CARDIFF COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Helena'

Date of murder – Spring 2019

OVERVIEW REPORT

FINAL VERSION

NOVEMBER 2021

Chair and Author - Carol Ellwood-Clarke
Supported by - Ged McManus

CONTENTS

Family tribute to Helena

The saying goes, ”only the good die young.“ There’s no more a truer saying when it comes to the passing of Helena. Helena loved being part of a big family, being a perfect daughter, a big sister, a loved granddaughter, and special niece. Helena was truly unique in every way possible, her attitude to life, in her personality and the way she dressed. Helena was so comfortable in her own skin and that comfort shone in a room, she made people feel comfortable in her presence. Helena found making friends so easy and had a big group of friends. These friends along with Helena’s family feel that the world has been robbed of a true kindred spirit. We as a family hope this review will help anyone who is suffering from domestic violence and abuse. Helena would be so proud if it did help someone else. We as a family only had 21 years with Helena, nowhere near enough time, but in those 21 years Helena has left a massive legacy. AAJ

1. INTRODUCTION

1.1 The panel offers its sincere condolences to Helena's family.

1.2 This report of a domestic homicide review (DHR) examines how agencies responded to, and supported, Helena, a resident of Cardiff, prior to her murder in Spring 2019. The review follows the principles within Home Office Domestic Homicide Review statutory guidance (2016)[1].

1.3 In addition to agency involvement the review also examines the past to identify any relevant background or trail of abuse, and 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.

1.4 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.

1.5 Helena had been in a relationship with Tim for two years. Tim had moved to Cardiff to study. Helena moved with Tim, initially to gain employment and later to continue her education. In Spring 2019, Helena was found deceased in the flat she shared with Tim. A post-mortem examination revealed that Helena had died from the application of pressure between the heart and the head.

The DHR will not cover the full circumstances surrounding Helena's murder as they have been subject to a criminal investigation.

1.6 Tim was arrested and charged with Helena's murder. Towards the end of 2020, following a criminal trial, Tim was found guilty of the murder of Helena. Tim was sentenced to life imprisonment, to serve a minimum of 18 years.

1.7 The Senior Investigating Officer at the conclusion of the trial said – 'Helena was a much-loved daughter and sister who had a bright and promising future. Her family have shown tremendous patience and dignity during this long and heart-breaking ordeal. We hope they can now begin to recover and rebuild their lives. Having murdered Helena during the early hours. Tim then waited more than 24 hours before calling 999. In this time, (Tim) took money from Helena's account,

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

went shopping, bought and consumed a large quantity of drugs, ordered pizza, and set up a Netflix account, before eventually – perhaps realising the inevitability of the situation – calling 999. At no time, did he show any meaningful concern for Helena's welfare or dignity. We would like to thank all the witnesses who assisted the investigation, the community of Cathays, as well as the prosecution team'.

1.8 Helena's family contributed to the review. The panel have expressed their appreciation to Helena's family for their contribution and involvement in the review process.

2. TIMESCALES

2.1 South Wales Police notified Cardiff Community Safety Partnership of the murder of Helena in August 2019. A virtual panel was established on 7 October 2019 which determined that the murder met the criteria for a Domestic Homicide Review. On 14 October 2019 the Home Office were notified of the decision.

2.2 In 2019 Cardiff Council deemed it appropriate to carry out a new process in procuring DHR Chairs and enlisted on a system called NEPO, which the Council had not used before. As this was a pilot, Procurement and Community Safety were going through a learning process, assessing how this would work and completing necessary forms and procedures. Agreement was obtained from Procurement, Legal and the Head of Service to appoint an Independent Chair via NEPO. All of these factors contributed in the delay in appointing an Independent Chair for this review.

2.3 On 2 June 2020 Carol Ellwood-Clarke was appointed as the Independent Chair. The first meeting of the review panel took place on 27 July 2020. This and subsequent panel meetings were held virtually during the Covid-19 pandemic and contact was maintained with the panel via email and telephone calls. In total the panel met six times.

2.4 The DHR covers the period from 1 January 2017 to 30 April 2019. The start date was determined to incorporate the timeframe that Helena and Tim moved to Cardiff. Events prior to this date were gathered from agencies and considered during the analysis of the review.

2.5 The domestic homicide review was presented to Cardiff Community Safety Partnership on 13 September 2021 and concluded on 29 November 2021 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 names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim, and her partner, which were agreed with Helena's 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
Helena	Victim	21	White British female
Tim	Partner	22	White British male

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 27 July 2020. These were shared with the family who were invited to comment on them.

4.2 The DHR panel set the period of review from 1 January 2017, which was prior to Helena's move to Cardiff, to 30 April 2019.

The purpose of a DHR is to:[2]

a] 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;

b] 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;

c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d] Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e] Contribute to a better understanding of the nature of domestic violence and abuse; and

f] Highlight good practice.

4.3 **Specific Terms**

1. Were there any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects or given rise to other concerns or instigated other interventions?
2. What indicators of domestic abuse did your agency have that could have identified Helena as a victim of domestic abuse and what was the response?
3. What knowledge did your agency have that indicated Tim might be a perpetrator of domestic abuse against Helena and what was the response? Did that knowledge identify any controlling or coercive behaviour by Tim?
4. When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about Helena and Tim? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
5. When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?
6. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
7. Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective needs and risks identified at the time and continually monitored and reviewed?
8. Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective?
9. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
10. Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Helena and/or Tim, or on your agency's ability to work effectively with other agencies?
11. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Helena and/or Tim?

12. What learning has emerged for your agency?
13. Are there any examples of outstanding or innovative practice arising from this case?
14. Does the learning in this review appear in other domestic homicide reviews commissioned by Cardiff Community Safety Partnership?

5. METHOD

5.1 On 2 June 2020 Carol Ellwood-Clarke was appointed as the Independent Chair and Author. The Chair was supported in the role by Ged McManus.

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 and the others, short reports. The Chair provided training to Individual Management Review (IMR)[3] Authors to assist in the completion of the written 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 sought.

5.4 The DHR Chair liaised with the panel members to identify family members or friends to help inform the DHR process. Contact with family was facilitated by the National Homicide Service worker, whom the Chair provided timely updates on at key points in the review. Due to the criminal investigation and court proceedings no direct contact was made with the family until after the conclusion in February 2021. Thereafter, the Chair engaged with the family. See Section 6.

5.5 In April 2021, the Chair liaised with Tim's Offender Manager to seek his engagement in the review. The Offender Manager facilitated a letter of introduction to be delivered to Tim. Tim agreed to be contribute to the review process and a meeting was held with Tim in the presence of his Offender Manager. The meeting took place online due to the ongoing Covid-19 pandemic. Tim's contribution to the review is reflected in the report where relevant.

5.6 Health Authorities involved in the review declined to share information held in relation to Tim without his expressed consent. The Chair was informed that this is

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

an overarching decision held by the relevant authorities that has been raised and highlighted to the Home Office on previous DHRs. The Chair liaised with Tim's Offender Manager and arranged for Tim to sign a letter of consent to allow access to his health and University records for the purposes of the DHR. In relation to Tim's health records, information was provided from PARIS which is the electronic notes for any community services and Mental Health services. There was no access to Tim's GP records.

5.7 The Chair of the Community Safety Partnership agreed for an extension of the timeframe for the DHR to be completed as a result of delays due to the criminal investigation and ongoing Covid-19 pandemic. The Home Office were notified of the extension.

5.8 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. The draft report was shared with Helena's family who were invited to make any additional contributions or corrections.

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

6.1 The Chair wrote to Helena's mother, father and sister to inform them of the review and included the Home Office Domestic Homicide Review leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet (AAFDA)[4].

6.2 Contact with the family was suspended until after the criminal trial and sentence. During this time the Chair maintained contact with the National Homicide Worker to advise on the progression of the DHR.

6.3 In April 2021, the Chair spoke with Helena's mother and father, via a video call. They were supported in this process by their National Homicide Service Worker. Helena's mother and father provided valuable information to the review, which has been reflected in the report where relevant.

6.4 The Chair spoke with Helena's sister via telephone who provided additional information for the review. Helena's sister was supported by her National Homicide Service Worker.

6.5 The police provided the Chair with extracts from statements from Helena's friends and previous work colleagues that had been obtained during the criminal

[4] https://aafda.org.uk/

investigation. Relevant information from these documents has been reflected within the report.

6.6 The Chair contacted the housing provider for Helena and Tim's rental property to establish if there was any additional information that could help inform the review. The Chair was informed that there was no relevant information and that the murder of Helena had come as a shock to them as she was a 'lovely girl' and that they were happy with their tenancy.

6.7 Helena's mentor from Inspire to Work, who had worked with Helena during the summer of 2018, was on maternity leave at the time of this review and it was determined that contact would not be progressed.

6.8 The Chair discussed the contents of the report with family, prior to the family being sent a draft copy. The report was also shared with the National Homicide Caseworker supporting the family.

6.9 Helena's father sought additional support from AAFDA, and the Chair liaised with the Senior Advocate from AAFDA appointed to the case and discussed the DHR review process as well as sharing a draft copy of the report.

7. CONTRIBUTORS TO THE REVIEW

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

Agency	IMR	Chronology	Report
University 1	✓	✓	
Cardiff and Vale University Health Board	✓	✓	
Cardiff Women's Aid	✓	✓	
Department of Works and Pensions			✓
Into Work Advice Service (Inspire to Work Project)	✓	✓	
South Wales Fire and Rescue			✓
South Wales Police	✓	✓	
University 2			✓
Welsh Ambulance Service NHS Trust	✓	✓	
West Mercia Police			✓

7.2 Nil returns were received from –

- University 2 (unable to provide without consent)
- National Probation Service

- Cardiff Adult Social Care
- Safer Wales
- Cardiff Alcohol and Drug Team

7.3 The IMR's 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 they had no management of the case or direct managerial responsibility for the staff involved with this case.

