Domestic Homicide Review of the death of Matthew in September 2022

Overview Report

Author: Chris Hogben

Commissioned by: Carmarthenshire Safer Communities Partnership

Date: July 2024

Contents

A Tribute to Matthew

Although Matthew's family were unable to contribute to this review, the Independent Chair has prepared the following tribute based on information made available to the review, including his university personal statement and referee statement.

Matthew was a young person who was successfully making his way in life despite the challenges that he faced in his childhood years. Those who knew him described him as a mature, enthusiastic young man who was honest, trustworthy and reliable. He worked hard educationally; he had a good attitude to his work and related well to his peers.

Matthew was fascinated by the way that different aircraft work and his dream of a career in aerospace engineering may well have come to pass had his life not been so tragically ended. It was clear that Matthew believed that he could achieve this. His personal statement recorded his love for physics and mathematics, highlighting how he enjoyed solving mathematical problems and studying Newton's laws of motion.

Matthew was also a good communicator who enjoyed spending time with others. His personal statement provided an account of his working in a local primary school for a week, helping pupils with their classwork and supporting the staff. He was keen to develop new skills and as well as working at the school, he attended an army residential course which enabled him to work on his problem solving and communication skills.

Although I never met Matthew during his short life, it is difficult not to be impressed by his clearly positive outlook and his significant achievements despite the disadvantages he faced. Had he been given the opportunity, it seems likely that Matthew would have been able to follow his dreams and make a valuable contribution to the community.

Chris Hogben.
Independent Chair.

1. Introduction

1.1 This domestic homicide review, (DHR), has been commissioned by the Carmarthenshire Safer Communities Partnership, (SCP), following the murder of Matthew in September 2022.

1.12 The circumstances that led to the commissioning of this review are; on a date in early September 2022, police and medical emergency staff were called to an address in Ammanford, Carmarthenshire. The victim, Matthew, was found deceased in the front garden of the premises. Matthew's brother Jacob and his mother were also present. It was determined that Matthew had suffered a number of stab wounds and a knife was recovered at the scene.

1.13 Jacob was arrested and subsequently charged with an offence of murder; he was remanded into custody to await trial.

1.14 Having pleaded guilty to Matthew's murder at an earlier hearing, Jacob appeared at Swansea Crown Court in June 2023 and was sentenced to life imprisonment with a minimum term of 18 years.

1.15 The review panel would like to express its sympathy to Matthew's family and friends for their sad loss.

1.2 Scope

1.21 This DHR examined the contact and involvement that organisations had with Matthew between 1 January 2017 and his death in September 2022.

1.22 In order to meet its purpose, the review also examined the contact and involvement that organisations had with Matthew's brother, Jacob, the perpetrator of abuse in this case, during the same period.

1.23 The reason why the panel determined that it would examine the period 1 January 2017 through to the tragic death of Matthew in September 2022, was to enable the review to focus on the contact services had with Matthew and Jacob during their transition to adulthood as looked after children. Jacob also had contact with services in 2017 as his behaviour started to deteriorate.

1.3 Purpose of the Review

1.31 The review considered the issues identified within the statutory guidance for the conduct of DHRs, issued under section 9(3) of the Domestic Violence, Crime and Victims Act, (2004), and aims to:

i, to establish the facts and produce a comprehensive and balanced analysis of the information to inform organisational learning and influence change.

ii. establish what lessons are to be learned from the domestic homicide of Matthew, with regard to the way in which local professionals and organisations work individually, and together, to safeguard victims;

iii. 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;

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

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

vi. identify potential gaps in services provision and/or potential barriers to accessing services;

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

viii. highlight good practice.

1.4 Timescales

1.41 In accordance with section 9 of the Domestic Violence, Crime and Victims Act 2004, a meeting of representatives from the Carmarthenshire Safer Communities Partnership, (SCP), including the Chair of the SCP, was held on 10 October 2022. It

confirmed that the criteria for a DHR had been met and this DHR was subsequently commissioned.

1.42 The Home Office were informed of the intention to commission the DHR on 11 October 2022.

1.43 The Independent Chair was appointed in December 2022 following a formal recruitment process. The initial scoping material was shared with the Independent Chair and the initial panel meeting held in January 2023.

1.44 The review panel met on:

- 27 January 2023, to discuss the terms of reference, the early scoping documents and to agree the IMR requirements.
- 21 April 2023, to consider the IMRs and to discuss the family engagement.
- 3 July 2023, to enable the panel to consider further IMR submissions and early learning emerging from the IMRs.
- 26 September 2023, to consider the key themes and potential learning emerging from the review.
- 2 November 2023, to consider the draft report, and specifically, the conclusions and recommendations.

1.45 Following the November 2023 panel meeting, the action plan was finalised and agreed through separate meetings with the Independent Chair or through email contact. Having been signed off by the individual agencies, the report was then presented to the Carmarthenshire SCP for formal approval on 11 July 2024 prior to submission to the Home Office Quality Assurance panel.

1.5 Confidentiality

1.51 The content and findings of this review are confidential and should only be made available to those professionals participating in the review process, and where appropriate, their organisational managers. It will remain confidential until it has been approved for publication by the Home Office Quality Assurance panel.

1.52 The subjects of this review are the victim Matthew and his brother Jacob, the perpetrator in this case. The names of the victim and the perpetrator are pseudonyms. The brothers' family

were offered the opportunity to choose the pseudonyms used within the report but declined to comment on them. The pseudonyms were created by the Independent Chair and approved by the panel.

1.53 Matthew was 22 years of age at the time of his death, his brother, Jacob, was 19 years old. Both of the subjects of this review were of white British ethnicity.

1.54 Any relevant addresses have been referred to in general terms to protect the identity of those involved.

1.6 Terms of Reference

1.61 Specific issues that will be considered, and if relevant, addressed by each agency in their IMR are:

- Were practitioners sensitive to the needs of Matthew and Jacob? Were they knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator of abuse? Was it reasonable to expect them, given their level of training and knowledge, to deliver against those expectations?
- Did practitioners have the knowledge and confidence to use the DASH, (Domestic Abuse, Stalking and Harassment), risk assessment[1] for domestic abuse victims and perpetrators? If so, were those assessments correctly used in the case of Matthew and Jacob?
- Were Matthew or Jacob subject to MARAC[2], (Multi-Agency Risk Assessment Conference), or another multi-agency forum?
- Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

[1] The purpose of the DASH Risk Assessment Checklist is to give a consistent risk assessment tool for practitioners who work with adult victims of domestic abuse. It's used to help practitioners identify those who are at high risk of harm and whose cases should be referred to a MARAC, (Multi-Agency Risk Assessment Conference), meeting in order to manage their risk.

[2] A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

- Were there missed opportunities for intervention? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in light of the assessments, given what was known or what should have been known, at that time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they sign posted to other agencies?
- Was anything known about the perpetrator? For example, were they subject to MAPPA[3], (Multi-Agency Public Protection Arrangements), MATAC[4], (Multi-Agency Tasking and Coordination) or any other perpetrator intervention programme? Were there any injunctions or protection orders that were, or had previously been in place?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their family? Was consideration of vulnerability or disability necessary? Were any of the other protected characteristics relevant in this case?
- Had Matthew or Jacob disclosed to any practitioners or professionals and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were senior managers or other agencies/professionals involved at the appropriate points?
- Did staff involved have the necessary skills and training?
- Are there lessons to be learned from this case relating to the way in which an agency, or agencies, worked to

[3] MAPPA is the process through which various agencies such as the police, the prison service and probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.
[4] MATAC involves partnership working to reduce reoffending by the most harmful and serial domestic abuse perpetrators and to safeguard victims and their families.

safeguard Matthew or Jacob, and to promote their welfare? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies or resourcing?
    - How accessible were services to Matthew and Jacob?
    - Did any restructuring take place during the period under review and if so, is it likely to have had an impact on the quality of service delivered?
- Did the covid pandemic impact on the services offered to Matthew or Jacob, or to their ability to access those services?

1.62 The full terms of reference can be found at appendix 2 to this report.

1.7 Dissemination

1.71 The following individuals/organisations will receive copies of this report:

- Carmarthenshire Safer Communities Partnership Board.
- The Mid and West Wales Violence against Women, Domestic Abuse and Sexual Violence Partnership Board.
- Mid and West Wales Safeguarding Board.
- Dyfed Powys Police and Crime Commissioner.
- The Domestic Abuse Commissioner for England and Wales.

1.72 The report and executive summary will be published on the Carmarthenshire SCP website following approval from the Home Office Quality Assurance panel.

1.73 Matthew's family have declined to receive a copy of the review.

2. Methodology

2.1 This overview report is an overview of information drawn from independent management reports, (IMRs), prepared by representatives from the organisations that had contact and involvement with Matthew or Jacob between 1 January 2017 and Matthew's death in September 2022.

2.2 A letter was sent to senior managers within each agency or body identified within the scope of the review, requesting the commissioning of IMRs. The aim of the IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context in which practitioners were working, (culture, leadership, supervision, training etc), to see whether the homicide indicates that practice needs to change or be improved, to support the highest standard of service delivery.
- Identify how and when those changes or improvements need to be delivered.
- Identify good practice within agencies.
- Provide an independent assessment of practice and service delivery by ensuring that the individual responsible for the IMR has not had involvement with anyone who is subject of the review. The IMR was signed off by a senior manager from that organisation before being submitted to the DHR panel.

Each of the following organisations completed an IMR or a short information report, (if an IMR was not required), for this DHR:

a. Dyfed-Powys Police.
b. South Wales Police.
c. Swansea Bay University Health Board.
d. Hywel Dda University Health Board.
e. Neath & Port Talbot County Borough Council Child and Adult Services.
f. Neath & Port Talbot Council Education Directorate.
g. Probation Service.
h. Neath & Port Talbot County Borough Council Housing Options Service.
i. Llamau.
j. Neath & Port Talbot College.

In each of the IMRs, interaction with Matthew or Jacob was recorded. In the main, this related to Matthew's contact with children's social care, health services and education. In Jacob's case, it was his contact with children's social care, education, police, health services and the probation service.

3. Parallel Reviews

3.1 The probation service have completed a serious further offence review with respect to their supervision of Jacob. The review lead liaised with the Independent Chair for this process and contributed to the DHR by sharing their findings.

4. The Review Process

4.1 Contributors to the Review

4.11 The review panel consisted of an Independent Chair and senior representatives of the organisations that had relevant contact with Matthew or Jacob. The IMR authors and the DHR panel members, have not been the immediate line manager of any staff involved with them.

4.12 The panel members were:

Kate Harrop	Carmarthenshire County Council.
Gill Adams	Carmarthenshire County Council.
Rebecca Robertshaw	Carmarthenshire County Council.
Richard Felton	Mid/West Wales Fire and Rescue Service.
Rachel Munkley	Hywel Dda University Health Board.
Natalie Hancock	VAWDASV Advisor, Mid/West Wales.
Mandy Mellor	Neath Port Talbot College.
Chris Frey-Davies	Neath Port Talbot Council.
Sam Jones	Neath Port Talbot Council.
Christine Harley	Probation Service.
Bryan Heard	South Wales Police.
Steve Thomas	Dyfed-Powys Police.
Katharine Thomas	Swansea Bay University Health Board.
Rachel Hayes	Swansea Bay University Health Board.

Yvonne Connolly Llamau[5].

4.13 The Independent Chair of the review panel is a retired senior police officer. As the strategic lead for crime investigation, criminal justice and safeguarding both adults and children within Kent Police, he has significant experience and knowledge of domestic abuse issues and legislation, as well as wider safeguarding issues. Having worked closely with partner agencies in the multi-agency safeguarding field, he has a clear understanding of the roles and responsibilities of those organisations. He has a background in serious crime investigation, including leading murder investigations, reviews and the chairing of multi-agency meetings. As well as working as the Independent Chair for DHRs, he also chairs Safeguarding Adult Reviews and works on Mental Health Homicide Reviews commissioned by NHS England. The Independent Chair has completed the new mandatory Home Office DHR training course.

4.14 The Independent Chair has no association with any authority in Wales and is completely independent of all of the agencies involved with this review.

5. Equality and Diversity

5.1 The report considered the nine protected characteristics, (age, disability, including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, ethnicity, sex and sexual orientation) as prescribed within the public sector Equalities Act duties,[6] to assess if they were relevant to any aspect of this review. The review considered whether access to services or delivery of services, were impacted upon by such issues.

[5] Llamau are a leading homelessness charity in Wales, supporting vulnerable young people who may be care leavers, involved with the criminal justice system, experienced domestic abuse or leading chaotic and disadvantaged lifestyles.

[6] The general duty requires public authorities, in the exercise of their functions, to have due regard to the need to eliminate unlawful discrimination, harassment, victimisation and any other unlawful conduct prohibited by the act.

a. Age - At the time of his death, Matthew was 22 years of age, Jacob was 19 years old, there are no known age considerations in this case.

b. Disability - Neither Matthew or Jacob identified as having any disabilities although Jacob had disclosed mental health issues and had received support for this during the review period. Jacob's engagement with mental health services is examined within this report.

c. Gender Assignment - This was not a consideration in this case.

d. Marriage and civil partnership - Matthew and Jacob were brothers and did not live together. Therefore, marriage and civil partnership were not issues in this review.

e. Race -This was not a consideration in this case.

f. Religion and beliefs - This was not a consideration in this case.

g. Sex - Sex is always a significant consideration in DHRs. Analysis from the British crime survey[7] suggests that 74.1% of domestic abuse victims identified by police forces in the year ending March 2022 were female. In this case, the victim Matthew was male, the perpetrator of abuse, Jacob, was also male. The panel noted that Matthew's gender may have contributed to the fact that he did not identify as a domestic abuse victim but there was no direct evidence to support this.

h. Sexual orientation - This was not a consideration in this case.

i. Pregnancy and maternity - This was not a consideration in this case.

5.2 Although some of these characteristics were relevant to the review and were considered by the panel, there was no evidence to suggest that they had an impact on the ability of the subjects of the review, to access services. Service delivery by any of the agencies involved was not impacted by these characteristics.

