Cardiff Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

'Helena'

Date of murder – Spring 2019

EXECUTIVE SUMMARY

November 2021

Chair – Ged McManus

Author – Carol Ellwood-Clarke

CONTENTS

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Cardiff Community Safety Partnership [the statutory Crime and Disorder Partnership] in reviewing the murder of Helena, a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim and her partner in order to protect their identities.

Name	Relationship	Age	Ethnicity
Helena	Victim	21	White British
Tim	Ex-partner	22	White British

1.3 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.

1.4 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.

1.5 Cardiff Community Safety Partnership held a scoping meeting on 7 October 2019 and determined the murder of Helena met the criteria for a domestic homicide review [DHR]. The Home Office were informed, and an independent domestic homicide review was commissioned. All agencies that potentially had contact with Helena and Tim, were asked to secure their files. The review was not progressed immediately due to the criminal trial, and the introduction of a new procurement process. Delays were then experienced in sourcing and commissioning an independent chair and author.

1.6 The first meeting of the DHR panel was held in July 2020. 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 independent management reviews. The DHR panel met six times.

1.7 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.

2. CONTRIBUTORS TO THE REVIEW

2.1 The table below shows the agencies that contributed to the review and the material they were able to supply.

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 of South Wales			✓
Welsh Ambulance Service NHS Trust	✓	✓	
West Mercia Police			✓

Nil returns were received from –

- University of South Wales (unable to provide without consent)
- National Probation Service
- Cardiff Adult Social Care
- Safer Wales
- Cardiff Alcohol and Drug Team

2.2 Cardiff and Vale University Health board provided information in relation to Helena. The board declined to provide information in relation to Tim without his consent. This is the board's policy following legal advice received. Tim provided consent in April 2021; however, there was a delay in the records being accessed.

3. THE REVIEW PANEL MEMBERS

3.1 The panel members were:

Review Panel Members		
Name	**Job Title**	**Organisation**
Beth Aynsley[1]	Independent Protecting Vulnerable Persons Manager	South Wales Police

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

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[2]	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 Vulnerable Persons Manager	South Wales Police
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	High Priestess	Alexandrian Tradition of Witchcraft
Stuart Wales*	Detective Inspector	South Wales Police
Nicola Winstanley	Business Manager	Cardiff Council

3.2 The Chair of the Cardiff Community Safety Partnership was satisfied that the Panel Chair and author were independent. In turn, the Panel Chair believed there was

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

sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report. Panel members had not previously been involved with the subjects or line management of those who had.

3.3 At its first meeting the panel discussed the need to ensure that expertise and advice was available in relation to Paganism. Jemma 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. The panel were satisfied that Jemma was appropriately qualified and experienced to provide expert advice on Paganism.

3.4 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.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 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.

4.2 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[3].

4.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He has experience as an

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

Independent Chair of a Safeguarding Adult Board (not in Wales). 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.

4.4 Between them they have undertaken over sixty of 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.

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

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 **The purpose of a DHR is to**:[4]

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-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.

5.2 **Timeframe under Review**

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

The DHR covers the period 1 January 2017 to Helena's murder in April 2019.

5.3 **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?

6. SUMMARY CHRONOLOGY

6.1 Helena

6.1.1 Helena was as 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'.

6.1.2 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.

6.2 Tim

6.2.1 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.

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

6.2.3 Tim enrolled at University of South Wales 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[5]. Tim stated he was caring

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

for his girlfriend who had mental health issues. In September 2018 Tim enrolled to repeat some of the year 1 modules.

6.3 Helena and Tim's relationship

6.3.1 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. 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.

6.3.2 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 of South Wales, 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.

6.3.3 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.

6.3.4 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.

6.4 Pre – 2017

6.4.1 In 2014 Helena was the victim of a physical assault by her then 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.

6.4.2 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.

6.5 2017

6.5.1 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[6].

6.5.2 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.

6.5.3 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.

6.5.4 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.

6.6 2018

6.6.1 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

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

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[7], Cardiff, MARAC[8] and the Arson Referral Team of the South Wales Fire & Rescue Service. The Public Protection Notice (PPN)[9] was shared with South Wales Police Mental Health Officer who shared details of the incident to other agencies.

6.6.2 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'[10] 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.

6.6.3 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[11]. Helena was contacted by Cardiff Women's Aid and South Wales Fire and Rescue Service. Helena declined support.

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

[8] Multi Agency Risk Assessment Conference

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

[10] 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.

[11] 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.

6.6.4 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.

6.6.5 On 12 April a multi-agency meeting was held within the MASH[12]. 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. The MARAC was held on 3 May.

6.6.6 On 4 May 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.

6.6.7 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 Payment (PIP)[13] and help with council tax arrears. Tim attended all appointments alongside Helena.

6.6.8 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.

6.7 2019

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

[12] 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.

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

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

7. CONCLUSION

7.1 Helena was killed by her partner, Tim, during an attack at their home. Tim was found guilty of Helena's murder and was sentenced to life imprisonment, with a requirement to serve a minimum of 18 years.

7.2 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.

7.3 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.

7.4 Almost one in three women aged 16-59 will experience domestic abuse in their lifetime[14] and two women a week are killed by a current or former partner in England and Wales[15]. In the year ending March 2019, 1.6 million women experienced domestic abuse[16].

7.5 In a spotlight report by Safelives in 2019, 'Safe and Well: Mental Health and Abuse'[17] it stated that 58% of victims with mental health issues were more than likely to experience physical abuse and 81% of victims with mental health issues were more than likely to experience controlling behaviour.

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

15 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).

16 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.

17 https://safelives.org.uk/sites/default/files/resources/Spotlight 7 - Mental health and domestic abuse.pdf

7.6 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.

7.7 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.

7.8 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.

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

7.10 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.

8. Multi Agency Learning developed by the DHR panel

8.1 **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.

Recommendation 1 applies.

8.2 **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 recognise and where relevant respond to any concerns.

Recommendation 2, 3 and 4 applies.

8.3 **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.

Recommendation 5 and 6 applies.

8.4 **Narrative**

Information from University of South Wales 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 taken 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.

Recommendation 7 applies.

9 Panel Recommendations

9.1 That Cardiff & Vale Regional Safeguarding Board explore with Digital Health Care Wales improving the means by which specific health teams can access GP records.

9.2 That all agencies contributing to this review provide evidence and assurances to Cardiff Community Safety Partnership that their agency can demonstrate professionals' knowledge and understanding in recognising and responding to domestic abuse, in particular cases of coercion and control and known vulnerabilities and disabilities.

9.3 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.

9.4 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.

9.5 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.

9.6 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.

9.7 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.

9.8 All single agency recommendations are shown in the Action Plan.