7.4 Below is a summary of agencies contributing to the review –

University 1
University 1 is a top five university for research excellence in a beautiful, student-friendly capital city. Founded in 1883 as the University College of South Wales and Monmouthshire, it became a founding college of the University of Wales in 1893.

Cardiff and Vale University Health Board
Cardiff and Vale University Health Board provides health services to residents and visitors within Cardiff and the Vale of Glamorgan. General Practice (GP services) are provided under the General Medical Services Contract 2004 this sits adjacent to the Primary Community and Intermediate Care Board of Cardiff and Vale UHB. As an agency the services provided by health professionals are diverse and cover all medical specialties; most people are known to health services from birth to murder, thus generating considerable recorded material.

Cardiff Women's Aid
Cardiff Women's Aid is a charity organisation which has worked for over 45 years to end all forms of violence against women, girls, children and young people. Since April 2018, Cardiff Women's Aid has worked in partnership with BAWSO[5] and Llamau[6] to deliver the Violence Against Women, Domestic Abuse & Sexual Violence Service across Cardiff under the RISE-Cardiff[7] service.

Department of Work and Pensions
The Department for Work and Pensions (DWP) is responsible for welfare, pensions and child maintenance policy. As the UK's biggest public service

[5] https://bawso.org.uk/contact-us/

[6] https://www.llamau.org.uk/

[7] https://rise-cardiff.cymru/

department it administers the State Pension and a range of working age, disability and ill health benefits to around 20 million claimants and customers.

Into Work Advice Service (Cardiff Council)

Into Work Advice Service brings together numerous funding streams, including Communities for Work and Communities for Work Plus, Welsh Government and various other European funding streams alongside the Council's own resources to create a cohesive employment, skills and agency service. There are approximately 140 staff in the overall service; with 25 in the youth team who are funded by: Local Authority funding, Welsh government, European Social Funding, Home Office, DWP, Supporting People funds.

South Wales Fire and Rescue Service

South Wales Fire and Rescue Service is the fire and rescue service covering the ten Welsh principal areas of Blaenau Gwent, Bridgend, Caerphilly, Cardiff, Merthyr Tydfil, Monmouthshire, Newport, Rhondda Cynon Taf, Torfaen and Vale of Glamorgan.

South Wales Police

South Wales Police provides a policing service to 1.3 million people covering 42% of Wales' population with around 49% of the total crime in Wales. 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 with other forces and partners to deliver services collaboratively 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.

Welsh Ambulance NHS Service Trust

Welsh Ambulance Services NHS Trust (WAST) is the national ambulance service for Wales, providing services to over 3 million people across 8,000 square miles of diverse and challenging urban, coastal and rural landscape. We provide emergency clinical care and non-emergency hospital transport. Our call handlers deal with more than half a million calls every year, 24 hours a day, 7 days a week and 365 days of the year. We attend more than 250,000 emergency calls annually, over 50,000 urgent calls and transport over 1.3 million non-emergency patients. We operate from 90 ambulance stations, 3 contact centres, 3 regional offices and 5 vehicle workshops. We are at the forefront of innovation in unplanned clinical

care, providing thousands of patients a year with advice, support and signposting to the right services through our "*hear and treat*" services. We host the NHS111 Wales service, which is an amalgamation of NHS Direct Wales (a 24 hour health advice service and information for the public) and the front end call handling and clinical triage elements of the GP out-of-hours services.

West Mercia Police

West Mercia Police, formerly known as West Mercia Constabulary, is the territorial police force responsible for policing the counties of Herefordshire, Shropshire and Worcestershire in England. The Force area covers 2,868 square miles making it the fourth largest police area in England and Wales.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Beth Aynsley[8]	Independent Protecting Vulnerable Persons Manager	South Wales Police
Carol Ellwood-Clarke	Independent Chair and Author	
Paula Hardy	Strategic Lead for Victims and Vulnerability	Police and Crime Commissioner's Office, South Wales
Nikki Harvey[9]	Head of Safeguarding	Welsh Ambulance Services NHS Trust
Linda Hughes-Jones	Head of Safeguarding	Cardiff & Vale University Health Board
Claire Humphries	Safeguarding Nurse Advisor	Cardiff & Vale University Health Board
Gwenan Jones-Parry	Safeguarding Specialist Paramedic	Welsh Ambulance Services NHS Trust
Nicola Jones	Domestic Abuse Co-ordinator	Cardiff Council
John Lane	Independent Protecting	South Wales Police

[8] Attended two panel meetings and was replaced by John Lane.

[9] Attended up to and including third panel meeting and was replaced by Gwenan Jones-Parry.

	Vulnerable Persons Manager	
Ged McManus	Independent Reviewer	
David Murray-Dickson	Adult Services Safeguarding Manager	Cardiff Council
Jenny Rogers	Community Safety Manager	Cardiff Council
Zbig Sobiesierski	Director of Continuing and Professional Education, University 1	University of Cardiff
Natalie Southgate	Improvement Project Manager	Gender Specific Services, Cardiff Council
Gareth Speers	Into Work Co-ordinator	Into Work Advice Service, Cardiff Council
Jemma Thompson[10]	High Priestess	Alexandrian Tradition of Witchcraft
Stuart Wales*	Detective Inspector	South Wales Police
Nicola Winstanley	Business Manager	Cardiff Council

* - Attended first meeting only

8.2 The Chair of Cardiff Community Safety Partnership was satisfied that the Panel Chair and author were independent. In turn, the Panel Chair believed 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 six times and the circumstances of Helena's murder were considered in detail with matters freely and robustly considered, to ensure all possible learning could be obtained. Due to the Covid-19 pandemic panel

[10] Jemma Thompson was appointed to the panel as an expert panel member. Jemma is a High Priestess in the Alexandrian Tradition of Witchcraft who has been an active member of the Pagan community for over 20 years and has recently been taken on by the Pagan Federation as a Chaplain. She is an active member of the Interfaith community, working with other religious leaders/spokespersons to dispel fear and misunderstanding and promote religious and cultural tolerance.

meetings met virtually. Outside of the meetings the Chair's queries were answered promptly via email or telephone call and in full.

8.4 The Community Safety Partnership were unable to secure the attendance of an independent domestic abuse professional at meetings for logistical reasons. However several members of the panel have extensive professional domestic abuse experience, for example the domestic abuse Co-ordinator for Cardiff Council and the Strategic Leads for Victim and Vulnerability for Crime Commissioner's Office both of whom were independent of agencies involved in the review. The chair of the DHR panel was satisfied that the panel had sufficient relevant experience.

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 sets 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] in 2017 after thirty 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[11].

9.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board. He served for over thirty 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 adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews, domestic homicide reviews and have completed the Home Office online training for undertaking DHRs.

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

9.5 Neither practitioner has worked for any agency providing information to the review.

10. PARALLEL REVIEWS

10.1 HM Coroner for South Wales Central opened and adjourned an inquest. Notification of the DHR was made to HM Coroner. Following the conclusion of the criminal trial and at the request of the family, an inquest was not held.

10.2 South Wales Police completed a criminal investigation following Helena's murder. Tim was charged with Helena's murder. At the end of 2020, following a trial at Newport Crown Court, Tim was found guilty of Helena's murder. At the beginning of 2021 Tim was sentenced to life imprisonment, with a requirement to serve a minimum sentence of 18 years.

10.3 The review was not aware of any other investigations that have taken place since Helena's murder.

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protective 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.[12]

11.3 The panel determined that Helena's mental health may have been a disability as within Section 4 of the Equality Act 2010. Further analysis of this is covered at 14.3.6.

Professionals applied the principle of Section 1 Mental Capacity Act 2005:

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

[12] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

There was nothing in agency records that indicated that any subjects of the review lacked capacity[13] in accordance with Mental Capacity Act 2005.

11.4 In 2016 Helena was subject of a mental health review undertaken by a Consultant Psychiatrist. The review identified that Helena had a history of abusive relationships with men, which Helena had not realised were abusive at the time. The psychiatrist reported that Helena's mood changes and 'dissociative' behaviours could be explained by Helena having - 'complex trauma related to abuse and leading to dissociative episodes.[14] The psychiatrist determined that Helena required psychological therapy. Relevant research in this area is included at Section 15.

11.5 This diagnosis was prior to the timescales of the review. The DHR panel have not had access to the evidence to support this diagnosis.

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[13] 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".

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]

[14] https://www.nhs.uk/mental-health/conditions/dissociative-disorders/
Symptoms of dissociative disorder can vary but may include:
feeling disconnected from yourself and the world around you
forgetting about certain time periods, events and personal information
feeling uncertain about who you are
having multiple distinct identities
feeling little or no physical pain
Dissociation is a way the mind copes with too much stress.

11.6 Helena was referred to Mental Health services for an assessment and specialist opinion on two occasions in 2017 and 2018 by her GP, however, on both occasion she did not attend appointments arranged for her to see a psychiatrist. The referrals by the GP referenced Helena's history of mental health problems: depression and a background of complex trauma causing dissociation. Helena had described 'multiple personalities' but also reported to the GP 'frequent blank episodes where she would go missing and engage in risky behaviour which she did not recall.'

11.7 At various times Helena was prescribed anti-depressants. There was evidence of Helena deliberately self-harming and in July 2017 Helena was admitted to hospital having taken an overdose of prescribed medication, Citalopram[15] 20 mg.

11.8 Helena applied for Personal Independence Payment (PIP)[16]. Helena's GP signed her off sick from work in relation to her mental health. The sick notes did not identify any disability or care and support needs. It was recorded that her mental health was linked to stress.

11.9 In March 2018, whilst in custody, Tim was assessed under the Mental Health Act as he had been expressing suicidal ideation. He was not assessed to require detaining under the Mental Health Act. Tim was provided with details of the Entry to Drug and Alcohol Services (EDAS)[17] and he stated he would attend his GP to discuss low mood.