---

7 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2022#sex

6. Family Engagement

6.1 The review panel considered which family members of Matthew and Jacob should be consulted and involved with the review process.

6.2 The Independent Chair was keen to involve the views of close family members of Matthew and Jacob. The Independent Chair wrote to the brothers' mother and separately to their father, to introduce himself, to explain the DHR process and to encourage their participation. He also provided them with the Home Office and AAFDA[8] information leaflets. The letters were delivered by the Police family liaison officers.

6.3 Unfortunately, neither the brothers' mother or father would engage with the review or provide any information as to others who may be able to provide information about the brothers. At the Independent Chair's request, the Dyfed-Powys Police Senior Investigating Officer, (SIO), raised the issue with the family to try and encourage engagement with the review but both the mother and father confirmed their intention to not participate or meet with the Independent Chair. The family did inform the SIO that they had no preference for pseudonyms and were happy for the review to use any random names.

6.4 The review reached out to Swansea University to try and identify students or staff who might be able to provide information relating to Matthew and help to bring his voice into the review. Unfortunately, the review was unable to trace anyone who could assist the review in this way. However, the university was able to provide a copy of his personal statement and his referee statement from his university application. Both of these documents provided some insight into Matthew's outlook on life. The following paragraphs are Matthew's words:

6.5 *'Learning and researching about the different principles of how different aircraft work is something that is really fascinating to me. The application of basic and complex mathematics and physic concepts to design and create new ways which can help*

[8] AAFDA---Advocacy After Fatal Domestic Abuse. A charitable organisation who provides specialist support to families affected by domestic homicide. They also provide support, training and resources to professional working in this field.

aviation is something that appears to be very exciting. I have always been interested in the universe, and if a career in aerospace engineering means that I have the potential to work and develop different spacecrafts, then studying a degree in aerospace engineering and gaining a better understanding of how satellites and planes work is something I would love to be a part of. Communicating and working with others to complete tasks is something I enjoy, especially working with the pressure of deadlines. Currently I am studying mathematics, physics, engineering and Welsh baccalaureate at A-level, which I am really enjoying. A key factor of mathematics is problem solving . Being able to solve mathematical problems is something that I find very satisfying. Physics involves the application of many of these mathematical skills, and in particular, I am enjoying the study of Newton's laws of motion and circular motion.

6.6 *I am interested in how engineering combines both mathematics and physics in the creation of many of the things that exist around us. At my comprehensive school, I was a school prefect, I enjoyed having the responsibility of helping staff and pupils in making the school a better and safer place. In Year 11, I achieved the endeavour award for striving to do my best in class and for successfully completing my exams. I was also awarded a certificate for education and school life from the Neath Port Talbot Council's Children's Services for doing well in my GCSEs. This year I achieved a certificate of recognition from Neath Port Talbot's Children's Services for doing well in my studies at college.*

6.7 *For five days I worked in my local primary school as a teacher's assistant in year 10. There I assisted teachers by helping pupils with some of their classwork, and tidying up after the pupils had left at the end of the day. The work helped develop my communication skills, as communicating with the teachers and pupils was key to getting most tasks done. Also, for five days, I went on an Army residential course in March 2016 where I picked up many new skills. I completed many different activities which enabled me to work on my problem solving and communication skills. Most activities involved team building and I particularly enjoyed the challenge of climbing Sugar Loaf Mountain which required hard work and determination to*

complete. I am looking forward to going to university. The space aspects of aerospace engineering is something which I am particularly looking forward to studying. Using mathematics and physics skills I have gained and applying those skills to real life scenarios is an exciting prospect and something which I am sure I will really enjoy'.

6.8 His referee statement provides the following description of Matthew as a young adult from someone who knew him well. '*Matthew is a first-class student with a mature and positive attitude to college work. He is a very happy student who has always been reliable, met deadlines and demonstrated himself to be a very diligent and conscientious student. Matthew possesses a respectful disposition, and has, throughout his period with the college, been very well disciplined, attentive and punctual. Matthew is a mature and enthusiastic young man, he is an honest, trustworthy and reliable individual who relates well to his peers'.*

6.9 The words of both Matthew himself, and his referee, paint a picture of a young man who, despite the challenges in his young life, had an opportunity to achieve his aspirations and to lead a successful life.

6.10 Whilst no family members wished to participate in the review process, the panel reached out to the police investigation team and were able to access some of the written statements provided by family members with their consent. Matthew's grandmother commented on what she saw as the motive for the homicide in that Jacob was jealous of the fact that Matthew was working hard to better himself through his university work. She stated that Jacob often called Matthew the 'golden boy' and resented his success. Matthew's uncle described him as being one of the nicest people you could wish to meet. He commented on Matthew having what he called a 'heart of gold'. He also talked about Matthew working hard at university. There was no mention within the statements of any suggestion that Matthew was unable to access services such as health, social care or education.

7. Background Information

7.1 The victim, Matthew was born in Wales in 2000 and was 22 years old at the time of his death. The perpetrator, Jacob, Matthew's brother, was born in 2002, also in Wales. They were two of five siblings.

7.2 Jacob and Matthew became known to Children's Social Care, (CSC), due to concerns about neglect. By February 2007, both children's names had been placed on the child protection register under the category of emotional abuse.

7.3 Jacob and Matthew were later accommodated voluntarily under section 20 Children Act 1989, (now section 76, Social Services Well-being (Wales), Act 2014), due to neglect and concerns about their mother's substance misuse, chaotic life style and inappropriate relationships. The brothers' parents' relationship was believed by professionals to be 'characterised by significant domestic abuse' which was witnessed by the children. There were also concerns that their mother was exposing the children to inappropriate adults who were actively engaging in illegal substance misuse. There were therefore, concerns that the children were at risk of emotional and physical harm. The social work team at that time did not believe that Matthew or Jacob's needs were being met consistently and felt that this was impacting upon their development. CSC files highlight that the boy's father failed to follow-up on advice from family, friends and professionals, to seek legal advice to safeguard the children. The father was no longer living with the boy's mother and was considered a potential safe carer. The files do note that their father was using cannabis, had a chaotic lifestyle and was engaging in criminal behaviour.

7.4 Although both children were returned to the mother's care in April 2007, this was very short lived with both Matthew and Jacob being returned to voluntary accommodation in July that year. After becoming subject of an interim care order in February 2008, both Matthew and Jacob were made subject of full care orders in November 2008. The brothers were subsequently placed into the care of a long-term foster family where they

remained until 2018, thus providing significant continuity in their care arrangements.

7.5 Matthew had left school prior to the period subject of this review. His school records show a hardworking and capable pupil who achieved good grades at GCSE[9] level. There is no reference within the school records of poor behaviour. The school records suggest that prior to September 2017, Jacob was also a very capable pupil with only minor behaviour logs recorded.

8. Narrative Chronology

2017

8.1 On 10 January, Neath Port Talbot, (NPT) Social Services recorded looked after child, (LAC)[10], reviews being conducted in respect of both Matthew and Jacob. This was followed by a supervisory review.

8.2 South Wales Police, (SWP), records showed that Jacob, along with two other youths, was warned about anti-social behaviour on 31 January and subsequently, on 18 February, received a warning letter to that effect.

8.3 On 15 February, Jacob was again involved in an incident of anti-social behaviour. On this occasion, he admitted throwing eggs at a house, apologised for his actions and again, he was warned about future behaviour.

8.4 On 20 February, NPT Social Services carried out a home visit to Jacob and his foster carers with respect to Jacob's deteriorating behaviour, including his use of alcohol. The foster carers were concerned about his influence on a younger placement at the same address and whether or not they could continue to provide care and support for Jacob. It was decided that a disruption meeting would be held and that an action plan would be put in place to address the issues raised.

[9] General Certificate of Secondary Education, (GCSE).
[10] A looked after child is a child or young person who is being cared for by their local authority.

8.5 NPT Social Services recorded on 7 March, that the foster carers reported concerns about Jacob misusing alcohol, wanting more freedom and that they could not keep Jacob safe. This reporting continued into April 2017, with the foster carers increasingly concerned about Jacob's behaviour and lack of respect for trust and boundaries. Despite ongoing support, the foster carers requested a change of placement for Jacob. On 4 April, a referral was made for a change of placement. It was noted though, that a school report that month showed very good attendance from Jacob and that the school believed that Jacob was on course to achieve good grades at GCSE level.

8.6 On 6 April that year, NPT Youth Justice recorded a prevention referral from CSC with respect to Jacob. This referral highlighted deteriorating behaviour, the use of alcohol and evidence of bullying that had been placed on social media. Jacob was allocated a case worker who would take responsibility for screening and action planning.

8.7 On 5 May, Jacob went on a respite weekend break to relieve the pressure on his foster carers.

8.8 On 6 June, the NPT Youth Justice case worker and a social worker carried out a home visit to meet Jacob and the family. A second meeting was held later that month on 13 June. A brief screening was completed and an intervention plan discussed and agreed with both Jacob and his carers. It is noted that the screening was very limited, the intervention plan was not clearly set out, possibly because they were completed by unqualified staff.

8.9 NPT Social Services engagement with Jacob continued throughout June. This included further short respite breaks and a supervised contact meeting between Jacob, Matthew and their mother. It was determined that the placement had stabilised and the referral for a change in placement with respect to Jacob, was withdrawn by the foster carers.

8.10 The engagement with Jacob continued in July. Jacob was engaging with services, his anger issues were getting better and his end of year school report suggested that he was on track to achieve good grades, with teachers describing him as positive

and committed. NPT Youth Justice closed their file with respect to Jacob on 13 July. On 20 July, NPT Social Services recorded that the foster carers saw Jacob's behaviour as challenging but that Matthew was progressing well. Jacob refused to go on a holiday to Florida with the foster carers.

8.11 An NPT Social Services visit on 29 August, recorded that Jacob's behaviour continued to put pressure on the placement.

8.12 September saw both a school report relating to Jacob bragging about taking illicit substances and then a report from the foster carers who were concerned about Jacob returning home apparently under the influence of substances. This information was shared with appropriate professionals. There was also a further short respite break arranged with another carer to relieve pressure on the placement.

8.13 The concerns about Jacob's behaviour continued into October, including concerns about the use of illicit substances. NPT Social Services determined that supervised contact with his mother would continue, supervised within the community. It was also noted that the school reported that Jacob's performance was good.

8.14 NPT Social Services recorded a LAC review with respect to Matthew stating an intention to explore the possibility of unsupervised contact with his mother. It also referred to the foster carers supporting Matthew in applying for opportunities in the aerospace industry. The review with respect to Jacob noted improved behaviour and that consideration was being given to him having unsupervised contact with his mother, albeit supported by his brother Matthew, who would also be present.

8.15 On 21 December, the school recorded the fact that Jacob was with a group of other youths who forced a fire door open and caused damage to a safety crash mat in the gymnasium.

2018

8.16 At the end of January, more concerns were raised by the foster carers about Jacob's deteriorating behaviour which included difficulties in his relationship with the foster carers themselves.

As a result, Jacob's placement ended on 31 January and he was placed into respite care.

8.17 On 2 February, Jacob made allegations about having been slapped in the face by his foster mother the previous day. A section 47 investigation[11] was commenced in line with existing safeguarding procedures. A professional abuse strategy meeting, (PASM)[12], was held, a joint visit carried out with Jacob and the foster mother was interviewed under caution. The PASM subsequently determined that the allegation was not substantiated and that no further action was required.

8.18 Matthew was spoken to by NPT Social Services, stating that he missed his brother but that he did not want to change his placement. Matthew was also supported in meeting with his father, who he had not seen for about 11 years.

8.19 On 1 March, Jacob started his new placement. NPT Social Services records for March recorded that Jacob's father had requested contact with him and that the social worker encouraged Jacob to have contact with his brother, Matthew.

8.20 On 17 April, Swansea Bay University Health Board, (SBUHB), record a statutory review health assessment for Jacob. This stated that his health needs were being met, he was happy with his new placement and was having some contact with his brother Matthew. There were no concerns for his emotional health.

8.21 On 8 May, Jacob's respite care placement was made permanent which was seen as offering some stability for Jacob.

8.22 The LAC review for Jacob in June recorded that Jacob had settled well into his new placement and that Jacob was not having behavioural issues. Throughout the month, efforts were made by social workers to support Jacob in establishing contact with family members. Whilst this worked well with Matthew, it

[11] A Section 47 Enquiry, (Children Act 1989), is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

[12] A professional strategy meeting convened to consider safeguarding concerns made against a practitioner/person in a position of trust.

was more challenging with other family members, particularly with his father.

8.23 On 29 June, NPT Social Services records stated that Matthew had a change of legal status. As he was now 18 years of age, he was no longer a looked after child and the placement was changed to 'when I am ready'.

8.24 NPT Social Services completed their first life story[13] session with Jacob on 5 July. This was a recommendation from the June LAC review, intended to assist Jacob in understanding why he was in care.

8.25 On 11 July, Jacob received a 3-day fixed exclusion from school for stealing drinks from the staff fridge. His end of year report, issued on 16 July, recorded that Jacob's attendance at school remained good but that there had been a negative change in his attitude, attainment and effort.

8.26 The NPT record dated 24 July, mentioned a recent exclusion from school because of disruptive behaviour in class but gave no further detail. It also highlighted the fact that his father had failed to attend contact meetings arranged with Jacob.

8.27 NPT Social Services' records for 29 August, tell us that Matthew was now supporting Jacob in meeting with his mother. Matthew's father had been in touch with him but this was not an issue due to Matthew's age. The social worker continued to ensure that Matthew's needs were being met.

8.28 November and December saw more issues with Jacob's behaviour. He was excluded from school for one day in November for swearing at a teacher and was considered for exclusion on 5 December for causing damage to a door. Because of the need for Jacob to sit exams, the school did not exclude him but kept him under close supervision to enable him to complete his exams. On 10 December, the foster carers were called to collect Jacob from school as he was under the influence of substances, believed to be cannabis. Jacob was

[13] Life story work means telling the story of a child's life history to enable the child to understand their past. This is explained in greater detail in section 9.2 of this report.

subsequently excluded for nine days according to school records.

