to coercive control was a learning point in a previous DHR[44] completed by Rhondda Cynon Taf Community Safety Partnership. Term 1 detailed the relevant learning on coercive control for this review.

15. CONCLUSIONS

15.1 Georgina was murdered by Gary.

15.2 Georgina and Gary had initially been in a relationship as teenagers. In 2019, after meeting again via social media, they recommenced their relationship. The relationship continued over the following years; however, it was often described as being an 'on and off' relationship.

15.3 Six months prior to her murder, Georgina was in a relationship with another male, John. On Christmas Day 2022, John assaulted Georgina, during which she sustained serious facial injuries. John was arrested, charged, and later received a custodial sentence.

15.4 After the assault, Georgina moved into temporary accommodation, out of the area. However, within a short time period, she had recommenced the relationship with Gary. From this point onwards, Georgina was not visible to her family and agencies. Georgina did not return to her own accommodation.

15.5 In both her relationships with Gary and John, Georgina was a victim of domestic abuse, including physical assaults and coercive control. Incidents of physical abuse were reported to the police.

[44] DHR Anna – published 2022

15.6 Georgina spoke openly about her relationship with Gary and described incidents of coercive control to professionals. Georgina's family also reported their concerns about Gary. The response to the domestic abuse was inconsistent. At times, the police were not notified of the abuse, and Gary was never arrested or questioned.

15.7 The Review Panel identified learning in relation to professionals' responses to the disclosures of domestic abuse and the implementation of a multi-agency approach when there is an escalation of risk factors and vulnerabilities. This learning has been captured in relevant recommendations along with single agency learning.

15.8 Georgina's family contributed to the review process. The Review Panel extends its thanks to them for their contributions and support during the completion of the review.

16. LEARNING IDENTIFIED

16.1 The Domestic Homicide Review Panel's Learning (Arising from panel discussions)

16.1.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies at Term 13. Each lesson is preceded by a narrative that seeks to set the context within which the lesson sits. When a lesson leads to an action, a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
The case identified a lack of professionals' knowledge on the identification and response to coercive and controlling behaviour.
Lesson
Ensuring that professionals are trained in relation to domestic abuse and coercive control is likely to increase the identification of cases, leading to support for victims of domestic abuse.
Learning 2 [Panel recommendation 2]

Narrative
The review identified opportunities to gather and analyse information within a multi-agency forum on the presentation of risks, vulnerabilities, domestic abuse, alcohol use, and self-neglect. This included an option for the MARAC to refer Georgina's case to a multi-agency forum to review, analyse, and respond to the presenting risks.
Lesson
Responding to escalation in risks, in a multi-agency forum, allows for a co-ordinated approach to the management of those risks.

Learning 3 [Panel recommendation 3, 4 and 6]
Narrative
The review identified the need for information to be available to professionals on how they can respond and support individuals whose alcohol consumption gives rise for concern, including an understanding that individuals who are alcohol dependent or who are known to misuse alcohol may have reduced capacity in decision making and the context of keeping themselves safe.
Lesson
The availability of information and policies and procedures available to support professionals responding to and engaging with individuals where there are concerns around alcohol consumption, can lead to increased support being offered or provided.

Learning 4 [Panel recommendation 5]
Narrative
There were opportunities on this case to refer to MARAC; however, this did not take place as there was a misconception that the victim's consent was required.
Lesson
Understanding of the MARAC criteria and referral process will lead to cases of high risk being referred to MARAC in accordance with MARAC policy.

Learning 5 [Panel recommendation 7]
Narrative
The victim on this case was involved with agencies across a number of Regional Safeguarding Boards.

Lesson
The published report to be shared with both West Glamorgan and Cardiff and Vale Regional Safeguarding Boards for the learning to be disseminated amongst agencies working within those regions.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
1	That Cwm Taf Morgannwg Community Safety Partnership seeks evidence and assurances from all agencies involved in this review on: • The numbers and range of multi-agency staff who have attended regional domestic abuse and coercive control training on an annual basis to support consistency of training attendance within the region and address identified gaps. • Engagement in the provision of multi-agency domestic abuse and coercive control training which may be provided in partnership with a range of other key stakeholders including the Regional Safeguarding Board, VAWDASV Regional Advisor and third sector specialist delivery partners. • The submission of domestic abuse referrals to specialist support agencies operating within the region and to the