11.10 Helena and Tim described themselves as practicing Pagan/Wiccan's[18]. The review sought advice and guidance from a High Priestess to understand more about this

[15] https://www.nhs.uk/medicines/citalopram/

[16] https://www.gov.uk/pip

[17] https://cavuhb.nhs.wales/our-services/e-das/

[18] https://www.paganfed.org/paganism/
Paganism is an umbrella term that covers a variety of polytheistic or pantheistic nature-worshipping religions/paths. Modern pagans seek to follow the natural cycles of the Sun and the Moon, celebrating significant events such as Solstices, Equinoxes and Harvest festivals. There is very little in the way of dogma in general Paganism, but the majority of paths focus on finding balance within oneself, as well as the idea of some kind of karmic balance - an understanding that the energy one sends out, will ultimately return to the sender. Neo Wicca, specifically, gives the explicit instruction "harm none". Many pagans perform rituals and ceremonies in keeping with those they believe their Ancestors to have practiced, and some Pagans will practice forms of Ceremonial Magic, Witchcraft or Shamanism. Paganism is, in general, a peaceful and life-affirming path. The freedom of having so little in the way of official dogma/guidance, however, does have another side in that it can be hard for pagans to know where to turn for spiritual or moral guidance.

faith and provide advice and guidance to the Chair and panel. Relevant information has been reflected within the report.

11.11 All subjects of the review are White British. Neither Helena nor Tim spoke Welsh. Their first language was English. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

12. DISSEMMINATION

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

- The family
- Cardiff Community Safety Partnership
- Cardiff Public Services Board
- Cardiff Regional Safeguarding Board
- All agencies that contributed to the review
- Welsh Government – Single Unified Safeguarding Review
- South Wales Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, OVERVIEW AND CHRONOLOGY

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 family and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, input from Helena's family, contact with Tim and material gathered by the police during their investigations.

13.1 Helena

13.1.1 Helena was a very happy and bubbly person who had a wide circle of friends. She was a confident and brave individual who was not in the slightest bit scared to venture further from home alone to see friends, regularly using public transport to get to different places. She was a 'lively little thing' and liked her music. Her family stated that she was always keen to see more of life, enjoy herself and take everything in. She was not scared of anything. Helena was quirky and friendly without an enemy in the world. She had a kind nature, and her family used the phrase 'she did not have a bad bone in her body'.

13.1.2 As a young child, Helena was into everything and was always keen to learn. She almost always had a book in her hand and both parents agreed that they never had any problems with her, describing her as 'awesome'. Helena clearly had a real desire to spend time in Cardiff and her father recalled that when she was around 14 or 15 years old, he took her to watch a Welsh Rugby match in Cardiff. Whilst in a pub, Stereophonics played over the music system and everyone sang along. Helena loved it and immediately said that she would move there when she was older. This was something she continued to talk about until she eventually did. Her parents were not worried at the prospect of her moving away one day as she was level-headed. Both agreed that she was always going to move to Cardiff at some stage and if it wasn't with Tim, it would have been with someone else.

13.2 Tim

13.2.1 Tim completed his 'A' levels and stayed on at college to study further to gain the qualifications he needed to study 3D animation at University. It was during this time that Tim met Helena.

13.2.2 Tim described how he had been brought up as a child in the Pagan belief and continued with this belief after leaving home.

13.2.3 Tim enrolled at University 2 on a BA programme, at Cardiff Campus which commenced in September 2017. During the first year Tim started with good engagement. From early 2018 Tim's attendance was poor, he did not attend lectures, his course work was either not completed or submitted late. The work he did submit did not reach the required grade. In February 2018, Tim was referred to the University's Progression Advice Team[19]. Tim stated he was caring for his girlfriend who had mental health issues.

13.2.4 In September 2018 Tim enrolled to repeat some of the year 1 modules.

13.3 Helena and Tim's relationship

13.3.1 Helena met Tim whilst still living at home. They spent time together in the gym at their local college. Tim would often stay at Helena's parents' house at weekends and Helena's mother met them both regularly on Friday lunchtimes, when she'd buy them a McDonalds. Helena spent almost all of her time with Tim, which had been the case with previous boyfriends. Helena's family described how they did everything together and seemed to enjoy each other's company.

[19] Aim is to support any student who are at risk of not completing their course and to support them to reach their full potential.

13.3.2 Helena studied childcare and then moved onto sociology. Tim was studying media or art. Helena and Tim had been in a relationship for more than a year when they moved to Cardiff together. Tim enrolled on a computer animation degree course at the University 2, whilst Helena worked in a call centre before she undertook foundation courses with providers affiliated to University 1. They both undertook some part time work; however, their approach to employment was described as chaotic; which impacted significantly on their finances and studies.

13.3.3 Helena's family stated that she had never talked about any religion until she met Tim and that not long after they met, she explained that he was Pagan, and that she was showing interest in it as Tim's mother practised a similar faith. Helena and Tim had had a small local friendship group who also had a strong interest in in Pagan/Wiccan beliefs.

13.3.4 Tim described himself as Helena's 'carer' to professionals, although this was never formally assessed by agencies and was seen as an informal role. Within this role, Tim accompanied Helena to most, if not all her lectures and studies, and meetings with University staff. Helena's family described Helena as being independent and not in need of a 'carer'. Helena's sister told the Chair that after moving to Cardiff, Helena, did not contact her as much, and that she became distant from her and her family. This is addressed later in Section 14.

13.4 Pre – 2017

13.4.1 In 2014 Helena was the victim of a physical assault by her boyfriend. Helena declined to support a prosecution. A DASH risk assessment was completed. No further action was taken against the perpetrator. Helena was 16 years old at this time.

13.4.2 In 2015, Helena was the victim of a sexual assault by an ex-partner. The matter was reported to the Police and following an investigation and advice from the Crown Prosecution Service no further action was taken against the perpetrator.

13.5 2017

13.5.1 In the early part of 2017 Helena was living in England. In May, she was seen by her GP and reported feeling low, experiencing poor sleep and had requested to restart on antidepressants. Helena was seen to have superficial deliberate self-harm injuries. Helena was referred to the Community Mental Health Team;

however, she did not attend the arranged appointment. Helena was issued with a fit note[20].

13.5.2 In July, Helena was admitted to hospital having taken an overdose of prescribed medication. Helena was by now living in Cardiff. Helena was still registered with her GP in England. Helena was discharged from hospital a day later. Upon admission Helena stated that she had had an argument with her boyfriend. Helena was not seen by a mental health service. Helena provided Tim's name as her next of kin. Helena's family were not aware of this incident until contact with the DHR.

13.5.3 In August, Helena registered with a GP in Cardiff. Helena's first appointment was in October 2017, who referred her to the Community Mental Health Team. The referral stated that Helena 'was not coping very well' and had had to take some time off work. Helena's referral was discussed at a multi-disciplinary team meeting, and Helena was sent a letter requesting her to contact the service to arrange an appointment with a psychiatrist. Helena did not contact the service.

13.5.4 In December, Helena was seen by her GP where she reported to be 'struggling with stress and new job'. The GP provided a report to Department of Work & Pensions highlighting her mental health issues and that she was awaiting an appointment from the Community Mental Health Team.

13.6 2018

13.6.1 On 7 March 2018 Helena contacted the Police via 999 and reported that Tim had assaulted her and grabbed her by the throat. During the call Helena stated that for the last couple of months Tim had been saying that he wanted to kill them both. Police attended at the property and found Tim outside, he told the police - 'I tried to kill myself and I tried to kill my partner'. Tim was arrested on suspicion of assault. Helena informed the police that she was unsure if she wanted to make a statement. A referral to Victim Support was declined. The incident was risk assessed as high and referrals were made to RISE[21], Cardiff, MARAC[22] and the Arson Referral Team of the South Wales Fire & Rescue Service. The Public Protection Notice (PPN)[23] was shared with South Wales Police Mental Health Officer who shared details of the incident to other agencies.

[20] https://www.gov.uk/government/collections/fit-note

[21] https://rise-cardiff.cymru/

[22] Multi Agency Risk Assessment Conference

[23] The PPN is a form used by South Wales Police.

13.6.2 Tim was subject to an assessment by a Health Care Professional whilst in custody and deemed fit for interview. Helena provided a statement which expressed concern for Tim's mental health. Helena did not support a prosecution for the assault. The investigation established that Helena and Tim were experiencing financial difficulties, which was having an impact on their mental health. Tim stated that he was using cannabis and that a conversation had taken place with Helena about them undertaking a suicide pact. The assault on Helena occurred during the suicide pact. A 'Police Watch'[24] and other safeguarding measures were instigated at the address. Contact was made with a Student Liaison Officer, from University 1, and it was noted that support on financial and housing benefits could be provided.

13.6.3 Tim stated during interview that they had argued, and he had acted in self-defence by grabbing Helena's throat. Tim denied any intention to kill Helena. Tim was released from custody on bail conditions. Tim was referred to E-DAS[25]. Helena was contacted by Cardiff Women's Aid and South Wales Fire and Rescue Service. Helena declined support. The condition of his bail was for him to live and sleep at a named address in the Wrexham area, not to contact Helena by any means and was not to enter street where Helena lived in Cardiff. There is no evidence that Tim breached his bail conditions.

13.6.4 On 21 March the police decided to take no further action in relation to the assault on 7 March. Helena was informed of the decision. Helena stated that her and Tim's financial situation was 'on track' and they were both receiving counselling. The decision took account of all available information and included consideration of whether a prosecution would be possible without the support of the victim.

[24]South Wales Police 'Police Watch' provides a visible police presence to both victim and the perpetrator and involves police patrols within the vicinity of the victim's home or the location of the incident. The patrols are carried out on a regular basis, initially for a period of six weeks immediately following reported incidents. Where a domestic abuse incident is reported to the police and the incident involves a HIGH RISK victim, upon receipt of the PPN the Risk Assessor / Domestic abuse officer will send a task to the relevant Sector Inspector requesting police watch.

[25] https://cavuhb.nhs.wales/our-services/e-das/

EDAS (or Entry to Drug and Alcohol Services) is a single point of entry for anyone who feels that they have an issue with any substance in both Cardiff and the Vale of Glamorgan. EDAS provide simple and effective access to the full range of substance misuse services in Cardiff and the Vale of Glamorgan.