8.29 On 19 December, there was an issue with Jacob entering the carer's bedroom to recover a confiscated mobile phone to message friends. Although Jacob apologised, the carers were not happy but the social worker mediated between both parties and resolved the issue.

2019

8.30 In January, Jacob had supervised contact with his father.

8.31 In February, Jacob was excluded from school on two occasions; the first for using cannabis and appearing to be under the influence of substance misuse, the second related to vaping at school. Support was provided by NPT Social Services on both occasions.

8.32 On 13 March, SBUHB recorded a LAC review health assessment with Jacob. His health needs were being met, he was feeling emotionally well and described his relationship with his carers as good. He declined any specialist support regarding his cannabis use, telling practitioners that he had stopped using the drug.

8.33 On 19 March, NPT Social Services received a call from Matthew's foster carer expressing concern about Matthew using cannabis and that his grades for his college work were deteriorating.

8.34 Following information from a member of staff at Jacob's school, SW Police officers attended, recovered a bag of white powder from Jacob's bag and arrested him for possessing drugs, an offence that Jacob admitted. A public protection notice, (PPN), was not submitted because a youth restorative form had been shared with the Youth Justice Service, (part of the NPT Social Services), and SW Police had been asked not to submit PPNs where it was clear that the relevant agency was already involved.

8.35 Jacob was only permitted to attend school to complete exams but was again excluded from school on 30 April for cannabis misuse. This time, he received an 18-day fixed exclusion, taking

Jacob through to the start of his GCSE exams and preventing the possibility of a permanent exclusion before his exams started. Jacob's foster carers were very concerned about Jacob's possession and use of controlled drugs as they had young children within the premises. Additional support was provided by NPT Social Services, to both the carers and, in terms of a tutor, to Jacob.

8.36 In June, the NPT Youth and Justice team allocated Jacob's drug misuse case to a social worker to produce the relevant report and a home visit was arranged in line with working practice. This was completed on 3 July, the report focused on issues including drug misuse and peer relationships. It assessed the risk of violence, possession of weapons or causing serious harm as low. It assessed the risk of re-offending and safety and well-being as medium.

8.37 On 11 July, Jacob appeared before the Neath Youth Bureau who determined that a non-criminal outcome would be appropriate with respect to Jacob's drug offending. This included a one-off drug awareness session that was administered immediately after his appearance before the bureau. The records show that Jacob was very aware of the consequences of continued drug use and offending, especially once he turned 18 years of age. This matter appeared to have been appropriately and proportionately dealt with. Jacob was supported throughout by a social worker.

8.38 NPT Social Service's records noted that Matthew achieved sufficient grades to access a 4-year foundation course in aerospace engineering when he received his results in August. On 4 September, he secured a place at Swansea University for this course.

8.39 On 10 September, Jacob enrolled at college to study a motor vehicle course but transferred a few days later, to an engineering course at Neath College. As a young person in care, Jacob was provided with support for the first week by a wellbeing officer at the college but he declined any further support.

8.40 In October, Jacob's carers raised concerns about Jacob having low mood issues. Jacob was taken to the GP who provided medication to aid sleep, recommended that he attend 'Mind

Neath'[14] for support and signposted him towards some self-help websites.

8.41 This was discussed at the LAC review for Jacob the following day, with the social worker taking actions to check if a CAMHS[15] referral had been made and to make a referral to the college-based counsellor. The SBUHB records for 14 October, confirmed that a CAMHS referral had been made and that the carer should accompany Jacob to future appointments as he may be too anxious to retain information provided to him. If the carer understood what was being said, they would be able to support Jacob's understanding.

8.42 On 16 October, the GP spoke to NPT Social Services, confirming her concerns about Jacob's mental health and that she had referred him to CAMHS. Her concerns included the fact that Jacob had admitted having thoughts about self-harming.

8.43 On 18 October, Jacob was admitted to A&E, Morriston hospital, having self-harmed through razor cuts to his chest and belly-button. SBUHB recorded that Jacob had made several recent self-harm attempts. He was feeling low, had low appetite, poor sleep and was unhappy with friends. It was felt that Jacob may wish to harm his friends. Jacob was referred to Ward F[16] for a psychiatric assessment, following which, he was discharged back to his placement. Jacob's social worker remained with him whilst receiving care in the hospital. The NPT Social Services record stated that a safety plan was agreed and advice and support offered to the carers. There was no mention of this in the SBUHB records.

8.44 The SBUHB records for 25 October, reported that a face-to-face assessment by CAMHS, both the part 1 assessment and the Wales Applied Risk Research Network, (WARRN), assessments[17], had been completed. The GP had made a referral following an attempt by Jacob to take his own life. Jacob

[14] Mind Neath provide advice and support to people experiencing mental ill health.
[15] Child and Adolescent Mental Health Service.
[16] Ward F at the Moriston hospital, Port Neath, is an inpatient mental health facility.
[17] Wales Applied Risk Research Network (WARRN) is a formulation-based technique for the assessment and management of serious risk (e.g. violence to others, suicide, etc.) for users of mental health services.

was accompanied to the CAMHS appointment by his carer and by a social worker.

8.45 On 8 November, Jacob attended a CAMHS appointment where it was recorded that his mood had improved, he was no longer having thoughts of self-harm or to end his life. He was referred to a psychiatrist.

8.46 On 20 November, Jacob was seen by a psychiatrist, (Powys), he presented as much improved in terms of mood and outlook, he talked positively of the future and denied any thoughts of self-harm. The consultant determined that there was no further need for appointments with the psychiatrist but that Jacob would be referred to CAMHS to enable his mood to be monitored and psychoeducation[18] could be offered to manage low mood and self-harm thoughts.

8.47 On 22 November, the NPTC College LAC report stated that Jacob was progressing well. There was no mention of mood issues or self-harming.

8.48 In early December, Jacob's carers raised concerns with NPT Social Services in relation to additional support to manage Jacob's self-harm or suicidal thoughts. A home visit was arranged with Jacob and his carers. Jacob talked about his father going back to prison and his relationship with a girlfriend ending. He also made historical allegations against his previous carers.

8.49 On 6 December, a member of the public reported an incident to SW Police where he had been asked for money and then assaulted by a youth who he named as Jacob. The victim of this assault knew Jacob and did not want any formal action taken with respect to it. Jacob was interviewed, described the other male as being the aggressor but did not want to make any allegations against him. No formal action was taken but Jacob's social worker was updated. The officer did not submit a PPN as they felt that it was unnecessary as Jacob's social worker had already been briefed. It was also noted that there had been a drive to reduce the number of PPN's submitted by front line

[18] Psychoeducation involves learning about and understanding mental health and wellbeing.

police officers where it was clear that the other agency was already involved or had been informed of the issues.

8.50 NPT Social services carried out a statutory visit to see Jacob on 9 December. Jacob informed them that the course was going well, that his attendance was improved and that he was eating and sleeping better. He admitted that he was still using cannabis and that he had recently had a fight with an older male. He also stated that he found the CAMHS appointments helpful.

2020

8.51 Jacob's carers informed NPT Social Services in January, that they were increasingly concerned about his attitude. They were also concerned about it's effect on others in placement with them and they felt that they could not offer him a 'when I am ready' placement[19] when he turned 18 years of age. The social worker discussed this with Jacob who understood the reason for the decision.

8.52 On 27 January, the NPT Social Services records indicated that Jacob had contact with the police the previous week, albeit it does not mention why. It documented that he was unhappy and wanted to move placement. The records stated that this information was shared with relevant professionals.

8.53 On 28 January, the SW Police records reported that Jacob was seen in a group of youths suspected of smoking cannabis, searches had been conducted but no drugs found. All relevant documentation was completed and the searches conducted in line with legislation and local Force policy. The following day, Jacob was spoken to by the SW Police regarding a fight with another male. On 30 January, his carer accompanied Jacob to a SW police station to be interviewed about an assault that had occurred on 6 December 2019. As the complainant did not wish to provide a witness statement and there was no other evidence to support a prosecution, no formal police action was taken.

8.54 On 4 February, Jacob returned home from college with a black eye having been fighting with another student. The following day,

[19] 'When I am ready' enables young people in foster care to continue living with their foster carers once they turn 18. It allows them to remain in a stable and nurturing family environment up to the age of 21 years.

his social worker met with him to carry out a disruption meeting. The social worker recorded that Jacob continued to misuse cannabis, was not motivated to attend college, was fighting with peers and was having thoughts about self-harm and suicide. The records documented that options around kick boxing and the Navy were discussed, together with a referral to CAMHS.

8.55 The NPT Social Service records indicated that Jacob had been having more contact with his mother and that this contact needed to be assessed for unsupervised contact due to Jacob's age, (17 years). It was noted that this had been delayed because of covid but both Jacob and his mother, wanted to proceed with overnight contact at the mother's address.

8.56 On 13 February, Jacob was excluded from college for fighting and his carers served notice to end his placement.

8.57 On both 17 and 20 February, Jacob's young person advisor, (YPA)[20], had supported his engagement in Bulldogs[21] and Down to Earth[22] projects.

8.58 On 24 February, Jacob was involved in an altercation with another student, witnessed by a staff member. He was subject of a two-week suspension.

8.59 On 25 February, Jacob met with CAHMS for a monthly review meeting. His mood was noted as good and he was not having self-harm thoughts. He would be reviewed in 4 weeks' time.

8.60 On 27 February, Jacob was reported by the carers as smoking cannabis and taking other drugs. Two days later, they reported finding other medication in Jacob's room. They demanded that Jacob was moved to another placement immediately.

8.61 On 2 March Jacob moved to another placement. He was clearly very unhappy about his previous carers reporting his drug use and informed the social worker that his cannabis use was not a problem. It was also recorded that he had started his psychotherapy.

[20] A YPA works closely with a young person, their carers and a range of agencies to support the young person's transition to adulthood.
[21] Bulldogs-A wellbeing project supporting young people aged 7-18 years in NPT.
[22] Down to Earth-A social project helping people to bring about positive change in their lives through meaningful outdoor activities.

8.62 On 23 March, the first national lockdown commenced due to the covid pandemic. Although Jacob's new carer reported that Jacob was happier, it is noted that his psychotherapist was sick. Jacob had returned to college and was attending all of the Down to Earth project sessions. Jacob's statutory review health assessment was conducted by telephone. The LAC nurse recorded Jacob as having better moods, no self-harming thoughts although he was still losing his temper through frustration. He denied using substances since starting in the new placement. He informed the LAC nurse that he had previously received support from the drug and alcohol agency, but did not clarify which. (The review has been unable to establish which one as the Welsh Centre for Action on Dependency and Addiction, (WCADA), or Dyfed Drug and Alcohol Service, (DDAS), have no record of contact with Jacob). The nurse had also spoken to out of area CAMHS who informed the nurse that another CAMHS worker had been allocated to Jacob but that appointments were delayed due to the pandemic. The nurse had spoken to Jacob's carer who they noted was self-isolating due to being at high risk from covid.

8.63 During April, contact was maintained with Jacob and his carer by phone. Jacob appeared to be coping well with the restrictions caused by the pandemic. The NPT Social Services records indicated that the proposal for Jacob to be able to stay with his mother overnight was approved. A PNC[23] check had been conducted and there were no concerns as his mother had 'turned her life around' and had moved away from drug misuse.

8.64 On 1 May, Jacob confirmed that his lap top had arrived to enable him to do his college work from home.

8.65 On 5 May, Jacob was spoken to by CAMHS by telephone. He reported that he felt mentally well and was discharged from the service, albeit he was informed that he could self-refer back to CAMHS if he needed to.

8.66 Throughout May, there were conflicting reports about Jacob doing well with his college work, with reports from the college, firstly saying that Jacob was not engaging with the online

[23] Police national computer.

classes, and then, on 20 May, that Jacob had decided to withdraw from the college course. Jacob had contacted both his social worker and a careers advisor with a view to joining the military.

8.67 NPT Social Services were also informed in May, that Matthew was not coping well with the covid 'lockdown' and, whereas he had been staying at his mother's address, he was now back at university halls of residence.

8.68 In June, the pandemic restrictions were changed to 'stay local' from 'stay at home'. Matthew moved back to his 'when I am ready' providers, his mother was reportedly struggling with her mental health. He continued with his university course and was being supported by his YPA.

8.69 On 22 June, Jacob's carer informed NPT Social Services that Jacob was a 'delight to have in the house', but later the same day, contacted Dyfed-Powys Police, to inform them that Jacob and others had made threats to harm a third party via social media, including assaulting the person and putting them '6 feet under'. As the potential victim in this matter did not want Dyfed-Powys Police to take any formal action, Jacob was given words of advice by the police.

8.70 On 6 July, the covid pandemic restrictions across Wales were lifted.

8.71 On 8 July, Jacob moved into supported lodgings. He reported feeling emotionally well and throughout July, he was supported by his Llamau support worker and by his social worker. Jacob presented as coping well, providing positive feedback to his social worker.

8.72 The LAC review record for the meeting held on 3 August, concluded that Jacob's mental health was better than it had been and that CAMHS would remain in touch with Jacob for another 6 weeks. Jacob's mother attended the review meeting, overnight contact was said to have gone well.

8.73 On 19 August, Jacob was due to have a 6-week review meeting but did not attend. A new meeting was set via text messages for 25 August which took place as planned. Unfortunately, Jacob

and his support worker were unable to complete his support plan as Jacob had another commitment at the college. It was agreed that Jacob and his support worker would speak the following day by phone but when the support worker tried to phone him, Jacob did not answer his phone. The support worker noted that she would attempt to contact Jacob again the following week.

8.74 The support worker spoke to Jacob by phone on 3 September and then met with him on 9 September. Jacob presented in a positive mood. He informed the support worker that he was looking forward to starting the new college course he had enrolled on. He also spoke about getting a part time job, saving money and having driving lessons.

8.75 On 17 September, the supported lodgings provider informed NPT Social Services that the college had rung them stating that Jacob had not been attending his course and that when he had, he was under the influence of substances. The supported lodging provider undertook to discuss a referral to WCADA.

8.76 The support worker messaged Jacob on 21 September to confirm he had been paid his allowance. They also informed Jacob that they had asked his social worker to enquire about financial support to buy new clothing for college. There is no record of a reply.