	Cwm Taf Morgannwg Multi-Agency Risk Assessment Conferences. The Community Safety Partnership commits to scrutinizing agency referral and MARAC data bi-annually to support that improvements in knowledge from training into practice are occurring within the region • The accessibility of information on domestic abuse, including coercive control within agencies via appropriate audit activity eg. survey data, seeking to ensure that a base-line of regional awareness raising information and materials are available for dissemination within all agencies.
2	That Cwm Taf Morgannwg Community Safety Partnership disseminates the learning from this case, with particular emphasis on the options for professionals to implement a multi-agency process to review, analyse, and manage risk, including how the MARAC can interact with adult safeguarding processes when dealing with similar cases.
3	That Cwm Taf Morgannwg Community Safety Partnership in conjunction with Cwm Taf Morgannwg Substance Misuse Area Planning Board, reviews the information available to professionals on how they can invoke a multi-agency response to individuals whose alcohol consumption gives rise for concern. This could include a review of the 'Multi-Agency Staff Protocol for the Management of Cases of Serious Self-Neglect' to capture this area of learning.
4	That Cwm Taf Morgannwg Community Safety Partnership, in conjunction with Cwm Taf Morgannwg Substance Misuse Area Planning Board, disseminates the learning on this review in relation to the guidance that is available to professionals on how they can work with individuals whose alcohol consumption gives rise for concerns.
5	That Cwm Taf Morgannwg Community Safety Partnership should support additional training for agencies operating in the region in respect of MARAC criteria and referral process whilst ensuring that agencies understand that where they hold concerns that the MARAC threshold is potentially met for a victim of domestic abuse, they do not require the "permission or consent" of the victim to submit a MARAC referral; and that all agencies should hold a clear understanding of how to refer in to the MARAC and the purpose of this.
6	That Cwm Taf Morgannwg Community Safety Partnership seeks evidence and assurances from agencies involved in this review that that individuals who are alcohol dependent or who are known to misuse alcohol may have reduced capacity in decision making and the context of keeping themselves safe. This should

	include an understanding of the potential of alcohol-related brain damage that may impact on a victim's ability to keep themselves safe or which may impact their ability to engage effectively in support.
7	That Cwm Taf Morgannwg Community Safety Partnership share the published report with both West Glamorgan and Cardiff and Vale Regional Safeguarding Boards for the learning to be disseminated within those regions.

17.2 Single Agency Recommendations

17.2.1 There were no single agency recommendations because all learning identified had been addressed at the conclusion of the review, as detailed in Term 13.

Appendix A –

Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	That Cwm Taf Morgannwg Community Safety Partnership seeks evidence and assurances from all agencies involved in this review on: • The numbers and range of multi-agency staff who have attended regional domestic abuse and coercive control training on an annual basis to support consistency of training attendance within the region and address identified gaps.						

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	• Engagement in the provision of multi-agency domestic abuse and coercive control training which may be provided in partnership with a range of other key stakeholders including the Regional Safeguarding Board, VAWDASV Regional Advisor and third sector specialist delivery partners. • The submission of domestic abuse referrals to specialist support agencies operating within the region and to the Cwm Taf Morgannwg Multi-Agency Risk						

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	Assessment Conferences. The Community Safety Partnership commits to scrutinizing agency referral and MARAC data bi-annually to support that improvements in knowledge from training into practice are occurring within the region The accessibility of information on domestic abuse, including coercive control within agencies via appropriate audit activity eg. survey data, seeking to ensure that a base-line of regional awareness raising information and materials are available for dissemination within all agencies.						

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
2	That Cwm Taf Morgannwg Community Safety Partnership disseminates the learning from this case, with particular emphasis on the options for professionals to implement a multi-agency process to review, analyse, and manage risk, including how the MARAC can interact with adult safeguarding processes when dealing with similar cases.						
3	That Cwm Taf Morgannwg Community Safety Partnership in conjunction with Cwm Taf Morgannwg Substance Misuse Area Planning Board, reviews the information available to professionals on how they can invoke a multi-agency response to individuals whose alcohol consumption gives rise for concern. This could include a review of						

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	the 'Multi-Agency Staff Protocol for the Management of Cases of Serious Self-Neglect' to capture this area of learning.						
4	That Cwm Taf Morgannwg Community Safety Partnership, in conjunction with Cwm Taf Morgannwg Substance Misuse Area Planning Board, disseminates the learning on this review in relation to the guidance that is available to professionals on how they can work with individuals whose alcohol consumption gives rise for concerns.						
5	That Cwm Taf Morgannwg Community Safety Partnership should support additional training for agencies operating in the region in respect of MARAC criteria and referral process						

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	whilst ensuring that agencies understand that where they hold concerns that the MARAC threshold is potentially met for a victim of domestic abuse, they do not require the "permission or consent" of the victim to submit a MARAC referral; and that all agencies should hold a clear understanding of how to refer in to the MARAC and the purpose of this.						
6	That Cwm Taf Morgannwg Community Safety Partnership seeks evidence and assurances from agencies involved in this review that that individuals who are alcohol dependent or who are known to misuse alcohol may have reduced capacity in decision making and the context of keeping themselves safe. This should include an						

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	understanding of the potential of alcohol-related brain damage that may impact on a victim's ability to keep themselves safe or which may impact their ability to engage effectively in support.						
7	That Cwm Taf Morgannwg Community Safety Partnership share the published report with both West Glamorgan and Cardiff and Vale Regional Safeguarding Boards for the learning to be disseminated within those regions.						