13.6.5 On 12 April a multi-agency meeting was held within the MASH[26]. It was noted that Helena did not support a prosecution and that both Helena and Tim were vulnerable and receiving support from their respective Universities. Helena was reported to be staying with friends and that the relationship had ended, but that this may not be a permanent decision. The meeting agreed for the incident to be progressed to MARAC on 3 May.

13.6.6 The MARAC meeting was held on 3 May. The following actions were agreed –

1. For South Wales Police to speak to BCU[27] student liaison officer about the case to be completed ASAP.
2. For South Wales Police BCU student liaison officer to explore Helena's plan for the summer to be completed ASAP.
3. For C&V UHB Mental Health Services to review if Tim had accessed support in Wrexham to be completed by 10/05/2018.

The actions were endorsed;
1. Completed.
2. Completed. Together residing in Cardiff. No support at this time.
3. Completed. Tim is not known to any mental health services in Wrexham, he may well just be managed by his GP.

13.6.7 The following day Helena had a telephone consultation with a GP. Helena discussed her mental health issues and requested another fit note. Helena agreed to be referred to the Community Mental Health Team. Helena received a letter from the Community Mental Health Team and telephoned them to arrange an appointment with a psychiatrist. An appointment date was sent for 7 June. Helena did not attend the appointment and was referred back to her GP.

13.6.8 Between May and October Helena was supported by Inspire To Work Project (I2W) to secure a place on the Pathways to a Degree course at University 1. Helena was assisted to apply for financial support and to attend meetings with University Tutors. Helena was supported to apply for Personal Independence

[26] Cardiff Multi Agency Safeguarding Hub - The integrated service became operational in September 2016 and has been modelled on the already successful pilots from across the UK. Forty five members of staff made up of police officers, social workers, education welfare officers, nurses, and probation officers, from organisations such as South Wales Police, City of Cardiff Council, Cardiff and the Vale University Health Board, National Probation Service and Wales Community Rehabilitation Company.
[27] BCU – Base Command Unit.

Payment (PIP)[28] and help with council tax arrears. Tim attended all appointments alongside Helena.

13.6.9 In November a meeting was held with Helena due to her non-attendance at classes. Tim also attended this meeting. Adjustments were made to Helena's course which allowed her to continue to study. During this meeting Tim stated that Helena had self-harmed.

13.7 2019

13.7.1 Helena continued with her studies, and attended all classes, except for one. Tim attended with Helena. Helena completed the coursework and passed the course.

13.7.2 In the spring of 2019 Helena was found deceased in the flat she shared with Tim.

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Term 1

Were there any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects or given rise to other concerns or instigated other interventions?

14.1.1 In 2014 and 2015 Helena was the victim of a crime, that had been perpetrated by a previous partner. These matters were reported to the police. In both incidents Helena did not support a prosecution and following an investigation, no criminal charges were brought against the offender. In the 2015, Helena stated that she no longer wished to continue with the investigation as it was affecting her college work, and attendance, and she did not want it to be affected anymore.

14.1.2 In 2016 during the completion of a comprehensive Mental Health Assessment Helena disclosed that there had been domestic abuse within her family. The assessment identified that Helena had a history of abusive relationships with men, which Helena had not realised were abusive at the time. The psychiatrist reported that Helena's mood changes and 'dissociative' behaviours could be explained by Helena having - 'complex trauma related to abuse and leading to dissociative episodes.'

14.1.3 In July 2017 Helena was admitted to hospital having taken an overdose of prescribed medication. Helena stated that she had taken the medication following an argument with her boyfriend. This incident occurred shortly after Helena had

[28] https://www.gov.uk/pip

moved to Cardiff. No details were obtained as to who Helena's boyfriend was at that time.

14.1.4 Helena was not assessed by the Mental Health services. In addition, there was no documentation to say that an assessment by Mental Health services had been offered and if so, if it had been refused by Helena. This should have been recorded. There was also no record that Helena had been asked about domestic abuse. The panel were informed that Cardiff and Vale University Health Board now has in place since that time 'Ask & Act'.

14.1.5 "Ask and Act" is a process of targeted enquiry to identify violence against women, domestic abuse, and sexual violence. The term targeted enquiry describes the recognition of indicators of violence against women, domestic abuse, and sexual violence as a prompt for a professional to ask their client whether they have been affected by any of these issues. The aims of "Ask and Act" are:

- To increase identification of those experiencing violence against women, domestic abuse, and sexual violence.
- To offer referrals and interventions for those identified which provide specialist support based on the risk and need of the client.
- To begin to create a culture across the Public Service where addressing violence against women, domestic abuse and sexual violence is understood in the correct context, where disclosure is accepted and facilitated, and support is appropriate and consistent.
- To improve the response to those who experience violence against women, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health; and
- To pro-actively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm.

14.1.6 Whilst 'Ask and Act' was not in place when Helena was admitted to hospital in 2017, had it been available, and, had Helena disclosed domestic abuse, Helena, then, if she consented, would have been referred on to support and an assessment by a Health Independent Domestic Abuse Advocate whose role it is to see victims that disclose domestic abuse whilst in hospital.

14.1.7 The panel were informed that the "Ask and Act" process is in place to support staff identify victims and offer services that will provide the necessary support. There is a "flagging" system in place to ensure that victims who re- attend are targeted with necessary interventions. Welsh Women's Aid have been contracted by the Welsh Government to train the trainers to deliver the Ask and Act programme for Group 2 and 3 of the National Training Framework. The main

vehicle for the delivery of the Violence Against Women, Domestic Abuse & Sexual Violence (Wales) 2015 Act is the Violence Against Women, Domestic Abuse & Sexual Violence National Training Framework (NTF). The NTF is applicable to all organisations identified within the region as 'relevant authorities'. In Cardiff & the Vale of Glamorgan these organisations include:

Cardiff Council, Vale of Glamorgan Council, Cardiff & Vale University Health Board, Velindre NHS Trust, Welsh Blood Service and South Wales Fire & Rescue Service (SWFRS rolled out separately).

The roll out dates were at the discretion of Welsh Government. Groups 4 – 6 are Wales wide.

Group 1 - All staff regardless of role, to complete the e-learning/interactive briefing to raise awareness of VAWDASV Rolled out 2018 (40minutes-1hour).

Group 2 - Professionals that come into contact with the public and have the opportunity to Ask & Act Rolled out November 2020 (2.5hour session).

Group 3 - Individuals in "champion" roles within an organisation, supporting colleagues and family members of those affected. Roles requiring more than "Ask & Act". Planned roll out July 2020 (1 full day).

Group 4 - Professionals whose client group is specifically those affected by Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV). (This is specialist IDVA training funded by Welsh Government).

Group 5 - Service Managers working in 'VAWDASV' Sector. (Specialist training organised by Welsh Government).

Group 6 - Strategic leaders with responsibility of fostering a culture and infrastructure of acknowledging issues affecting a workforce, client group, friends and family. (A series of short video clips produced by Welsh Government that covers a variety of VAWDASV issues – available on YouTube).

14.1.8 Whilst the panel agreed that there had been a missed opportunity in 2017, they acknowledged the work and implementation of the process and have therefore not made a recommendation for this point of learning.

14.1.9 Helena disclosed during contact with the Department of Sexual Health in 2018 that she had been a victim of abuse from a previous partner and that she felt safe with her current partner, (Tim). Helena also described two previous relationships where she had been a victim of domestic and sexual violence.

14.1.10 In March 2018 Helena was the victim of domestic abuse. Tim was the perpetrator. This was the only incident reported to South Wales Police prior to Helena's murder. The incident was risk assessed as high, Tim was arrested, and released on

conditional bail, whilst an investigation was undertaken. As Tim was released on bail a Domestic Violence Protection Notice (DVPN) could not be applied for. No criminal charges were progressed for this incident. This is analysed under Term 2 and 3.

14.2 Term 2

What indicators of domestic abuse did your agency have that could have identified Helena as a victim of domestic abuse and what was the response?

14.2.1 Cardiff and Vale University Health Board held information that identified Helena as a victim of domestic abuse which included information contained within a mental health assessment completed in 2016. Although, the latter information was not available until Helena registered with a GP in August 2017. This information was shared by Helena's GP with mental health services at the point of referral in October 2017. The information was not shared during the MARAC held in May 2019. The panel were informed that in preparation for MARAC cases a brief review of medical notes takes place, looking at recent presentations to inform the MARAC. As the information was in paper format it was not readily accessible when the health notes were reviewed for the MARAC.

14.2.2 In July 2017, Helena informed health professionals that she had taken an overdose following an argument with her boyfriend. This was not progressed further, and Helena was not referred into services. See Term 1.

14.2.3 Whilst living in England, Helena had disclosed to health professionals that she had been a victim of domestic and sexual violence in previous relationships. Helena also described evidence of coercive and controlling behaviour in that relationship. This information was not shared at MARAC in May 2018. The panel were informed that Safeguarding Nurse Advisors do not have access to GP notes even though they come under the umbrella of 'Health' they are part of Digital Health Care Wales. The panel identified this as an area of learning and have made a relevant recommendation. [Recommendation 1]

14.2.4 On 7 March 2018 Helena reported that she had been assaulted by Tim. Helena described how Tim had grabbed her by the throat, pushed her into the bedroom and asked her – 'Do you want to die?'. The investigation identified that Helena and Tim had financial difficulties. Tim was using cannabis daily, spending his money on drugs, which meant they were unable to pay the rent. Tim stated to the police that Helena and himself had agreed to a 'suicide pact' in which he would set fire to the flat as a means of avoiding paying for the rent. Tim admitted that they had argued and that he had 'snapped' when he discovered damage to his laptop, and he had tried to strangle Helena.