8.77 On 28 September, the local covid restrictions were imposed again, restricting movements.

8.78 On 30 September, a number of attempts were made to contact Jacob by the support worker but were unsuccessful. The support worker contacted NPT Social Services on 2 October to express concerns about Jacob's drug use, low mood and his threats to cause damage to a previous carer's property.

8.79 On 7 October, Jacob had a telephone conversation with his support worker where he informed them that he was settling in well in his lodgings, that he was enjoying college and discussed issues relating to his benefits.

8.80 The 6-week review meeting, held via MS Teams on 14 October, was well attended and provided positive feedback regarding Jacob's progress. It was noted that Jacob admitted regular use

of cannabis and that he had declined the offer of support from WCADA.

8.81 The LAC review meeting was held on 28 October; it was well attended and covered the same information as the review meeting on 14 October. There were no concerns about Jacob's mental health, and Jacob was attending his course. The next LAC review meeting was set for 23 April 2021. Information was shared with appropriate agencies.

8.82 On 2 November, the support worker updated NPT Social Services and the YPA, that Jacob had not returned home on the Saturday evening, refusing to do so when spoken to by phone and sounded as if he was under the influence of substances. It was noted that this was the first time this had happened. Later the same day, NPT Social Services contacted Jacob's mother, who confirmed that Jacob was staying there and wanted to remain there.

8.83 The support worker met with Jacob on 4 November for a support session. Jacob stated that he wanted to reduce his cannabis use and he was referred to the college-based counsellor.

8.84 On 5 November, Jacob turned 18 years of age. He was subject of a visit from his social worker and was reported as being in a good mood. He declined to engage with WCADA. As Jacob no longer qualified as a looked after child, SBUHB closed his LAC file on 9 November.

8.85 On 19 November, the support worker spoke to Jacob by phone. Jacob admitted using various drugs a few days before but had not used illicit substances since. He reported symptoms similar to paranoia. He also admitted self-harming with superficial cuts to his arms. He informed the support worker that he intended to visit his mother for the weekend. The support worker updated both the YPA and the supported lodging provider. The YPA agreed to support Jacob to attend his GP surgery. The GP subsequently referred Jacob to mental health services.

8.86 On 24 November, Jacob met with his support worker at the supported lodging placement. Jacob explained that he felt that visiting his mother over the weekend had helped him. Jacob felt that he was suffering from a mental illness and would speak to

the college-based counsellor after he had seen someone from the mental health team.

8.87 Jacob attended the emergency department at the Morriston Hospital, on 28 November, he reported feeling unwell. The hospital records recorded that Jacob had been using drugs, was anxious and short of breath, and he wanted help. Although he had previously had thoughts of self-harming, he reported that he had no such thoughts of doing so. He was discharged with an advice leaflet and contact details for the alcohol and drug team.

8.88 On 30 November, Jacob had returned to the supported lodging address, apparently under the influence of substances. He subsequently felt very ill, saying that he had taken about 4g of amphetamine and some ketamine as he wanted to overdose. Jacob was taken to hospital by ambulance. When discharged, Jacob was picked up by his father and did not return to the supported lodgings address. Attempts by the support worker to contact Jacob by phone were unsuccessful. It was only when the support worker intimated that she would have to report Jacob as missing, that Jacob then contacted her via his mother's phone. Jacob stated that he had left his phone at a friend's, hence the support worker was unable to contact him. He stated his intention to remain at his mother's address for the time being.

8.89 The support worker contacted Jacob on his mother's phone again on 2 December. Jacob stated his intention was to return to his lodging placement that evening. The support worker contacted the GP surgery to follow up his mental health assessment and the YPA contacted the college to explain why Jacob was absent. It was noted that the NPT Social Services deputy team manager had advised that a safety plan be put in place but this did not appear to have happened. It was also worthy of note, that the emergency duty team, (EDT)[24], were briefed on Jacob's issues.

8.90 The support worker spoke to Jacob on 7 December. Jacob appeared to be in a positive mood and discussed people to contact if required. Due to the covid restrictions and self-isolation within the lodgings, Jacob and the support worker agreed to

[24] EDT---Out of hours social care provision.

keep in touch by phone and text messaging. Jacob was still waiting for his mental health assessment.

8.91 The 6-week review meeting was held on 9 December. The main concerns were the delay in the mental health assessment and the need to support Jacob to reduce his substance misuse.

8.92 The support worker met with Jacob on 15 December. The notes recorded that Jacob was in a positive mood, was exercising regularly and had regained his appetite. His plans for Christmas were discussed and they centered around staying with his mother. The following day, higher level covid restrictions were imposed across Wales.

8.93 On 17 December, the SBUHB records documented Jacob being offered a referral to the early intervention psychosis, (EIP)[25], service but Jacob would not engage with the team.

8.94 The support worker had telephone contact with Jacob on 21 December during which, Jacob was very positive. She tried to contact him again on 31 December but got no answer.

2021

8.95 The support worker contacted Jacob by phone on 6 January and arranged to meet with him on 11 January. Unfortunately, at this time the support worker was self-isolating so rearranged the meeting for 18 January. During the call, Jacob informed the support worker that he had received a letter from the community mental health team, (CMHT). They had tried to ring him but he had not answered his phone. He said he would contact them to arrange an appointment.

8.96 On 8 February, Jacob had a telephone conversation with the support worker. He appeared to be in a good mood. He stated he was having regular contact with his family and that he was using less cannabis. The support worker arranged to meet with Jacob the following day to help him with banking issues and to follow up with the CMHT letter.

8.97 On 11 February, Jacob's supported lodgings provider contacted the support worker by email, raising concerns about Jacob's

[25] An EIP service is a multidisciplinary community mental health service that provides treatment and support to people experiencing, or at high risk of developing, psychosis.

mental health and drug abuse. The information was shared with the social worker and YPA.

8.98 On 18 February, Jacob was supported by the support worker to attend an appointment with the adult mental health team. Jacob was very positive about the meeting. The SBUHB records documented that Jacob was accepted for a period of assessment by the EIP service.

8.99 On 23 February, NPT Social Services recorded a supervision meeting with the first foster carers. They reported that Matthew phoned them every week and had been staying at his mother's address.

8.100 On 24 February, the support worker attempted to contact Jacob by phone but there was no answer.

8.101 On 27 February, SW Police received a report of an assault by four youths, one of whom was Jacob. He was arrested but the injured party refused to make a formal complaint or to assist the investigation so no further action was taken against Jacob or the other youths.

8.102 On 2 March, the 6 weekly review meeting was held on MS Teams, Jacob did not attend as he was out with friends. The meeting discussed Jacob's progress and the fact that he intended to take up the therapy sessions offered by the mental health team meeting. There were still concerns about his drug use. It was noted that Jacob was regularly staying at his mother's address at weekends. The support worker met with Jacob the following day to discuss his support plan. There were no reported issues and the meeting went well.

8.103 SW Police report having an intelligence log that was submitted on 10 March, naming Jacob as one of three males believed to be carrying offensive weapons. Warning markers were created on the Niche system[26] in line with their force policy and procedures. The information was appropriately shared with NPT Social Services.

[26] Niche is a police records management system.

8.104 On 12 March, Welsh national policy changed on covid restrictions, it was reduced to ‘staying local’.

8.105 The NPT Social Services case supervision on 16 March recorded that Jacob’s mental health was not being seen as such a concern but that he was not engaging with the YPA and the fact that he was still misusing substances remained as a concern. It was noted that the supported lodgings review went well.

8.106 On17 March, the support worker met with Jacob who mentioned that his mother was going to be allocated a house but that he had no intention to move in with her. He was also positive about his next mental health team meeting.

8.107 The pathway review meeting was held on 23 March and was well attended, including by Jacob. Jacob reported that he wanted to make a formal complaint about previous foster carers and that the YPA agreed to support him in dealing with the paperwork. Jacob reported engaging with therapy sessions for trauma via the mental health team which he felt would help him. Jacob also reported having had some suicidal thoughts on occasions and that he had been using cannabis although he claimed that he had reduced the amount he was using. Jacob went on to report that he now had a good relationship with his mother and was visiting her and his siblings on a regular basis. He mentioned having a good relationship with his brother who lived in Swansea, (Matthew).

8.108 The support worker discussed the safety plan with Jacob by phone on 25 March. As Jacob appeared agitated and was finding it hard to cope with his thoughts, Jacob was advised to contact his GP. The same day, SBUHB recorded Jacob as not attending his adult mental health appointment but, that a follow up appointment was made.

8.109 On 7 April, a strategy meeting was held between SW Police and NPT Social Services about the allegations made by Jacob relating to his previous foster carers. In line with policy and best practice, a professional allegations strategy meeting, (PASM), was arranged.

8.110 On 14 April, the support worker met with Jacob who spoke positively about his relationship with his mother and siblings. He also reported that he felt that the therapy sessions were helping him.

8.111 Between 14 and 16 April, a PASM was held and actions were carried out to progress the allegations made by Jacob with respect to his former foster carers. A review PASM was arranged for 16 June.

8.112 On 19 April, rules on covid restrictions were relaxed allowing more people to meet outside.

8.113 On 20 April, Jacob attended Morriston hospital A&E having taken what the SBUHB records described, as a deliberate overdose. He was admitted to the hospital where he remained until 22 April when he was discharged. He was referred back to the EIP service. Jacob was supported by both his support worker and a YPA, (his normal YPA was on leave). Jacob informed services that he had not intended to end his own life but rather was trying to end the bad thoughts he was having.

8.114 On 26 April, the support worker spoke to Jacob by phone. Jacob was staying at his mother's address and reported that he was feeling okay. They spoke again by phone on 28 April, agreeing to meet face to face on 5 May.

8.115 On 29 April, a pathway review meeting was held in which Matthew considered joining his brother in making allegations against the previous foster carers. Matthew was supported by a YPA to make his complaint to the SW Police.

8.116 On 4 May, the 6-week review meeting was held via MS Teams. There were no issues with Jacob's independence skills and he liked his placement. Jacob had been staying at his mother's address for a week at a time and was enjoying spending time with his mother and brother. Jacob reported that he was also finding the therapy sessions helpful.

8.117 The support worker met with Jacob on 5 May to discuss his support plan and to pick up actions from the 6-week review meeting. Jacob informed the support worker that he was not

sure if the therapy sessions were really helping him as he did most of the talking but he would continue with them though.

8.118 On12 May, the support worker attended a pre-planned meeting with Jacob at the supported lodgings premises but Jacob was not in and did not answer his phone. The supported lodging provider confirmed that Jacob was still buying cannabis.

8.119 On 14 May, Jacob failed to attend his adult mental health appointment.

8.120 On 17 May, Jacob was supposed to be attending the Bulldog project with his YPA. Jacob did not attend the appointment or respond to phone calls and text messages from his support worker. Jacob did contact the support worker the following day to confirm that he was ok. They then met on 26 May for what the support worker described as a very positive support session. Jacob confirmed that he was still engaging with the mental health team and that family relationships were good.

8.121 On 2 June, Jacob was not present when his support worker visited the supported lodging address. The supported lodging provider confirmed that Jacob was staying at his mother's address and that he had not responded to phone calls or text messages. The support worker was able to speak to Jacob the next day and arranged to meet him on 9 June.

8.122 On 15 June, Jacob sent apologies for not being able to attend the 6-week review meeting which did not take place as the YPA and the supported lodging provider did not attend.

8.123 The support worker spoke to Jacob by phone on 17 June. Jacob was very positive about a music session he attended the previous day and the fact that he intended to stay with his mother for a few days.

8.124 On 23 June, the SBUHB records showed that Jacob again failed to attend his mental health appointment.

8.125 On 1 July, Jacob was informed that SW Police would not be taking the complaint against the previous foster carers forward. The decision to take no further action was based around the fact that it amounted to an allegation of common assault and that it was outside the statutory prosecution time limits, thus the

decision was in line with legislation and policy. The matter had also been subject of a PASM in April 2021.

8.126 On 2 July, Matthew's YPA reported Matthew's allegations of physical and emotional harm by previous foster carers to the SW Police.

8.127 On 8 July, following a home visit, Jacob was discharged by the adult mental health team. The reason for this is not recorded on the documents provided to the review.

8.128 On 19 July, the YPA spoke to Jacob by phone. Jacob reported that he was still meeting with CAMHS and said that he had declined medication when it was offered. It was noted that Jacob reported attending mental health meetings yet the SBUHB records suggest that he generally did not attend them.

8.129 On 20 July, at the pathway review, Jacob stated that he had been staying with his mother and that he had fought with his brother Matthew, resulting in Matthew receiving a black eye. Jacob added that everything was sorted out now.

8.130 On 22 July, a PASM was held to discuss the further allegations made by Jacob and Matthew about the previous foster carers. It was determined that there would not be a SW Police investigation but that the allegations should be put to the foster carers to afford them the opportunity to respond. This decision was based on the fact that this was an allegation of common assault which is therefore subject of a statutory period of limitation, which had already expired. A further PASM was agreed for 23 September.

8.131 The NPT Social Services team manager spoke to Jacob by phone on 9 August to confirm that SW Police would not be taking the allegations against the previous foster carers forward but that social services were still looking into the matter. Jacob confirmed that he was still staying at his mother's address and that his brother Matthew was also staying there.

8.132 On 24 August, the SBUHB records detailed the fact that Jacob was discharged from EIP as the multi-disciplinary team meeting felt that there was no ongoing psychotic illness. Jacob was provided with a discharge letter detailing his right to re-refer

under part 3 of the Mental Health Measure (MHM Wales 2010). Jacob was referred to the local primary mental health support services, (LPMHSS). Unfortunately, Jacob did not respond to several attempts made by LPMHSS to contact him.

8.133 On 9 September, the support worker met with Jacob. The notes recorded that Jacob was feeling okay and agreed to respond to messages. He asked the support worker to speak to the YPA to see if they could help to fund the purchase of a bike for him.

8.134 On 13 September, the support worker texted Jacob to inform him that the support worker would be off work with covid.