14.2.5 The police had considered utilising powers under Section 136 Mental Health Act[29] but as there was evidence of criminal offences, Tim was arrested. A Public Protection Notice (PPN) was submitted to the Domestic Abuse Unit. The incident was risk assessed as high and referred into agencies. Due to the risk around the fire a referral was made to the Arson Referral Team of South Wales Fire and Rescue who contacted Helena to progress target hardening. The PPN was also shared with South Wales Police Mental Health Officer (MHLO).

14.2.6 The panel were informed that the MHLO initially came under the remit of each BCU, in 2020 they were centrally supervised. The role has a range of duties, including - reviewing incidents where there has been a mental health matter, attendance at daily meetings, including suicide prevention meetings, addressing, escalating non-compliance and breaches of procedures, sharing best practice and working with partner agencies to reduce the number of repeat callers/frequency service users. The PPN was shared with the MHLO after Tim had been assessed in custody, who had determined that there was no evidence of severe or enduring mental illness. There were no further calls to police after this incident. Had Tim been a frequent caller where concerns were raised each time around his Mental health then the MHLO would have been expected to have called a professionals meeting to discuss the demand.

14.2.7 Helena did not provide a statement of complaint against Tim. Helena informed the police it was her intention to remain in a relationship. Helena disclosed that she had been formally diagnosed with 'disassociated disorder'. Helena was asked about the 'suicide pact' and explained that she had 'sort of' entered into the pact as she loved Tim and did not want to be without him if he did kill himself. Helena stated that she did not really want to die, but when in that environment in the flat with Tim, she did feel that way. Helena further stated that they had discussed Tim potentially, 'choking her' before killing himself, but nothing had been decided and Helena thought this might be romantic.

14.2.8 The police completed several enquiries whilst the investigation was being progressed, which included the instigation of a 'Police Watch' and enquiries with the Student Liaison Officer to ascertain what services they had in place, which

[29] https://www.mind.org.uk/information-support/legal-rights/police-and-mental-health/sections-135-136/
Section 136 allows the police to take you to (or keep you at) a place of safety. They can do this without a warrant if:
you appear to have a mental disorder, AND
you are in any place other than a house, flat or room where a person is living, or garden or garage that only one household has access to, AND
you are "in need of immediate care or control" (meaning the police think it is necessary to keep you or others safe).

may be of assistance to Helena and Tim. The contact with the University was good practice and the panel were informed that this had been identified as an area of learning within a previous DHR and that work had been undertaken since this time to create working relationships and information sharing processes.

14.2.9 In terms of the 'Police Watch' a task was created for Helena to be seen and provided with an introductory letter detailing the scheme. There was no record that Helena was seen and made aware of the service and the relevant task was kept 'live' for 15 weeks before being closed on 1 July 2018. The officers involved in the 'Police Watch' have left the organisation. The panel were informed that when victims are seen there is a requirement for a form to be completed which would indicate the victim's awareness of the scheme; and have provided contact details for a Domestic Abuse Officer; Cardiff Women's Centre; housing/financial/legal/ advice and a record of a Patrol Strategy going forward. The panel have seen no evidence that Helena was seen as part of the 'Police Watch'; however, there is a record of the police contact with Helena and how and when she was provided with updates on the case and liaison with other agencies. South Wales Police have identified this as an area of learning and made a single agency recommendation.

14.2.10 The criminal case was initially reviewed by the police who concluded that there had been no intention by Tim to kill Helena and that an offence of Common Assault (Section 39 Criminal Justice Act 1988) should be considered. Lines of enquiry and actions were identified, however on 21 March 2018 after a police review, a decision was made for no further action to be taken. Helena was updated.

14.2.11 The panel were informed that since this case, South Wales Police have commissioned training in relation to domestic abuse, and in particular coercion and control. The training will be delivered by Safelives as part of a national programme entitled 'DA Matters', and will be delivered in conjunction with Learning Development Services in spring 2022[30]. The programme has been designed with the agreement of the College of Policing. It is recognised that this is a significant training program, which will add considerable value to organisational understanding of the subject matter and improve victim interaction and engagement as a result. In addition, to the planned training, South Wales Police actively review and progress those cases of domestic abuse, where a victim has not provided their support, and seek to gain an evidence-led prosecution, utilising all investigative opportunities.

[30] This is the earliest available opportunity due to various other training commitments for LDS and the inevitable backlog due to Covid-19. 'DA Matters' training will train about 800 officers/staff, with a 'train the trainer' provision, providing further internal training thereafter.

14.2.12 Helena was seen on several occasions by health professionals, prior to the incident in March 2018. It is unclear from the notes that the GP was aware of the PPN following the assault in March 2018; however, the panel were informed that GP's do receive PPN's from the police. The review acknowledged the importance that this information is shared with GPs who may be the only contact with a victim, and it is important that they have a way to identify victims of domestic abuse so that there is an opportunity to support them.

14.2.13 An initiative in line with the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 is the IRIS project[31] which targets GP practices to provide support and advice. At the time of this case Helena's GP were not part of the IRIS project but the panel were informed the GP practice are currently completing their training. The review acknowledged that Helena had more contact with her GP than any other health professional and they were best placed to assess her vulnerabilities.

14.2.14 In May 2019 University of Bristol published a blog – 'What Is To Be Done About Sexual and Domestic Abuse at UK Universities?'[32] It acknowledged that no study had investigated domestic abuse specifically at UK universities, but there were indicators that it occurred amongst students and staff and cited the Office of National Statistics[33] which indicate that young adults aged 18 to 24 tend to be at higher risk of domestic abuse, including the wider studies (e.g. Hester et al., 2017; Walby and Allen, 2004), showing that approximately 20% of women and 4% of men experience domestic abuse. The panel agreed that as well as learning for the wider community, they determined that targeted awareness raising, on victims and perpetrators, needed to be undertaken with Higher and Further Education sector for students and staff. [Recommendation 4]

14.3 Term 3

What knowledge did your agency have that indicated Tim might be a perpetrator of domestic abuse against Helena and what was the response? Did that knowledge identify any controlling or coercive behaviour by Tim?

[31] https://irisi.org/

[32] https://policystudies.blogs.bristol.ac.uk/2019/05/03/what-is-to-be-done-about-sexual-and-domestic-abuse-at-uk-universities/

[33] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2017

14.3.1 The first recorded incident of domestic abuse which identified Tim as a perpetrator of domestic abuse was following his arrest for assaulting Helena in March 2018.

14.3.2 The panel heard how Tim accompanied Helena to all appointments with her Youth Employment Mentor and during her course lectures and associated meetings. Tim's role was described as that of Helena's 'carer' and that she needed him present for support in terms of her mental health and anxiety. This arrangement was accepted by professionals without question and arrangements were made to facilitate his attendance.

14.3.3 The panel considered Tim's role and if this could have been an indication of coercive control. Tim's role as Helena's 'carer' was informal. Helena had applied for Personal Independence Payment (PIP) which allows an application by a third party for carers allowance. The panel saw no reference to this application being considered in accordance with the Social Service and Well Being Act (Wales) 2014. In addition, there was no evidence of involvement or contact with Adult Social Care or that Helena had been identified as someone who was in need of care and support.

14.3.4 Tim told the Chair that Helena wanted to be with him 24/7, and that whilst he did a lot of things around the flat as well as support her emotionally, Helena would not leave the house without him. Tim described this occurring as soon as they had moved to Cardiff. Tim accepted that this was different behaviour to when Helena was living with her family. Tim's explanation for this change in behaviour was that Helena had moved away from living with a big supportive family and was not used to being alone. Tim stated that Helena constantly reminded him that it was his role to care for her. Tim stated that on the one occasion where he tried to leave the relationship, that Helena took an overdose (July 2017). Tim accepted that people may see his behaviour as controlling, but he denied this and stated that Helena wanted to be with him all the time. The panel acknowledged that the view of Tim identified him as a perpetrator of domestic abuse, and that his comments were 'victim blaming'.

14.3.5 Helena's family strongly denied that she was in need of 'care'. They were shocked to find out that professionals had accepted that Helena needed the support of Tim during her studies at University and that he had adopted this role of 'carer'. Helena's family re-iterated to the Chair how Helena was strong willed, independent, and brave.

14.3.6 The panel acknowledged that women who are disabled are more at risk of abuse and given her ongoing mental health difficulties it is highly likely that she would have been considered disabled using the Disability Discrimination Act definition. The panel agreed that professionals should have undertaken further enquiries

with Helena to fully understand the dynamics of their relationship. The panel determined that Tim's behaviour was coercive and controlling. The panel have identified this as an area of learning and made a relevant recommendation in terms of coercion and control and recognition of disability. [Recommendation 2]

14.3.7 Helena's family told the Chair that on reflection since Helena's murder they now saw Tim's behaviour as an 'element of control'. Helena's father described that if ever he gave money to Helena, Tim would take it straight off her and that the same would happen if other people gave her money also. He recalled Helena's grandmother giving her £20 for a takeaway meal and Tim taking it straight off Helena and putting it in his pocket. At the time, he stated he assumed this was just because Helena could be clumsy and forgetful but now in hindsight, he believes this to be control. The family informed the Chair that they were not aware that these acts by Tim were a form of domestic abuse.

14.3.8 Helena's sister informed the Chair that after Helena moved to Cardiff with Tim their contact dwindled, whereas they had been very close before the move. Helena described an incident when Helena and Tim came to visit, and that she was surprised at the change in Helena, who was dependent on Tim, which she stated was not in a good way and that Helena had to be with Tim and could not be alone with her sister.

14.3.9 It was known that Helena and Tim had some financial difficulties for which they received support via their Universities. Helena's family were not aware of the financial difficulties. They family expressed their surprise to the Chair as they always thought this would have been something Helena would have come and discussed with them.