8.135 On 18 September, Jacob was identified by the previous foster carer as being responsible for damage caused at their home address. This was reported to SW Police who subsequently interviewed Jacob under caution. Jacob admitted the offence and initially an out of court disposal resolution was attempted. Jacob did not comply with this so he was summoned to appear before Swansea Magistrates Court where he pleaded guilty to an offence of criminal damage.

8.136 On 27 September, SW Police were contacted about the allegations made by Matthew and Jacob against the previous foster carer. A statement was subsequently taken from Matthew on 15 December, but due to appointments being cancelled, a statement was not obtained from Jacob until March 2022. The allegation of assault was deemed to have exceeded the statutory time limit to bring a prosecution within, the other allegations were determined to be strict discipline that would be better taken forward by social services. As the statutory limitation for assault had been exceeded and as there was no other evidence to support a prosecution for another offence, no further formal police action was taken.

8.137 During October and early November, support was provided to Jacob, Matthew and to the previous foster carers who were subject to the allegations made.

8.138 The NPT Social Services records for 19 November recorded the fact that Matthew was continuing his contact with his mother and that he had asked for support with respect to his cannabis use and budgeting.

8.139 On 9 December, the support worker spoke to Jacob by phone to arrange a meeting the next day. Jacob was at his mother's home and would not be able to meet the support worker.

8.140 On 16 December, NPT Social Services had arranged to take Jacob to a SW Police station to make his statement regarding the allegations against his previous foster carers, but Jacob did not answer the door.

8.141 Jacob's support worker was able to speak to Jacob by phone on 20 December. He informed the support worker that he was staying at his mother's address and had been doing some work with his father which he enjoyed. He stated that his mental health was good and that he was no longer engaging with support services as he felt he could sort things out better for himself. He did admit that he smoked cannabis when he was at his mother's address.

2022

8.142 On 11 January, the support worker and the supported lodging provider, spoke by phone about Jacob having not returned to the placement due to covid and that he was staying at his mother's address. There was also a discussion about Jacob making inappropriate comments to female supported lodgings staff, (about her figure), and how that should be handled.

8.143 On 24 January, the support worker spoke to Jacob by phone. Jacob was happy that issues about the inappropriate conversation and concerns about food had been resolved.

8.144 The 6-week review meeting on 2 February noted that there were no major issues with the placement. Jacob had continued to visit his mother and family on a regular basis but there were arguments and he was not enjoying the visits like he used to. Jacob said he would limit the visits until things improved. Jacob was not engaging with mental health services.

8.145 On 8 February, Jacob was told he had to leave the placement due to his erratic, violent and abusive behaviour. The support worker and the YPA had attended the supported lodgings address and spoken to Jacob who was erratic in conversation. He was making limited sense, talking about visions and issues

with his family and their ‘disgusting behaviour’. Jacob insisted that he did not need help with his mental health. Jacob was taken to his mother’s address at his request before going to a new placement the following week. It is noted that the new proposed placement declined to take Jacob due to his erratic behaviour during the introductory meeting. It was also noted that a safety plan was put in place with his mother whilst he was staying there.

8.146 On 9 February, the pathway review meeting minutes acknowledged that Matthew was still using cannabis and that his mental health was fluctuating due to the ongoing situation regarding the allegations made against the previous foster carer. Support was being provided.

8.147 On 10 February, both the support worker and the YPA attempted to contact Jacob by phone but were unsuccessful. It was noted in the NPT Social Services records that Jacob had decided to live with his mother until 7 April 2022. On 14 February, the records noted that Jacob, Matthew and their mother, were all misusing cannabis.

8.148 On 24 February, the support worker contacted Jacob by phone, following his request via a text message, to advise him about benefit claims whilst he was living with his mother.

8.149 On 28 February, a new YPA was allocated to Jacob due to the previous YPA moving to a new role.

8.150 On 15 March, NPT Social Services were informed by SW Police that Jacob had failed to attend court with respect to a criminal damage charge and that a warrant had been issued for his arrest.

8.151 On 23 March, Jacob contacted his YPA by text, asking if he could have counselling again. The YPA explored options with MIND[27] and with the hospital mental health team.

8.152 The support worker spoke to Jacob by phone on 30 March. Jacob stated that he was okay but would like to be considered for supported accommodation in Neath and Port Talbot with

[27] MIND---a charitable organisation who provide advice and support for people with mental health issues.

Llamau. He also informed the support worker that he was considering re-engaging with mental health services, specifically a counsellor. The following day, the YPA texted Jacob to explain that Jacob would be contacted by his GP regarding his mental health.

8.153 The GP made contact with Jacob on 1 April. The GP records noted that there was no overt psychosis, that Jacob denied any suicidal or self-harm thoughts but did become a lot more tense and verbally angry when describing his dysfunctional family dynamics. Jacob gave consent for the GP to contact his social worker and the GP agreed a follow up meeting in two weeks' time.

8.154 On 5 April, Jacob had a mental health crisis. His GP contacted him as requested by phone but was initially told by Jacob to ring him back as he could not talk at that time. When the GP said he could not do that, Jacob became very agitated and said 'F*** it-sign me into a mental institute'. He then went on to make threats to kill himself. The GP then spoke to the YPA who was with Jacob. There had been a falling out with family members and Jacob could no longer stay with them; indeed, no family member would accept him. The YPA was making arrangements for emergency housing options. The GP advised the YPA to take Jacob to the hospital.

8.155 Jacob was assessed by the mental health crisis team at Prince Philip Hospital later that day. Hywel Dda University Health Board, (HDdUHB), mental health records noted that Jacob was describing having over sexualised thoughts about his mother that had led to a falling out with family members. He spoke about low mood and imagining putting a rope around his neck. The assessment team recorded that his mental health had declined since he returned to live with his mother. Jacob was prescribed zopiclone[28] 7.5mg and diazepam[29] 2 mg and he was discharged with a plan to refer him for therapy support and for support from the Neath Mental Health Crisis Resolution Home Treatment Team, (CRHTT). Emergency accommodation was arranged for

[28] Zopiclone is a sedative medication used to treat people who have difficulty sleeping.
[29] Diazepam is a medication used to treat anxiety disorders and symptoms of alcohol withdrawl. It is often referred to under the brand name, Valium.

him at Beaufort House[30], which is in the Neath area. A safety plan was put in place for him, and the CRHTT made contact with Jacob the next day.

8.156 On 6 April, the Mental Health assessment team visited Jacob but, as he had only just woken up, they left him with a letter, advising that they would return later that day. The YPA transported Jacob to the NPT hospital for his assessment.

8.157 There is no record of the result of this assessment although it is noted that the case had been referred to the NPT CRHTT due to Jacob's change of address.

8.158 On the same day, SW Police records documented that the decision not to proceed with the allegations made by Matthew and Jacob had been shared with relevant parties. It recorded that Matthew was disappointed with the result whilst Jacob felt better because the allegation had been formally recorded. It was noted that the NPT Social Service records for 7 April, record that the foster carers resigned once the allegations were shared with them.

8.159 During the rest of April, there was a significant amount of work undertaken by Jacob's support worker, YPA and by NPT Housing with respect to Jacob's accommodation. A formal supported accommodation referral was made and Jacob was accompanied by the YPA to his mother's address to collect clothing.

8.160 On 20 April, the professional abuse strategy meeting endorsed the decision to record the allegations made by Matthew and Jacob as unsubstantiated as there was no independent evidence available. The fostering team would carry out their own risk assessment.

8.161 On 26 April, Jacob and his YPA were informed that Jacob had been accepted on the list for supported accommodation. The YPA also confirmed with the Tonna Hospital Mental Health Team that Jacob would like an appointment with them.

[30] Beaufort House, Neath, provides emergency housing for the homeless and support for those with mental ill health.

8.162 On 28 April, Jacob had an assessment for supported accommodation with the Caredig Housing Association, who cater for clients with medium to high needs, particularly mental health.

8.163 On 4 May, staff at Beaufort House responded to Jacob shouting, punching and kicking the door. He stated that he felt like killing people and he had had enough of his family. This was de-escalated by staff who provided support to Jacob but the fact that he had expressed a desire to harm others does not appear to have been escalated as it should have been.

8.164 On 20 May, the YPA took Jacob to Neath Police Station as it was recognised that he was wanted on warrant for failing to attend court in February. Jacob was arrested and taken before the next available court.

8.165 On 5 June, Jacob was subject of a SW Police 'stop and search', and was found to be in possession of cannabis. It was decided to deal with this through the restorative justice process.

8.166 Jacob met with the probation service, supported by his YPA, on 6 June. It was noted that he was very open about his drug use and mental health issues. Although the records do not record the reason for the meeting, it is assumed that it related to sentencing options for the Magistrate's Court.

8.167 On 14 June, Jacob was spoken to by the housing support and resettlement assistant due to his knocking on other doors asking for cannabis. There is no record as to whether a warning was administered but Jacob stated that he would not do it again.

8.168 On 17 June, Jacob was arrested for failing to appear at court for criminal damage offences and he was placed before the court. He was aggressive and abusive towards the officers. He was sentenced to an 18-month community order[31].

8.169 On 19 June, Jacob contacted his YPA whilst very distressed and clearly having a mental health crisis. He was threatening to kill himself and others at Beaufort House. SW Police records documented that Jacob had told officers on their attendance,

[31] A community order is a sentence that does not require imprisonment but enables the court to order the defendant to participate in certain activities intended to educate them and to reduce the risk of further offending. Those sentenced to community orders are subject to probation service supervision for the life of the community order.

that he had been hearing voices telling him to ‘go on a killing spree’. Arrangements were made for Jacob to be taken to Ward F at the NPT hospital to enable him to be assessed by the crisis team. Jacob was taken to the hospital by the officers who subsequently submitted a PPN form. The records do not specify which agencies this was shared with.

8.170 The SBUHB records show that Jacob was assessed by the CRHTT but no outcomes were recorded. It was noted within the records that Jacob was having thoughts about self-harm but was not planning to act on them. He discussed thoughts to harm others but these were due to frustration with people living in the shared accommodation.

8.171 On 20 June, Jacob attended Prince Philip Hospital with a cut arm but did not wait to be seen by a clinician. Later that day, Jacob contacted his YPA to inform him that he was now staying with his father as he did not wish to return to Beaufort House.

8.172 On 21 June, NPT Housing were contacted by Jacob who left a message saying he would no longer be staying at Beaufort House and did not want the property he had been offered at Caredig. It was also noted that Jacob’s case was allocated to a probation practitioner in the Swansea Probation team.

8.173 At 22:55 on 21 June, Jacob’s father contacted DP Police to report that his son Jacob had been released from hospital and was making threats to kill his brother, his family and to burn their house down. Jacob was arrested and interviewed under caution. A Domestic Abuse, Stalking and honour-based violence risk assessment, (DASH), was completed. Neither Matthew nor his mother, were supportive of a prosecution so no further police action was taken. DP Police also contacted the HDdUHB Crisis team whilst Jacob was in custody. Officers were signposted to services in NPT as Jacob currently resided in Beaufort House.

8.174 On 22 June, probation reallocated Jacob’s case to a probation practitioner in Carmarthenshire and a letter was sent to Jacob inviting him to an appointment at the Llanelli office on 24 June. It was noted that one of the identified tasks was to establish if there were any immediate risk issues.

8.175 On 23 June, NPT Social Services records documented that Jacob had moved back to Beaufort House.

8.176 On 24 June, Jacob attended a meeting with the probation service and agreed that he understood the requirement of the order. Later that day, NPT Social Services records report Jacob informed them that he had been involved in a fight with his father and that he had expressed a desire to have a fight with his brother and kill him. DP Police were called but there was no record of police involvement. When questioned by the YPA about the comment on killing his brother, Jacob said he was only 'kidding'.

8.177 On 28 June, Jacob did not attend an appointment for Mental health care. 4 attempts to contact him were unsuccessful. His YPA was informed.

8.178 In late June, agencies had contradictory messages from Jacob regarding his accommodation requirements. On some occasions he was happy to accept an offer from Caredig housing providers, on other occasions he was not. This carried on into July.

8.179 On 1 July, Jacob failed to attend a probation appointment for unpaid work and was issued with a first warning letter.

6.180 SW Police records for 2 July refer to DP Police informing them of the threats made by Jacob on 21 June. DP Police completed a DASH risk assessment, which they assessed as standard and shared this with SW Police, along with details of the threats made. SW Police spoke with Matthew and placed critical information markers on Matthew's then current address.

8.181 On 7 July, NPT Housing issued Jacob with an arrears letter. A visit to his room revealed more damage, this time to a ceiling tile and some plastic. Jacob admitted that he had 'lost it' the night before and caused the damage through frustration. The following day, Jacob was taken to view some housing options. Whilst he started in a positive mood, this changed and he asked to be taken back to Beaufort House.

8.182 On 11 July, Jacob failed to attend his probation appointment for unpaid work. Rather than a breach letter, a further warning letter was sent to Jacob on 14 July.

8.183 On 18 July, a probation practitioner visited Jacob. Jacob informed the probation officer that he had a good relationship with his mother and sister but not his father. He stated that he suffered with his mental health and would like to have counselling. He also said he had regular contact with his sister's children but no safeguarding enquiries were undertaken.

8.184 On 19 July, Jacob contacted the ambulance service, stating that his mental health was poor and that he had thoughts of burning down Beaufort House. He then calmed down and retracted his comments, recognising that this would not be a good idea. He did not want a mental health assessment.

8.185 The probation records for the same day, registered the fact that Jacob again failed to attend his appointment for unpaid work. The reason for not attending was accepted as Jacob was living in the Swansea area and the appointment was in Dyfed Powys.

8.186 On 20 July, the housing records noted Jacob's disclosures to their staff which indicated worsening mental health, speaking very negatively about family members including his brother. They updated the support officer and contacted the mental health crisis team. The CRHTT assessed Jacob later that day and their records suggest he was 'capacious' and understood the consequences of what had been said. They also commented on poor insight and on-going use of cannabis. Jacob was discharged for ongoing home treatment. NPT Social Services stated that Jacob was deemed to be able to keep himself safe. It was noted that social services supported Jacob whilst in hospital.