14.3.10 The panel had access to evidence provided by Helena and Tim's friends, in which they describe their relationship. This evidence includes further examples of coercive and controlling behaviour. Below are some of the relevant extracts of that information –

14.3.11 A Tutor of Helena's stated – 'When Helena first came to college she was quite ordinarily dressed. She had nice red hair. When she got together with Tim she started to dress differently. She also cut her hair very short. I don't know whether this was influenced by Tim or whether it was Helena establishing her own identity - as most students do when they are growing up. I had concerns for her relationship with Tim quite early on. I felt he was quite instrumental in Helena dropping out of college. She seemed to pull away from her friends and stop attending classes when she got together with him however, she continued to attend the college building as he was always there. She seemed to change as a person overnight from this happy, sociable girl to a sad and quiet girl'.

14.3.12 A friend stated – ‘Helena was a lovely person and couldn't do enough for us, that's how we ended up moving in with her. Helena was a bubbly person, but it was clear her life revolved around Tim. It was always 'his way' even when they were using her money. An example of this was when we all went to Bristol to see a band. Helena paid for both his train and gig ticket, but after queuing for 45 mins, Tim said he wanted to go for a cigarette. They never came back and when I spoke to Helena afterwards she said that Tim decided he wanted to leave so they came home without us. Tim always got his own way. I would describe Tim as 'odd' and very 'passive aggressive'. He would be fine with things on the surface but would be funny about Helena doing things without him. Helena said that Tim was always 'under' with his rent which forced her to make it up. Tim and Helena were always together, and you couldn't talk to Helena without him being there. I still can't fully describe what Tim like, other than to say he was always 'watching' and was wearing a public 'mask'. Helena once told me that she'd had some problems with him, she didn't say what other than to say Tim always had to have his way’.

14.3.13 A previous work colleague stated – ‘Helena was a lovely girl. She was always happy and friendly and didn’t have a bad bone in her body. Tim would meet Helena after work and would kick off if Helena was with anyone else (girl or boy). Helena came into work a few times and said that she and Tim had had an argument. She would usually say that it was because Tim got moody if Helena wasn't paying all of her attention to him. One day after work, Helena did not know that Tim was coming to meet her so we finished work and walked out together. Tim walked around the corner as we were walking down the street. Tim wasn't happy with Helena - he was giving her stinking looks and looked very angry. Tim didn’t say anything to me. Helena didn't say anything to me either, she just instantly stopped her laughing and joking and they walked off together’.

14.3.14 The panel reflected on the information that was known to family and friends that had been gathered as part of the homicide investigation. The panel considered the information in terms of the definition of coercive and controlling behaviour as defined by Section 76 Serious Crime Act 2015. The panel agreed that Tim’s behaviour, along with the other elements of the case, now known, clearly identified coercion and control. This included evidence of –

- Isolation
- Taking control of aspects of Helena’s life
- Attendance at appointments and studies
- Financial abuse
- Undertaking a ‘carer’ role and describing Helena as being dependant on him

14.3.15 The panel discussed that these 'traits' were known to Helena's family, friends and community but that they had not been reported to professionals as they were not recognised as being domestic abuse. Often Tim was referred to in the context of 'being weird'. The panel have identified the understanding of domestic abuse and coercion and control as an area of learning and made a relevant recommendation for the Community Safety Partnership. [Recommendation 3]

14.3.16 The panel discussed what options were available for Tim to address his offending behaviour, given that he had not been convicted for any offences of domestic abuse. The panel were informed that within Cardiff there is the Drive project[34]. The project has strict criteria, which work with high-risk perpetrators of domestic abuse.

14.3.17 The panel were informed about CLEAR[35], which is a commissioned intervention. CLEAR was developed by Respect[3637] in partnership with Welsh Women's Aid as an integral part of Change That Lasts. It is aimed at working with men who are using abusive behaviours in their relationships but have not yet received services and may not be ready to disclose. In this sense it is pre-contemplative and provides a space for them to develop a narrative and language for their abusive behaviours and so begin to take responsibility for them. Key to this is that CLEAR does not require disclosure prior to involvement, meaning this is a goal of the intervention rather than a pre-requisite to accessing the service. Another aspect of the intervention is that it is prior to becoming 'entrenched' in services and so reaches out for men to self-refer. It is not a behaviour change intervention but more a motivational project that tries to identify patterns and address issues that may be impacting on men's use of violence, as well as linking them into other services. Each referral to CLEAR is assessed for capacity to engage, motivation and also the level of harm. This represents a move away from measuring risk based on incidents and looks instead at where those using abuse are with taking responsibility and their process of change. When there is a very 'high-harm' individual, CLEAR would also refer to other processes such as MARAC and possibly, based on their needs, DRIVE. In all cases there is an assessment that includes multi-agency information that means someone is either worked with by CLEAR or signposted to another intervention or process. This strand is an

[34] http://driveproject.org.uk/

[35] Change that Lasts Early Awareness Raising.
[36] https://www.respect.uk.net/

[37] https://www.respect.uk.net/pages/59-change-that-lasts

innovation within Change That Lasts in Wales and reflects the commitment to integrating perpetrators and work with them into the model.

14.3.18 The panel identified learning in relation to information being available for professionals and the community as to how perpetrators can access programmes and information on how they can seek help, particularly when they have not been convicted of a criminal offence. In addition, the panel deemed that the learning from the review should be shared with Welsh Government to support further enhancement of work within this area. The panel have made relevant recommendations. [Recommendation 5 & 6]

14.4 Term 4

When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about Helena and Tim? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

14.4.1 South Wales Police acted appropriately and in line with policy and procedure. The risk grading was appropriate given the information available. Concerns in relation to both Helena and Tim's mental health were acted on and contact was made with South Wales Mental Health Officer, who made further contact with the University to provide additional support. Referrals were made to other agencies and the PPN was discussed at MASH and MARAC.

14.4.2 The incident in July 2017 identified domestic abuse and provided an opportunity to engage with Helena and establish further information in relation to her relationship and associated risks. [See Term 1].

14.4.3 The review identified that practitioners readily accepted Tim's role as Helena's 'carer' without challenge or professional curiosity. This has been identified as learning and analysed under Term 2.

14.4.3 Cardiff Women's Aid and Into Work Advice Service have identified a requirement to take account of the learning from this case. [See Term 12].

14.5 Term 5

When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

14.5.1 Helena was updated throughout the criminal investigation. Referrals were made and Helena was provided with information for agencies who could provide her

with support. This included support around the domestic abuse, finances, mental health and support with her studies. The consideration of counselling and support services via the university was sensible and in terms of accessibility, support through this avenue may be more appealing to students. South Wales Police liaised with the Community Mental Health Team but as Helena was not engaged with the service at that time the Police were advised that a referral was required from Helena's GP.

14.5.2 Helena was referred to Cardiff Women's Aid IDVA service who contacted her to offer support and provided her with information in relation to the available options. Helena declined to engage with the service.

14.5.3 Helena was supported by a Youth Employment Mentor who helped Helena access financial information, further education, and provided support to attend meetings. The panel were informed that engagement with the Into Work Advice Service is voluntary and meetings with participants are undertaken in locations/settings etc that suit the needs of the participant; including having a partner, carer, parent present if requested directly by the participant.

14.5.4 Helena was provided with advice and guidance by the Student Support, and Finance and Money teams. Within the academic team, the focus was on signposting to and providing academic support available within Continuing and Professional Education. Adaptations were made to help Helena continue with her education which included –

- allowing Helena to study 3 courses rather than 6 in the 2018-19 academic session.
- Access to a quiet room where Helena could go if she found any topics/discussions upsetting in class (this was never used).
- Extensions to deadlines. Helena went on to complete the course remotely (via recorded lectures and independent reading, enabling her to complete the required coursework and pass the course).

14.5.5 Welsh Women's Aid have created a free seven-week course for anyone in Cardiff who wants to learn how to help protect women in their community against violence. The Ask Me project[38] is available to anyone over 18 years old and aims to teach communities how to be more helpful towards survivors as well as finding ways to challenge unhelpful myths, attitudes, and stigmas surrounding abuse, including financial abuse.

[38] https://www.walesonline.co.uk/news/local-news/free-course-cardiff-helps-tackle-23052933

14.5.6 Domestic Abuse Services within Cardiff Council provide training in accordance with the National Training Framework and financial abuse is covered within that training and as part of the wider VAWDASV agenda.

14.6 Term 6

What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

14.6.1 Helena's admission to hospital in July 2017, did not result in a mental health assessment. [See Term 1]. As Helena was not registered with a GP in Cardiff, a discharge letter was sent to her GP in England. Helena registered with a GP in Cardiff in August 2017.

14.6.2 Health held information from Helena's previous notes that identified her as vulnerable. This was contained within the Mental Health assessment from 2016. In October 2017 Helena was referred by a GP to the Community Mental Health team. The GP had access to the Mental Health assessment from 2016 and made a referral for a specialist assessment to be undertaken. A second referral was made in May 2018. Helena did not attend any appointments with the Community Mental Health Team.

14.6.3 Helena's GP was the only professional who held the information from the Mental Health assessment in 2016. Apart from her GP, Helena had very little contact with any other health professionals. During contact with her GP Helena did discuss her mental issues and appropriate referrals were made. Helena's history of domestic abuse was not discussed by her GP. Helena's contact with the GP on 4 May 2018, when a second referral was made to the Community Mental Health team was the day after the MARAC.

14.6.4 Had Helena attended either of the appointments with the Community Mental Health team it would have provided an opportunity to explore her vulnerabilities further and offer support. Helena's non-attendance was not discussed by her GP. Had the GP known of the domestic abuse and the MARAC it would have been an opportunity to review why she had not engaged with previous assessments offered by the GP. The panel have seen evidence that the closure of the cases by CMHT were in accordance with policy and on each occasion, Helena was referred back to her GP when she did not attend. The panel have been informed that since this time a telephone triage system has been implemented.

14.6.5 The information held by GP was not shared at MARAC as the Safeguarding Nurse Advisors on MASH preparing the reports for daily discussions and MARAC did not have access to GP records. This has been addressed in recommendation 1.