8.187 On 22 July, the SBUHB records detail a multi-disciplinary team meeting discussing Jacob's case. A decision was made for the occupational therapist, (OT), to make contact with him. Jacob was seen by the crisis recovery unit, (CRU), that day and it was noted that the medication was helping Jacob. He was also referred to the LPMHSS for therapy and agreed to be contacted over the weekend by the CRHTT.

8.188 Jacob did not answer his phone over the weekend but attended his appointment with the psychiatrist on 25 July. Jacob presented as positive and the psychiatrist had no concerns.

8.189 On 26 July, Jacob's case was transferred to another probation officer. A letter was issued in relation to an unpaid work appointment for 4 August.

8.190 The CRHTT attempted to contact Jacob by phone the same day but this was unsuccessful.

8.191 Jacob had CRHTT appointments that he attended on 28 and 29 July. Both appointments went well. On 31 July, CRHTT attempted to contact Jacob by phone but he did not answer the call.

8.192 That evening, DP Police stopped Matthew driving his car. Jacob was a rear seat passenger. Matthew was arrested on suspicion of drug driving; a blood sample was taken and he was released under investigation. Jacob was found to be in possession of a small amount of cannabis, no further action was taken with respect to this. The investigation with respect to Matthew was never finalised due to his death in September.

8.193 On 1 August, the NPT Social Services reported a pathway assessment where the fact that Matthew and Jacob were not getting on well, was identified. The record stated that Matthew had informed the YPA that 'there had been verbal arguments and threats of violence between them' and it was also recognised that Jacob had previously threatened to kill Matthew. Advice was given to both brothers to give each other some space for now. The minutes recorded the fact that there was no SW Police input to the assessment or invitation to SW Police to contribute to it.

8.194 The same day, probation staff had attended Jacob's address to transport him to his probation appointment but unfortunately, Jacob was not there. The probation staff telephoned Jacob. He was staying at his mother's address and could not attend the appointment. The appointment was re-arranged for 5 August.

8.195 Later the same day, DP Police recorded a domestic incident involving an argument between Matthew and Jacob with threats of violence made by Jacob. Jacob was removed to another address by officers. No actual offences had been committed and a DASH risk assessment was completed.

8.196 The same day, SBUHB records described a telephone call to Jacob from the CRHTT in which Jacob made strange comments, including alleging that Matthew was sleeping with his mother. Eventually Jacob calmed down and apologised. He denied using substances other than cannabis. An appointment was made with the CRU for 3 August and he was also advised to avoid contact with his family.

8.197 On the late evening of the same day, 1 August, SW Police were notified by the ambulance service that they had been called by Jacob as he was suffering a mental health crisis and had self-harmed. There was no mention of him harming others. SW Police officers subsequently took Jacob to Morriston hospital where, according to SBUHB records, Jacob was treated for self-harm injuries and discharged. There was no record of discharge planning or any safety plan being in place. SW Police officers submitted a PPN to share information with the mental health services.

8.198 On 3 August, Jacob was offered support from the staff at his accommodation but declined, saying he had appointments but could not remember the details. Jacob failed to attend his appointment that day with the CRU. The SBUHB notes referred to a telephone call being made to update social services.

8.199 On 4 August, Jacob failed to attend his unpaid work appointment with the probation service but attended his appointment with them on 5 August. He was described as engaging well. It was decided to transfer his probation case to Swansea and that the unpaid work commitments would be agreed by that probation office.

8.200 SBUHB recorded the fact that an OT visited Jacob on 5 August and later that day, a support worker made a further call to discuss referrals and the CRU appointment.

8.201 On 8 August, Jacob was supported to his crisis team appointment by his YPA. SBUHB medical records state that Jacob presented in good spirits but appeared to be under the influence of substances, something Jacob denied. They discussed ways that Jacob could improve his mental health. Jacob accepted this and expressed a desire for psychological

therapy[32]. Jacob was referred back to LPMHSS for psychological therapy and discharged.

8.202 On 9 August, Jacob was supported by housing staff to view other accommodation but after a short while, Jacob began to disengage and was not listening to what was said. Jacob's YPA assisted with getting food from a food bank and then collecting medication from a pharmacy. The same day, the probation service sent Jacob a letter to notify him of an unpaid work appointment on 16 August. It was noted that probation and other professionals had started informing Jacob's YPA of appointments to enhance his attendance record.

8.203 On 11 August, NPT Social Services were informed by an email from housing, that Jacob was unhappy with the flat he had been allocated.

8.204 On 16 August, Jacob was placed on the waiting list for LPMHSS following the referral from CRHTT. The same day, Jacob was suspended from receiving further unpaid work appointments by the probation service. There was no reason given for this decision.

8.205 On 17 August, Jacob informed staff at Beaufort House that being accommodated there was impacting on his mental health and he wanted to leave. He also asked for contact with the crisis team. The staff had already contacted them for him but provided him with the telephone number as well.

8.206 On 22 August, Jacob failed to attend a probation service appointment but Jacob's support worker contacted the probation office to explain the circumstances which were accepted. Another appointment, a home visit, was made for 24 August.

8.207 On 24 August, the probation practitioner attended Jacob's accommodation and met with him. Jacob was described as engaging and another unpaid work assessment was completed due to the transfer of the case to a new practitioner. A further meeting was planned for 13 September.

[32] Psychological therapies, sometimes referred to as talking therapies, are used to try and improve the service user's mental health, wellbeing or to change behaviours.

8.208 On 25 August, Jacob's probation case was re-allocated to a practitioner in Swansea.

8.209 On 30 August, DP Police responded to reports of a pedestrian on the M4 walking towards the traffic. Jacob was spoken to by DP Police officers and conveyed to what he gave as a home address in Ammanford. The following day, Jacob contacted staff at Beaufort House to inform them that he was staying at his mother's address.

8.210 NPT Social Services records for 2 September, recorded a visit to Jacob by his YPA. Jacob had argued with Matthew who wanted to return him to Beaufort House. The YPA offered to support contact with the crisis team if Jacob wanted this. The YPA also offered to register Jacob with a local GP to make it easier for him to access medical services.

8.211 Social services records also documented that Matthew was spoken to by phone the same day. He reported being fine and looking forward to returning to university.

8.212 On 3 September, the SBUHB records documented that Jacob was reviewed by the liaison psychiatry team at Morriston Hospital. He had been brought into the emergency department, (ED), by taxi, having attempted to hang himself with a bed sheet. He reported having stopped taking his medication the previous week. He was deemed to have poor insight into his drug use and its impact on his mental health. There was no evidence of psychosis and no thoughts of harming others. He was discharged with a further appointment booked for 9 September. There was no evidence of discharge/safety planning in the records provided to the review or of any information being shared with partner agencies.

8.213 On a day in early September, the housing provider reported that Jacob had a confrontational night. He told staff that he was fine now but had been hearing voices and needed to get out of Beaufort House. He was going to stay with his mother for a few days. The information was not shared with partner agencies.

8.214 Matthew was due to meet with his YPA that day but cancelled as he was busy.

8.214 Later that day, DP Police officers attended Jacob and Matthew's mother's address where Matthew was found deceased and Jacob was arrested for the homicide.

9. Findings and Analysis

There were a number of themes identified by the review throughout the extensive contact that Jacob, and to a lesser degree, Matthew, had with services. It is recognised by the panel that the report focusses significantly on Jacob as the perpetrator of abuse in this case rather than the victim Matthew. Matthew was noted as having progressed well in his teenage and young adult years, this included securing a university placement. From the information available to the review, he did not need or appear to want, additional support as he was developing well without assistance. This resulted in limited relevant information being available to the review.

9.1 Adverse Childhood Experiences

Both brothers had been accommodated for most of their childhood years. After becoming subject of an interim care order in February 2008, they were made subject of a full care order in November that year. The concerns leading to this related to neglect and their mother's substance misuse, chaotic lifestyle and inappropriate relationships. Professionals believed that the brothers' parent's relationship was an abusive one, with the children witnessing the domestic abuse and being exposed to adults using illicit substances in their presence.

Adverse childhood experiences, (ACEs)[33], have been described as potentially traumatic events in a child's life that can have a negative, lasting effect on their health and well-being in later life. This includes maltreatment, abuse and living in an environment that is harmful to their development. ACEs can affect the developing brain, immune and endocrine systems. Due to the high level of stress in their environment, children who experience adverse events are more likely to develop behaviours that are

[33] O'Neil RS et al, Adverse Childhood Experiences, INTCAR, https://doi.org/10.1016/j.intcar.2021.100062

harmful to health such as smoking, use of illicit drugs, alcohol or anti-social behaviour. This can then put the individual on a pathway to poorer adult health with a higher risk of diseases and mental health issues.

In both Jacob and Matthew's cases, they were exposed to an abusive and chaotic environment, witnessing abuse between their parents, drug taking, not only by their parents but also by other adults. The environment was clearly deemed by professionals as being harmful to their development as the care order was sought. It is reasonable to conclude that ACEs may have impacted on both Jacob and Matthew as they moved from childhood through later teenage and early adult years.

From the records made available to the review, there was evidence of this being identified at an earlier stage but limited evidence of a trauma-informed approach across the life-course, specifically in this case, during adolescence. The review did recognise the life journey work conducted with Jacob which is covered in section 7.2 of this report.

9.2 Early Support-Transition to Adulthood

The review looked at how NPT County Borough Council Child and Adult Services discharged its responsibilities for Jacob and Matthew through the 'pathway+ team. The role of pathway + is to support children looked after, (CLA), and care leavers, from the age of 16 up to the age of 25 years. From 16 years of age, the young person would have a social work practitioner allocated as a case owner, the responsibility passing to a YPA when they reach the age of 18 years. It was noted by the review, that in NPT, the YPA would meet the young person when they were 15.5 years old, enabling an early opportunity to build an effective relationship. This would appear to be good practice.

In both Jacob and Matthew's cases, the YPA was allocated and met with them at an early stage. It was noted that this period of support for Jacob coincided with the covid pandemic and the uncertainties and restrictions that accompanied this. The NPT Children's Social Services, (CSC), senior management also determined that no young person open to what is now pathway+, would be closed to services during the period of restrictions.

Whilst this impacted on staff workloads, it is recognised as good practice.

There is a requirement for six monthly assessments as part of the pathway+ process. In the brother's cases, CSC records demonstrated that this was adhered to. Although the meetings took place and were appropriately recorded, the attendance of partner agencies was limited and there was little information provided by some agencies working with Jacob, i.e., no mental health assessments or feedback from therapy and counselling sessions. This may have been a missed opportunity as there were occasions where SW Police and SBUHB health teams may have been able to provide relevant information.

The panel noted that once Matthew and Jacob were legally adults, both were deemed to have capacity, and in the absence of any specific safeguarding concerns, the brothers dictated which agencies were involved in their pathway+ assessments and subsequent pathway+ meetings. Having turned 18, it is right that the adult should drive their pathway+ plan but, in Jacob's case, this may have masked care and support needs, and potentially, safeguarding issues. Could there be a need to develop a greater synergy between the pathway+ team and the response more frequently elicited across adult social care for those with care and support needs? The review noted that the NPT Local Authority is currently reviewing its response to adolescents, including transitional safeguarding.

Life story work means telling the story of a child's life history to enable the child to understand their past. All looked after children should have the opportunity to be engaged in building life story records which represent a realistic and honest account of their circumstances, their family, identity and an age-appropriate understanding of their journey into and through care. This work can be started at a young age, in an age-appropriate way, taking into account their level of emotional development. The child's allocated social worker would have overall responsibility for coordinating life story work.

In Jacob's case, the initial request for life story work to be commenced was made by the looked after children team in December 2014 when Jacob was 12 years old. It was not

commenced until July 2018, shortly before Jacob turned 16. The social worker who led on this work has left the authority and the records have limited information about the cause of this delay. The records were also light on information about the discussions that took place during this work and how others were engaged in the process, including education, foster carers and family members. The review noted that the pathway assessment for Jacob, completed on 22 August 2020, recorded that '*Jacob has an awareness of his life story as life story work has been completed with him and he has a life story book.*'

The scope of the review started after Matthew had left school, but it is clear that Jacob's behaviour, and performance at school, deteriorated in 2017. This coincided with Jacob's apparent use of illicit substances, alcohol and the breakdown in his long-term foster placement.

The panel considered the potential impact of the punitive approach taken by the foster carers at this time in response to Jacob's use of alcohol and illicit substances. The reaction to Jacob's early use of alcohol and substance misuse would suggest an intolerance to such behaviour as opposed to adopting a more supportive, trauma-informed approach. This may indicate views held by the foster carers that have been formed through life experiences about those who misuse substances/alcohol. There may be a need to ensure that the background and experiences that foster carers bring to the role are considered in supervision sessions with the fostering team, with foster carers having training in providing a trauma informed response in such circumstances.

It was clear to the panel that there was significant support for Jacob during this period from NPT CSC. This included home visits, short respite breaks and a prevention referral to NPT Youth Justice. A Youth Justice case worker was appointed, a brief screening exercise was conducted and an intervention plan agreed with Jacob and the foster carers. It was noted that the screening was very limited and the intervention plan was not clearly laid out. Youth Justice closed their file with respect to Jacob in July 2017. NPT CSC continued to provide additional

support but concerns about Jacob's behaviour continued, with substance misuse being a specific concern.

Although Jacob's behaviour continued to deteriorate, a decision was made in late 2017 to continue with his supervised contact with his mother. Matthew appeared to have no issues with his mother and a LAC review recorded an intention to explore unsupervised contact for Jacob with her. There was no link made by practitioners with respect to Jacob's continued substance misuse and his contact with his mother, a known long term drug user. This is covered further under the substance misuse sub-heading.

It was also noted that Jacob received significant support from his Llamau support worker, who from the available records, clearly worked closely with his YPA, to provide a range of support for Jacob. The records also suggested a good level of information sharing between the Llamau support worker and the YPA.

Although there was significant support in place for Jacob, his behaviour remained challenging during 2018-2019, which is well recorded. There was no recognition by NPT Social Services of how this contrasts with the progress Matthew was making. He appeared to be thriving at university, and consideration could have been given to how this might create a dynamic between the brothers. NPT Social Services have invested in training for practitioners who work with siblings to try and maintain a healthy sibling relationship. However, this work is focused on a younger cohort of children and does not appear to cover difficulties that may arise between siblings during adolescence. It was also recognised that the use of chronologies was a useful tool when dealing with complex cases but they were not used at an individual or multi-agency level. The use of chronologies may lead to more informed supervision sessions and potentially more effective interventions. It could also have helped practitioners to have a better understanding of the presenting issues.

9.3 Substance Misuse

It is clear from the records of agencies who had contact with both Matthew and Jacob, that both of the brothers used illicit substances, primarily cannabis. Whilst there were less recorded

incidents involving Matthew and the misuse of substances, it is a common theme with Jacob from his later years at school, through college and up to the death of Matthew in September 2022. What is less clear, were the steps taken to try and address Jacob's substance misuse.

The regular use of cannabis, especially high potency cannabis, is strongly linked to the risk of developing psychosis. Research looking at cannabis use and causal links to the development of psychosis[34] concluded, from information drawn from 11 sites across Europe, that people who used cannabis on a daily basis were three times more likely to have a diagnosis of first episode psychosis. This ratio increased to five times more likely for those cases involving the use of high potency cannabis.

Jacob was recorded as misusing substances at school and then at college. As previously discussed, the foster carers took a very punitive approach to Jacob's apparent misuse of illicit drugs and on occasions, alcohol, rather than seeking to employ a more trauma informed approach. This made the placement more challenging and led to a breakdown in his relationship with the foster carers.

The records clearly show information regarding Jacob, and on occasions, Matthew, was shared with professionals. In March 2019, the SBUHB recorded a LAC review health assessment with Jacob where he denied using cannabis anymore and he declined to be referred to specialist support services. Shortly after this, Jacob was arrested for possession of drugs whilst at school. Whilst NPT CSC do not have a record of a SW Police report being received, Jacob was referred to NPT Youth Justice team who carried out a risk assessment with Jacob. He was assessed as being at low risk of causing serious harm to others but at medium risk of reoffending. He appeared before the Neath Youth Bureau in July that year, there was no criminal justice outcome but Jacob did attend a one-off drugs awareness session. There was no record of any further follow up on this.

[34] **'The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI; a multicentre case-control study**' by Di Forti et al, the Lancet Psychiatry, DOI:10.1016/S2215-0366(19)30048-3

Throughout the early months of 2020, there was significant information about Jacob's drug use, primarily cannabis, but at a LAC review health assessment, carried out by phone due to the covid restrictions in place, Jacob denied using illicit substances. This continued throughout the year, resulting in Jacob admitting to regularly using cannabis but again declining a referral for support from WCADA. On the 5th of November that year, SBUHB records documented that Jacob again declined a WCADA referral for support during his final LAC review health assessment. As Jacob had turned 18, he no longer qualified as a LAC so his LAC file was closed.

Later that month, having been admitted to hospital A&E feeling unwell, hospital records suggested that Jacob had been misusing drugs. He was discharged with an advice leaflet and contact details for WCADA. There was no evidence that Jacob made any contact with these services. It was noted that two days later, Jacob was again taken to hospital having become ill in his supported lodgings. He admitted taking amphetamine and Ketamine as he wanted to overdose. When discharged, he was picked up by his father and did not return to the supported lodgings. The support worker tried to contact Jacob by phone without success and it was only when the support worker intimated that she would report Jacob as missing that he made contact using his mother's phone.

Although the drug misuse by their mother, father and their associates had been identified whilst the brothers were very young, and indeed played part of the decision making that led to them being subject to care orders, there is limited recognition of the drug related risks posed by the brothers' contact with their mother and father as they approached adulthood. On 14 February 2022, NPT Social Services records referenced the fact that Jacob, Matthew and their mother were all misusing cannabis. Despite the apparent risk and the significant level of information relating to Jacob's misuse of drugs, there appeared to have been little planning to address this risk other than offering a referral to drug support services that Jacob declined on each occasion.

The panel noted that there were no legal powers to enforce co-operation with services offered but there were other options that could have been explored. One consideration may have been involving WCADA in the pathway+ meetings, to create a more joined up approach. This could have resulted in the pathway+ meeting developing a clear plan to address Jacob's substance misuse so may have been a missed opportunity.

9.4 Mental Health

There are a number of concerns raised about Jacob's mental health which seemed to deteriorate in the period before Matthew's death, which rightly resulted in referrals to mental health services. There was little evidence of those mental health assessments providing feedback to support any joined-up risk assessments or risk mitigation planning. Although the medical records suggested that there were proposed interventions arising out of the mental health assessments, there was very limited evidence of any assessment of outcomes.

The review identified the fact that the records of individual agencies provided conflicting views of Jacob's engagement with mental health services, and in particular, counselling and therapy meetings. It would appear that Jacob was reporting to his YPA and support worker that interventions were working well, yet the health records show a significant level of 'did not attends' and little or no assessment of the outcomes of these interventions. This may reflect the importance of a more joined up approach and the provision of feedback to support cross agency risk management.

Professional curiosity is widely recognised as helping practitioners avoid making assumptions about people's life style, the decisions they make and the risks they pose to themselves and others. In Jacob's case, the assessments carried out appeared to take information provided by Jacob at face value with very little evidence of professional curiosity to better understand the risks that Jacob posed both to himself and to others.

An example of this is highlighted in August 2022, when Jacob was admitted to hospital after experiencing a significant mental

health crisis and self-harming. The SBUHB assessment records did not include any exploration of the nature and content of the auditory hallucinations or their impact on risk and protective factors to minimise that risk. In addition, Jacob did visit his family whilst being supported by the CRHTT, which may have triggered the episode of deliberate self-harming. Although the injuries were superficial, his actions would suggest a level of impulsivity due to emotional dysregulation[35] which had been present earlier in the day when the CRHTT staff had contacted Jacob by phone. The notes do not reflect exploration of risk to himself or to others at that time, despite the fact that Jacob was expressing high levels of anger towards his family together with possible sexual preoccupation and persecutory ideation. The assessment notes provide little evidence of these issues being explored in any depth or any risk mitigation being considered.

Whilst Jacob's main residence was within the SBUHB area, he regularly stayed with family members, primarily his mother's address which is covered by HDdUHB. Whilst the HDdUHB record no contact with Matthew, Jacob had contact with a GP on a couple of occasions in 2022 and then the Crisis team when he suffered a mental health episode in April 2022. The contact with the GP in April 2022 resulted in a prompt referral to the crisis team who saw Jacob later the same day. The crisis team carried out an assessment and discussed a safety plan with Jacob. This included home treatment by the NPT CRHTT after having confirmed Jacob's plans to return to accommodation within that area. Whilst the clinical decision making and the discussion with Jacob regarding a safety plan would appear to be of a good standard, there was no evidence of safeguarding considerations, risk assessment or risk mitigation planning with respect to risk of harm to others, particularly his mother.

9.5 Probation Supervision

On 25 May 2022, a pre-sentence report was requested by the Swansea Magistrates Court with respect to the forthcoming sentencing of Jacob. The hearing was set for 17 June 2022. The report was completed promptly with the relevant engagement

[35] Emotional dysregulation is characterised by an inability to flexibly respond to and manage emotional states, resulting in emotional reactions that deviate from social norms.

and its recommendations were supported by Jacob himself. He was subsequently sentenced to an 18-month community service order and thus, was subject to probation service supervision.

The review has established that all of the appropriate checks, including domestic abuse checks, were conducted as part of the pre-sentence report information gathering in line with good practice.

On 15 July 2022, the probation service prepared an initial sentence plan. This included an assessment of risk of harm and further offending, which, based on the information available, assessed Jacob as being at medium risk in both categories. The basis of the medium risk assessment was his current wellbeing, his needing input from mental health services and having difficulty in managing conflict pro-socially. The probation service were not sighted on either the threats made during the mental health episode that Jacob had in April 2022 or the threats to kill members of his family in June that year.

Whilst there is an expectation that a risk assessment is reviewed when there is a change of circumstances, which would also be an opportunity to re-assess the risk management plan, there was no review of the risk assessment with respect to Jacob between the initial assessment and the death of Matthew in early September 2022. As Jacob moved between the Swansea area and Dyfed-Powys, good practice under the existing transfer policy, would have been for a review of the risk assessment to have been conducted. During such a review, domestic abuse and safeguarding checks are required to inform the risk management plan. As there was no review, and therefore no domestic abuse checks carried out, the probation practitioner was unaware of the incident in June 2022, (the day after his court sentencing), where Jacob made threats to kill and commit arson towards his mother and brother. Knowledge of this information would have significantly changed the risk assessment, initiating risk mitigation and safeguarding planning.

Although Jacob's case was initially allocated to a qualified probation officer, his case was reallocated to a probation service officer without a clear rationale for this decision to evidence its suitability. The full complexities of this case were not fully

considered because the full information was not available. A probation officer is someone that has achieved a specific qualification and has experience in working with individuals that present with complex needs, circumstances and risks. They will have enhanced skills and experience in the assessment of risk and developing risk management plans. A probation service officer will have completed the necessary training to enable them to assess and manage individuals who present a low-medium risk of serious harm. They would be less experienced in the assessment and management of individuals who have complex needs. They will have completed the necessary domestic abuse and safeguarding training.

During the initial start of the community service order, there was a lack of clarity with respect to Jacob's intended address and therefore, which probation office would have the supervision responsibility for Jacob. It is good practice to confirm an individual's address at the sentence stage to avoid delays and to provide early clarity regarding the local authority area responsible for the case. The review noted that the probation service has now introduced a transfer policy where cases are tracked when moving areas. The new process will highlight relevant cases and ensure that senior managers have oversight and can intervene, where a case is not accepted in the receiving area within 20 working days.

It is also clear that although Jacob was only under probation supervision for a short period of time before the commission of the homicide offence, he missed a number of appointments; this included the appointments to participate in his initial sentence plan and all of his unpaid work appointments. Enforcement action was commenced but this did not result in breach action being undertaken. Jacob was suspended from further unpaid work appointments which is in line with policy for those who miss three unpaid work commitments.

9.6 Identifying and Referring Domestic Abuse

The review considered the issue of domestic abuse training as a key element of enabling front line practitioners to identify the risk of domestic abuse in service users. It was clear that each of the agencies involved in this review have policies, and provide

training for staff, relating to domestic abuse. It was noted that the level of domestic abuse training staff had received was not consistent system wide.

Although agencies reported a number of disclosures from Jacob relating to thoughts of harming family members, particularly during the six months prior to the homicide offence, there were few, if any, referrals raising domestic abuse concerns. This includes incidents in April, May and early June where Jacob's mental health was deteriorating. He described feelings of anger and disgust about his family and talked about having thoughts of killing people and over sexualised thoughts about his mother. Whilst there was some limited sharing of information between agencies, this was inconsistent, with no evidence of the threat of domestic abuse being identified. Primarily, agencies sought to deal with issues raised in silos rather than in a co-ordinated manner and without any one organisation taking ownership of managing the risk of harm that Jacob presented, both to others within his family or indeed to himself.

The panel also considered the issue of sibling related domestic abuse and whether front line practitioners would have the skills and knowledge to identify threats of harm to siblings as domestic abuse. Panel members described a generally good understanding of domestic abuse across their front-line practitioner teams, particularly where it relates to intimate partners. It was widely accepted that there was less understanding of sibling related domestic abuse which is relatively rare in terms of reported domestic abuse. Whilst untested, it is highly likely that practitioners would not have identified the risk that Jacob presented to family members, particularly his brother, as domestic abuse. This may explain the limited number of referrals.

On 21June, DP Police received a report of Jacob making threats to kill his brother, his family and to burn their house down. This was witnessed by Jacob's father. Jacob was arrested and interviewed but as his mother and brother did not wish to support a prosecution, no further action was taken. The incident was correctly identified as a domestic abuse allegation and a DASH risk assessment was carried out, deeming this to be a standard

risk assessment. It was noted by the review that the DASH risk assessment recorded that there was no information provided, each question was shown as ‘refused’. There is no record as to what information was considered in determining this as standard risk.

Assessing these threats to kill family members as standard risk is an issue of concern to the review. Jacob was an individual who had significant mental health concerns, had disclosed to a number of practitioners that he had thoughts and/or desires to cause harm to family members and others, expressed anger about his family, and was abusing substances on a regular basis. Whilst there are a number of objective elements to the DASH risk assessment, there is also room for professional judgement. If the relevant information was not immediately available, a greater degree of professional curiosity could have secured available information to enable a better understanding of the risk Jacob presented. It is likely that a decision maker, with an understanding of all of the available information held by safeguarding partners, would have assessed Jacob as presenting a high risk of harm to his family members. This would have led to Jacob being considered at a multi-agency risk assessment conference meeting, (MARAC), ensuring appropriate information sharing between relevant agencies and more effective risk assessment and risk management planning. The review considered this to be a significant missed opportunity to put a cross-agency response in place to better mitigate the risk of harm to others.

Whilst information relating to this incident was passed to SW Police, for safeguarding purposes, clearly, the likely victims of domestic abuse resided in the Dyfed-Powys policing area. As previously described in this report, other key agencies, particularly the probation service, were unsighted on this incident and this significantly impacted on their risk assessment for Jacob’s supervision.

9.7 Information Sharing

The sharing of information between agencies to enable a more complete understanding of Jacob’s care and support needs and

the risks he presented both to others and to himself were key issues throughout the review.

Although the pathway+ assessment meetings were held appropriately, the CSC records suggested that there was little information provided by some of the agencies working with Jacob to support the process. The police and health teams may have been able to provide relevant information. This might have included mental health assessments and feedback from therapy and counselling sessions. Jacob's engagement with the counselling and therapy interventions was inconsistent, yet agencies accepted Jacob's account of sessions without challenge as there was no cross-agency information sharing.

There was a significant amount of information relating to Jacob's substance misuse in the first half of 2020 but limited evidence of effective sharing of the information between agencies or of any cross-agency risk management planning. The LAC review health assessment completed in that period, recorded that Jacob denied using substances and declined an offer of a referral to WCADA. There was no record of information being provided by partner agencies or of Jacob's denials being challenged.