14.6.6 The DASH identified that Helena was at high risk of domestic abuse. This then triggered referrals and information sharing with agencies. Initial contact was made by the PPN Coordinator who is trained to respond to victims in a sensitive manner and identify potential indicators of domestic abuse, including potential minimisation of the incident. Given their knowledge and experience, it is reasonable to expect them to fulfil these expectations. Helena was referred to Cardiff Women's Aid IDVA service, however, Helena did not want to engage with any further assessments or support with the agency. The panel reflected on Helena's choice not to engage with services and acknowledged that she had capacity to make her own decision regarding engagement. The panel considered if Helena's decision may have been as a result of coercive control from Tim; however, the panel saw no evidence to confirm that Helena's decision was due to coercion and control perpetrated by Tim.

14.6.7 The PPN was sent to the MASH, but there was a delay in the PPN, and case details being discussed. [See Term 10].

14.6.8 On 3 May a MARAC was held. This was nearly two months after the incident. The IDVA had attempted to contact Helena the day before the meeting, but this had been unsuccessful. The actions from the MARAC were completed in a timely manner. Three weeks later the police contacted Helena. Helena stated – 'all was well at present, and she was still in a relationship with Tim, and they would be remaining at their present address for the foreseeable future and were receiving help regarding their Mental Health issues'. The Officer provided Helena with their contact details for future reference. It was recorded that no other support or advice was required at this time.

14.6.9 The review panel have been informed that MARACs are now held every two weeks. There has been a cultural change in relation to MARACs with agencies working towards an evidenced based approach, taken account of Human Rights legislation in relation to 'Right to Life' for the victim. In addition, high risk domestic abuse cases are discussed in a daily meeting within the MASH. [See Term 10].

14.6.10 A Mental Health Assessment was conducted with Tim whilst he was in custody. This was undertaken by a Consultant Psychiatrist, and two Doctors[39], Approved Mental Health Practitioner and Approved Social Worker from the Crisis Team. The outcome of the assessment concluded there was no evidence of any severe or enduring mental illness found. Tim was advised to attend his GP.

14.7 Term 7

[39] For the requirements of Section 12 Mental Health Act 1983.

Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective needs and risks identified at the time and continually monitored and reviewed?

14.7.1 This has been addressed within Term 5, 6 and 9.

14.8 Term 8

Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective?

14.8.1 The review has seen evidence from all agencies involved in the review that policies and procedures for domestic abuse and safeguarding were in place. With the exception of the incident in July 2017 these policies and procedures were utilised.

14.8.2 During contact with the Department of Sexual Health a basic domestic abuse screening was undertaken, which asks four questions to provide opportunities individuals to identify themselves of domestic abuse and be provided information on available support.

14.8.3 University 1 has promoted awareness for students affected by violence and abuse through 'It's not on'. The information pages on student Health and Wellbeing internal intranet site state:

'If you are aware that a student is being or has been affected by violence and abuse, please make them aware of the specialist support available to them and recommend that they contact the Disclosure Response Team. We support students affected by all types of violence and abuse.'
https://intranet.cardiff.ac.uk/staff/supporting-your-work/teach-and-support-students/support-students/students-health-and-wellbeing/students-affected-by-violence-and-abuse

In addition, the panel were made aware of a previous campaign that had taken place with the launch of TALK[40], a University partnership with local domestic abuse charity, Atal y Fro, and the Police and Crime Commissioner to identify and support students who are experiencing, or have been a victim of, domestic abuse and sexual violence. TALK stands for Tell, Advise, Listen and Keep Safe, and aims to tackle domestic abuse and sexual violence by improving early identification and

[40] https://www.cardiff.ac.uk/news/view/473805-supporting-student-victims-of-domestic-abuse-and-sexual-violence

intervention; increasing reporting by increasing victim confidence and encouraging prevention.

14.8.4 The panel were unable to receive information from University 2 without the consent of Tim as there was no information sharing agreement in place between the University and the Community Safety Partnership. The panel have identified this as an area of learning for the Community Safety Partnership to work with the University to agree information sharing pathways and made a relevant recommendation. [Recommendation 7]

14.9 Term 9

Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

14.9.1 Actions and safeguarding measures were taken in accordance with the risk identified in March 2018. Target hardening and arson reduction referrals were made following the disclosure that Tim had suggested he would 'blow up the place'. The university were contacted, and it was requested that they contact Helena to consider what support could be provided, including financial support and housing. Enquiries were made and information was shared by South Wales Police Mental Health Liaison Officer with the CMHTs due to the concerns regarding both Helena and Tim's mental health. Helena was referred to Cardiff Women's Aid IDVA service for support.

14.9.2 The review considered all the actions and enquiries undertaken in March 2018 and agreed that the support and appropriate services were offered and provided at that time.

14.10 Term 10

Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Helena and/or Tim, or on your agency's ability to work effectively with other agencies?

14.10.1 In March 2018, there was a delay in Helena's case being raised at the daily discussion within MASH. The case was not discussed until 12 April 2018. The panel were informed that the delay was due to an inefficient process being in place to manage a high volume of cases at that time. Despite the delay in Helena's case there was no delay to information sharing and implementation of safeguarding measures.

14.10.2 Since this time, a new process has been introduced whereby high risk PPNs are processed before 10.00hrs each day and discussed within the MASH the same

afternoon. The MASH operates Monday to Friday, (partners only service MASH from Mon-Fri), there are currently around 170 High Risk domestic abuse cases per month, currently around 125 of those are put through to the Daily Mash discussion (it was around 85 cases per month pre-Covid- 19 pandemic). South Wales Police have identified learning in relation to the MASH and have made a single agency recommendation, which includes an agreement to undertake audits of the high risk domestic abuse cases discussed at MASH, including compliance to timeframes.

14.11 Term 11

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Helena and/or Tim?

14.11.1 Diversity is addressed under Section 11 and therefore will not be repeated here.

14.11.2 Helena's family informed the Chair that Helena had been a Christian prior to meeting Tim. Tim stated that he had been brought up in Pagan faith and that Helena became interested in paganism, after their relationship commenced. Helena undertook some research online and decided to be Wiccan. Tim stated that Helena was into magic and spells, and that they had met one other person in Cardiff who was Wiccan and shared belief in magic and spells, which Tim did not believe in. Tim stated that their beliefs did not have any impact on their relationship.

14.11.3 The panel were supported in the review by an expert panel member in the field of paganism who provided information and guidance to the panel. The expert advised the panel that Paganism can be a very isolated path and can potentially place the seeker in a vulnerable position without the right support network. Paganism, in general, embraces the idea of a universal energy, which can be tapped in to by the practitioner/follower. The idea of magic or spell work is generally accepted across pagan traditions, so it would be unusual for someone to identify as a Pagan, but to "not believe" in those elements.

14.11.4 For one who follows a mainstream religion, such as a branch of Christianity, Judaism, or Islam, it is a simple thing to visit a place of worship and find a member of the Clergy/priesthood/spiritual leader with whom to discuss ideas, and a congregation of like-minded people to worship with. For somebody who has recently discovered the world of paganism, it can feel rather lonely. When that person finds someone who follows the same/or similar path, it can spark an instant feeling of connection. Should someone new to paganism find someone who has been on the path for longer, they may well hold them in high esteem and

look to them to help guide/advise them - this CAN be dangerous should that power/status be abused.

14.11.5 The panel were provided with information gathered during the police investigation that Helena had met another contact who was following the same path that she had chosen for herself, and that Tim was quick to discount what the other person believed in, potentially sabotaging the forming of a bond of friendship/pagan connection which would have made her feel less isolated, and, in fact, potentially help her to feel empowered. The panel recognised this as coercive behaviour perpetrated by Tim.

14.11.6 The panel considered if Helena and Tim's belief in Paganism had any impact on this case. The review found no evidence that Helena and Tim's belief impacted on services or engagement with professionals.

14.12 Term 12

What learning has emerged for your agency?

Cardiff and Vale University Health Board

14.12.1 There was no follow up discussion following Helena's disclosure of domestic abuse in 2017. The "Ask and Act" process is now in place to support staff identify victims and offer services that will provide the necessary support. There is also a "flagging" system in place to ensure that victims who re- attend are targeted with necessary interventions.

14.12.2 Awareness of victims of domestic abuse through information sharing from agencies, including via a PPN.

Cardiff Women's Aid

14.12.3 Further training and development to efficiently train staff to be confident in identifying indicators of risk and potential incident minimisation concerns. Coercive control is not always fully understood and is a key warning sign for potential escalation of domestic abuse incidents.

14.12.4 Establishing contact with victims at the earliest opportunity is extremely important; this case identified that the PPN Coordinator successfully established contact with Helena at the earliest opportunity which is in line with best practice guidance.

Into Work Advice Service (Inspire to Work Project)

14.12.5 Reviewing training requirement for staff in relation to advanced safeguarding.

South Wales Police

14.12.6 Delay in discussion within the MASH; however, a new process is now in place to manage high risk domestic abuse PPN's.

14.12.7 South Wales Police have a performance framework that scrutinises the Force's response to domestic abuse at all levels of the organisation. This is underpinned and summarised as follows:

1. Domestic Abuse features as a priority area within internal performance processes.

2. Force policy and guidance has been refreshed and publicised internally.

3. Selection and promotion processes include assessing knowledge and understanding of protecting the public and the Police and Crime Commissioner's priorities.

4. Introduction of Victim Satisfaction surveys to inform continued improvements.

14.13 Term 13

Are there any examples of outstanding or innovative practice arising from this case?

14.13.1 The review acknowledged the liaison between agencies, MARAC and University, which had been an area of learning from a previous DHR[41] and evidenced that the learning had been taken forward and put into practice.

14.13.2 The review identified that the use of 'routine enquiry' around domestic abuse was undertaken during contact with the Department of Sexual Health and provided an opportunity for Helena to disclose domestic abuse.

14.14 Term 14

Does the learning in this review appear in other domestic homicide reviews commissioned by Cardiff Community Safety Partnership?

14.14.1 The panel heard that a previous domestic homicide review had identified the need for awareness raising about domestic abuse, in relation to how and to whom to report it as well as the associated services to victims. In addition, learning had been identified in relation to awareness raising of coercive and controlling behaviour, especially amongst young people and their families.

[41] DHR06

14.14.2 The panel have acknowledged this previous learning, but still agreed that the learning and recommendations from this case were relevant for Cardiff Community Safety Partnership.

15. CONCLUSIONS

15.1 Helena was killed by her partner, Tim, during an attack at their home. Tim was found guilty of Helena's murder following a trial at Newport Crown Court in December 2020. In February 2021, Tim was sentenced to life imprisonment, with a requirement to serve a minimum of 18 years.

15.2 As a young couple, Helena and Tim had moved to Cardiff to continue with their education. Helena had struggled with her mental health and the University worked with Helena and a Youth Employment Mentor to ensure that Helena was able to study and complete relevant coursework. Helena successfully completed her studies and passed her course.

15.3 Health professionals were aware that Helena had been a victim of domestic and sexual abuse in previous relationships. This information was not shared with partner agencies. Agencies were only aware of one incident of domestic abuse between Helena and Tim. This incident was high risk.

15.4 Almost one in three women aged 16-59 will experience domestic abuse in their lifetime[42] and two women a week are killed by a current or former partner in England and Wales[43]. In the year ending March 2019, 1.6 million women experienced domestic abuse[44].

15.5 In a spotlight report by Safelives in 2019, 'Safe and Well: Mental Health and Abuse'[45] it stated that 58% of victims with mental health issues were more than

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42 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2019
Office for National Statistics (2019) Domestic abuse in England and Wales overview: November 2019.

43 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2018#how-are-victims-and-suspects-related
Office for National Statistics (2019) Homicide in England and Wales: year ending March 2018 (average taken over 10 years).

44 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019
Office for National Statistics (2019) Domestic abuse victim characteristics, England and Wales: year ending March 2019.

45 https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf

likely to experience physical abuse and 81% of victims with mental health issues were more than likely to experience controlling behaviour.

15.6 The panel considered these statistics and the level of violence that was used in March, which included strangulation and a threat to kill. The panel also reflected on the information that had been gathered in terms of coercion and control within the relationship. The panel determined that when Helena contacted the police in March 2018, it would not have been the first time that there had been domestic abuse in their relationship.

15.7 The review has identified that domestic abuse has many forms, including coercive control and professionals need to be mindful of this within their respective roles and ensure that where necessary challenge and professional curiosity is undertaken.

15.8 The review has identified the need for a wider understanding amongst family, friends and community in relation to domestic abuse, including coercion and control and how concerns can be reported, and information obtained on domestic abuse and available support.

15.9 The learning from the review has been captured into relevant recommendations which will be progressed through Cardiff Community Safety Partnership.

15.10 The review panel were supported by a High Priestess, from Alexandrian Tradition of Witchcraft who provided valuable support and guidance to the panel on Paganism. The DHR panel wish to express their thanks for the support provided.

15.11 Helena's family contributed to the review process throughout and provided valuable and relevant information to assist the DHR panel. The DHR panel are grateful for the family's contribution.

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 Term 12. Each lesson is preceded by a narrative which 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
Information was held within records that was not readily accessible to the review due to access not been available for some health professionals and information sharing agreements not being in place.

Learning
Access to all relevant information is important when reviewing cases, and assessing risk, when responding to incidents of domestic abuse.

Learning 2 [Panel recommendation 2, 3 and 4]
Narrative
The review identified a widespread lack of knowledge and awareness, across professionals and the wider community surrounding the dynamics of domestic abuse, particularly in relation to coercive and controlling behaviour. This was also linked to the evidence that where a victim of domestic abuse has known additional vulnerabilities they are at a higher level of risk of abuse.
Learning
Raising awareness of domestic abuse, particularly the different types of abuse, and how and where incidents can be reported, and advice obtained will provide people with the knowledge to recognised and where relevant respond to any concerns.

Learning 3 [Panel recommendation 5 and 6]
Narrative
Where perpetrators are not convicted of domestic abuse crimes, there needs to be in place the availability of support and the opportunity for them to engage with services to address their offending behaviour, to reduce the risk to victims and prevent incidents of abuse escalating. This includes professionals' knowledge on how to access information and the referral pathways for perpetrators to seek support.
Learning
To ensure that perpetrators of domestic abuse have access to information on the support available to help them to address their offending behaviour.

Learning 4 [Panel recommendation 7]
Narrative
Information from University 2 was not accessible for this review, without the consent of the named subjects, due to no information sharing agreement being in place. The sharing of information for statutory reviews is key to ensure that all information is analysed and taking into consideration.
Learning
To ensure that information sharing pathways are in place for all Higher and Further Education providers to inform safeguarding processes and statutory reviews.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
1	That Cardiff & Vale Regional Safeguarding Board explore with Digital Health Care Wales improving the means by which specific health teams can access GP records.
2	That all agencies contributing to this review provide evidence and assurances to Cardiff Community Safety Partnership that their agency can demonstrate professional's knowledge and understanding in recognising and responding to domestic abuse, in particular cases of coercion and control and known vulnerabilities and disabilities.
3	That Cardiff Community Safety Partnership ensures that information is available to the wider community on the dynamics of domestic abuse, including coercion and control, and how they can report concerns or seek access to support.
4	That Cardiff Community Safety Partnership, in conjunction with all Higher and Further Education providers undertake a targeted communication strategy to highlight the dynamics of domestic abuse, including coercion and control amongst the student population.
5	That the Cardiff Community Safety Partnership ensures the Regional VAWDASV Strategy details what access to support and information, including perpetrator programmes is available in responding to perpetrators of domestic abuse.
6	That the Cardiff Community Safety Partners ensures the learning in relation to public and professionals' confidence to identify and respond to perpetrators, and the need for increased knowledge of referral pathways for services available for perpetrators is shared with the Welsh Government to support further enhancement of the existing National Framework.
7	That the Cardiff Community Safety Partnership ensures that information sharing pathways are embedded within all Higher and Further education establishments and partner agencies involved in this review.

17.2 Single agency recommendations

17.2.1 Single agency recommendation are contained within the action plan.

Appendix A

Definition of Domestic Abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[46]

- 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]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.

[46] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list.

Appendix C

EVENTS TABLE

The following table contains a summary of important events that will help with the context of the domestic homicide review. It is drawn up from material provided by the agencies that contributed to the review.

Events Table	
Date	**Event - Pre terms of reference**
25.06.06	Helena present during domestic abuse incident.
25.03.09	Helena victim of crime. (Incident identified during homicide investigation).
02.09.14	Helena victim of assault by partner.
17.12.15	Helena victim of crime.
2016	Mental health assessment undertaken with Helena.
Date	**Events within terms of reference**
06.05.17	Helena seen by GP.
12.05.17	Helena seen by GP – fit note renewed.
28.07.17	Helena admitted to hospital having taken an overdose of prescribed medication.
29.07.17	Helena discharged from hospital.
23.08.17	Helena registered with GP practice in Cardiff.
5.10.17	Helena seen by GP. Health.
24.10.17	CMHT received referral for Helena.
25.10.17	MDT meeting held and agreed to offer Helena an appointment with a psychiatrist. Letter sent to Helena.
18.12.17	Helena seen by GP.
19.01.18	Helena had telephone consultation with GP.
07.02.18	Helena seen in sexual health clinic. Routine appointment.
7.03.18	Police attended domestic abuse incident between Helena and Tim. Tim was arrested. Several PPN's and referrals were submitted. A 'Police Watch' was set up. Incident risk assessed as high.
08.03.18	Tim was subject of mental health assessment whilst in custody. Tim released on bail with conditions.
08.03.18	Fire and Rescue contacted Helena regarding target hardening. Recorded that Helena declined services as not living at property.
08.03.18	Cardiff Women's Aid contacted Helena.
15.03.18	GP received PPN for incident on 7 March 2018.
19.03.18	Fire and Rescue attempted to telephone Helena. Voicemail left.
21.03.18	Police decision that no further action to be taken regarding incident on 7 March 2018.
12.04.18	Multi-agency meeting held.
21.04.18	DWP received claim for universal credit.
02.05.18	Cardiff Women's Aid IDVA attempted to contact Helena.
03.05.18	MARAC meeting held.
04.05.18	Helena had telephone consultation with GP. Referred to CMHT.

09.05.18	Meeting between Helena, Tim and Youth Employment Mentor.
14.05.18	Meeting between Helena, Tim and Youth Employment Mentor.
16.05.18	CMHT sent letter to Helena.
21.05.18	Helena cancelled meeting with Youth Employment Mentor.
21.05.18	Helena telephoned CMHT to book an appointment.
24.05.18	Helena contacted by police following incident on 7 March 2018.
30.05.18	Youth Employment Mentor met with Helena and Tim.
31.05.18	CMHT sent letter to Helena offering an appointment with a psychiatrist on 7 June 2018.
June 2018	University 1 discussed options to support Helena's study and finances with Youth Employment Mentor.
07.06.18	Helena did not attend her appointment with psychiatrist. Referred back to GP.
14.06.18	Youth Employment Mentor met with Helena and Tim.
01.07.18	Police Watch closed.
10.07.18	Youth Employment Mentor accompanied Helena and Tim into PIP assessment.
17.07.18	Youth Employment Mentor accompanied Helena and Tim to meeting to discuss finances. Contact made with CMHT.
14.08.18	Youth Employment Mentor accompanied Helena and Tim to meeting at University.
28.08.18	Youth Employment Mentor met with Helena and Tim.
31.08.18	Helena had telephone consultation with GP.
Aug – Sept 2018	Helena enrolled on and began studying a Pathway to a Degree programme at University 1.
14.09.18	Youth Employment Mentor met with Helena and Tim.
30.10.18	Youth Employment Mentor met with Helena and Tim.
22.11.18	Meeting held at University 1 regarding course attendance.
4.12.18	Helena seen by a GP.
10.12.18	Helena seen in sexual health clinic. Routine appointment.
Spring term 2019	Helena attended classes at University 1.
April 19	Helena found deceased.