There were a number of concerns raised about Jacob's deteriorating mental health in the months before Matthew's death and these concerns rightly resulted in referrals to mental health services. The records of individual agencies however, provided little evidence of information sharing between agencies. The review particularly noted that there was no feedback to support any joined-up risk assessments or mitigation planning. The lack of information sharing about the outcomes of the assessments and the interventions utilised, also led to Jacob being able to mislead his YPA and support worker into believing that these interventions were working well, when in reality, Jacob's engagement was, at best, limited.

The lack of information sharing had an impact on the risk assessment carried out by the probation service in July 2022 as part of their initial sentence plan. Whilst the issues about the need for the probation service to pro-actively seek information from partner agencies has been covered under section 9.5 of this report, it is important to reflect on the fact that other

agencies held information that, had the probation service been sighted on it, would have led to them revising their medium risk assessment to one of high risk. The review would specifically identify the threats made by Jacob during his mental health episode in April 2022 and the threats to kill members of his family in June the same year. The latter threats being made whilst Jacob was under probation service supervision.

Whilst there were incidents in April, May and early June where Jacob's mental health was deteriorating and he expressed feelings of anger towards his family, thoughts of killing people and over sexualised thoughts about his mother, it is the incident on 21 June 2022 that perhaps highlights the impact that limited information sharing had on the ability of agencies to identify and mitigate the risk that Jacob presented. Jacob made a clear threat to kill members of his family and to burn their house down, reported to the DP Police by his father who witnessed the making of these threats. The DP Police decision makers were not sighted on relevant information relating to previous incidents when they assessed the risk that Jacob presented and they made a decision that the threshold for MARAC was not achieved. Information was not proactively shared with partner agencies even though Jacob was under probation service supervision. Whilst the review identified concerns about the decision-making process with respect to the DASH risk assessment and the decision not to hold a MARAC, these are examined under section 9.6 of this report. The review does reflect on the fact that this was a missed opportunity to bring agencies together to effectively share information, risk assess and to put in place a coordinated, cross agency, risk mitigation plan.

In Jacob's case, with better information sharing, the social services would have been aware of police, probation and mental health interactions with him. The probation service would have been sighted on the domestic abuse issues, including the threats to kill in June 2022, and the police would have had access to a more detailed history which may have enhanced their understanding of the risk that Jacob presented. As the panel rightly observed, had the many interactions services had with Jacob been visible at the time, this could have prompted

professional curiosity and initiated significant information gathering to support risk assessment and decision making by front line practitioners.

As well as considering the challenges in sharing information between the agencies working to support Matthew and Jacob, and to manage the risks that Jacob presented, it is also important to consider current initiatives that may make cross agency information more effective.

The multi-agency safeguarding tracker, (MAST), is an information platform that enables partner agencies to securely share headline data, under pinned by an agreed information governance structure. Each safeguarding partner provides headline data only, (no case data). The information is subsequently turned into intelligence to support safeguarding activities at the tactical level and to promote professional curiosity. It could also be used for other purposes such as reporting, analysis and strategic planning.

The panel noted that having successfully completed the proof-of-concept stage, MAST is due to be deployed 'live' in the spring of 2024.

10. Conclusions and Recommendations

10.1 Matthew and Jacob were both exposed to significant ACEs, at a very young age. This included an abusive and chaotic environment, witnessing abuse between their parents and drug abuse, not only by their parents but by other adults, resulting in both boys being accommodated under a care order. The impact of these potentially traumatic events in a child's life are widely recognised in recent research. There was evidence of this being identified at the time but no evidence of early intervention considered with respect to either child. The review noted the more trauma informed work at a later stage.

10.2 Life story work with accommodated children is seen as good practice and this work was carried out in Jacob's case. In practice, this is work that can be started in an age-appropriate manner with children from a young age. It was noted that in

Jacob's case, although the work was initially flagged to be undertaken in 2014, when Jacob was 12 years of age, the records suggested that it was not commenced until some four years later in 2018. The records provided limited information on the work carried out or who, if anyone, was engaged in this work. Good practice would suggest that life story work, where carried out effectively, is more than simply sharing their history with a child but rather, an opportunity to reconcile relationships, form deeper bonds and to support healing. The commencement of such work with a child on the 'cusp' of adulthood and the transition through adolescence, would not align with best practice. It was also noted that there was no evidence of the life story work being communicated to the wider support network, including partner agencies who may have had some input or needed to understand the impact on their role.

Recommendation 1

NPT CSC should review the design, delivery and timelines for life story work with a particular focus on:

- Commencing the work in an age-appropriate manner at a younger age.
- Which agencies, or who from the wider support network, should be involved with the life story work or have some input.
- How the life story work is communicated with relevant partners or support network members.

10.3 The review considered how NPT CSC and ASC discharged its responsibilities for Jacob and Matthew through the pathway+ team. There was clear evidence of good practice noted with the YPA being allocated and meeting with both boys at an early stage, enabling an early opportunity to start building an effective relationship. It was also noted that within CSC, a management decision was taken that no young person open to them would be closed to services during the covid restriction periods. This was also recognised as good practice by the review.

10.4 The records suggest that the pathway+ six monthly assessment meetings for both brothers took place appropriately. It was however, noted that there was limited attendance from partner

agencies and little information provided by those agencies working with Jacob. It is recognised that once they reached eighteen years, and therefore they were legally adults, the brothers were able to dictate which agencies were involved with their pathway+ assessment meetings. However, there were opportunities, both before Jacob reached this age and afterwards, where consideration may have been given to the involvement of drug and alcohol specialist services to try and encourage Jacob's engagement with respect to his drug misuse. The ability of the young adult to 'drive' the pathway plan was rightly supported, as a result, the records of these meetings were important in terms of capturing other elements of what is happening in the young person's life. Clearly the care leavers have a right to privacy, but any safeguarding concerns would override that right. The mental health assessments and feedback from the therapy and counselling sessions could have added value to these assessments. There would also have been information held by the police which may have assisted those working with Jacob. This may require a greater synergy between the pathway+ team and the response more frequently elicited across ASC in terms of care and support.

10.5 The panel noted the challenges relating to both practitioner attendance at pathway+ meetings and their recording. Panel members felt that good information sharing between agencies, the support provided 'on the ground' to the young adult, and good record keeping to evidence this, was important. It was noted that NPT Local Authority is currently reviewing its response to adolescence, including transitional safeguarding.

Recommendation 2

As part of their ongoing review, NPT CSC should consider how wider partners can be encouraged to feed into pathway+ assessments to enable a more holistic understanding of the issues that the young person faces and a more effective response to meeting their care and support needs during adolescence and the transition to adulthood.

10.6 The scope of the review started after Matthew had left school but it is very clear that Jacob's behaviour and performance at school deteriorated in 2017, coinciding with his apparent use of illicit

substances and the breakdown of his relationship with his long-term foster placement. The panel considered the foster carer's reaction to Jacob's early use of alcohol and his drug misuse which appeared to be very punitive in approach. This might suggest an intolerance of such behaviour as opposed to taking a more supportive, trauma informed approach. The panel felt that this may have indicated views held by the foster carers that had been formed through life experiences about those who misuse substances or alcohol. This could identify a need to ensure that foster carers receive training in providing a trauma informed response to such issues and that views on this subject are considered during supervision sessions.

Recommendation 3

NPT CSC should ensure that the background and experiences that carers bring to the role are opened up for reflection during supervision sessions and that all foster carers are provided with training to enable them to be trauma-informed and trauma-responsive.

10.7 It is clear from the records made available to the review, that both of the brothers used illicit substances, particularly cannabis. Whilst there are less recorded incidents involving Matthew, it is a common theme with Jacob from the latter years at school through to Matthew's death in 2022.

10.8 The review period also coincided with both Matthew and Jacob having contact with their mother and subsequently, their father. Although drug misuse by their parents and their parents' associates when they were younger, was a key reason for Matthew and Jacob being subject to care orders, there is limited recognition of the drug related risks posed by the brothers having family contact as they approached adulthood. Despite the apparent risk and the significant amount of information relating to Jacob's misuse of drugs, and indeed that of other family members, there was little evidence of planning to address the risk other than offering Jacob a referral to drug and alcohol services which was declined by Jacob on each occasion. It was likely that drug use became 'normalised' for Jacob, particularly as his engagement with his family increased.

10.9 The panel noted that there are no legal powers to enforce co-operation with services offered but there were options that could have been explored further. Jacob had a history of not engaging with services following referrals, although with limited information sharing, this may not have been widely understood. Options could have included involving drug and alcohol services within the pathway+ meetings to try and create a more joined up approach, the pathway+ meeting could have developed a clear plan to address Jacob's drug misuse, or consideration could have been given to the use of substance misuse outreach workers to try to build a relationship with Jacob and encourage engagement.

Recommendation 4

Where the service user has multiple needs and there is evidence of significant substance misuse, agencies should ensure that front line practitioners understand that risk assessments should be based on effective cross agency information sharing and subject to a joined-up risk mitigation plan. This will mean one agency taking the lead, coordinating the information sharing, risk mitigation planning and then overseeing delivery.

10.10 There were a number of concerns raised about Jacob's mental health during the months preceding Matthew's death in September 2022. In each case, Jacob was able to access mental health services promptly following referrals. However, the assessments appeared to take the information provided by Jacob at face value with little or no evidence within the records of any professional curiosity to better understand the risks that Jacob presented, both to himself and to others. The example explored at section 9.4 within this report followed Jacob's self-harming in August 2022, just a month before Matthew's homicide. Despite the fact that Jacob was expressing high levels of anger towards his family, together with possible sexual preoccupation and persecutory ideation, the assessment notes provided little evidence of these issues being explored in any depth or any form of risk mitigation being considered.

10.11 The review also identified that although there were a number of referrals to mental health services with respect to Jacob, there was little evidence of assessment of outcomes or those

assessments providing feedback to support any joined-up risk assessment or risk mitigation planning. It was also noted that the records of individual agencies provided conflicting views of Jacob's engagement with mental health services, in particular the counselling and therapy meetings. Jacob informed his YPA and support worker that the interventions were working well yet the health records show a significant level of 'did not attends' and little or no assessment of any outcomes. The review would suggest that this demonstrates the importance of a more joined up approach through the provision of feedback to support cross agency risk management.

Recommendation 5

The health boards should satisfy themselves that front line mental health practitioners understand the need to use professional curiosity to explore the risks that an individual may present to themselves and to others.

Recommendation 6

The health boards should ensure that front line practitioners understand the need to keep accurate and detailed records of assessments and that feedback from those assessments is shared appropriately to better support cross agency, and where appropriate, cross border, risk mitigation planning.

10.12 In May 2022, Swansea Magistrates Court requested a pre-sentence report with respect to Jacob's court hearing set for 17 June. The report was completed promptly with all relevant checks being conducted in line with best practice. As Jacob was sentenced to an 18-month community service order, Jacob was subject to probation service supervision.

10.13 In July 2022, the probation service prepared an initial sentence plan in line with policy which required the practitioner to carry out an assessment of risk of harm and further offending. Jacob was assessed as being medium risk in both categories. This assessment of risk of harm and further offending should have involved cross agency domestic abuse and safeguarding checks being carried out but this did not happen. Had the checks been conducted, the probation service would have been sighted on the incident on 21 June 2022 where Jacob made threats to kill

and commit arson towards his brother and mother. The probation service accepted that knowledge of this information would have significantly changed the risk assessment, initiating risk mitigation and safeguarding planning.

Recommendation 7

The local PDU should ensure that risk assessments are reviewed with respect to individuals under their supervision, when circumstances change or where cases are reallocated across borders. This will include carrying out the appropriate domestic abuse and safeguarding checks to support the risk assessment process.

10.14 Jacob's case was a complex matter taking into account the fact that Jacob was sentenced in one area but living in another. The risk was not in the area in which he resided and he was not residing in the area in which the unpaid work was to be carried out. During the initial days of the community service order, there was a lack of clarity around which probation service region would be responsible for supervising Jacob. Good practice would suggest that an individual's address should be confirmed at the sentencing stage to provide clarity with respect to the local authority area responsible for the case. However, this did not happen when Jacob was sentenced. The panel noted that the probation service has now introduced a transfer policy that enables cases to be tracked when moving across regional boundaries. Importantly, this enables senior managers to have clear oversight of such cases and provide intervention if the case has not been accepted in the receiving area within 20 working days.

10.15 The complexity of the case, including the fact that Jacob was vulnerable in his own right with mental health issues, substance misuse and being a care leaver, resulted in its initial allocation to a qualified probation officer. However, the case was subsequently reallocated to a probation service officer without any clear rationale being recorded for this decision. Whilst the probation service officer will have completed the necessary training to manage cases of low to medium risk, the probation officers have the skills and experience to manage cases

involving individuals with complex needs. The review noted that the probation service recognised this as an error.

Recommendation 8

The local PDU should quality assure the implementation of the new transfer policy after an agreed period of time to satisfy itself that the policy is delivering the required quality of service and that it enables the appropriate level of senior management oversight of complex cases.

Recommendation 9

The local PDU should review its case allocation practices and the recording of related decision making to ensure that complex cases are managed by practitioners with the appropriate levels of skill and experience. Allocation decisions should be clearly recorded and auditable.

10.16 Identifying and referring domestic abuse concerns was a significant issue within this review. The panel considered domestic abuse training as a key element to equip front-line practitioners with the skills and confidence to identify the risk of domestic abuse in service users. It was clear to the panel that each of the agencies involved with the review have appropriate policies in place, and provide training for staff, relating to domestic abuse. It was however, noted that although training was available within each agency, the level of domestic abuse training staff had received was not consistent system wide.

Recommendation 10

The identified agencies should ensure that they have measures in place to ensure that practitioners complete domestic abuse and safeguarding training relevant to their roles.

10.17 During the six-month period prior to the homicide offence in September 2022, there were a number of disclosures made by Jacob to practitioners relating to thoughts of causing harm to family members that did not result in domestic abuse referrals being made. This included incidents in April, May and early June where Jacob's mental health was deteriorating. He described feelings of anger towards his family, thoughts of killing people and had over sexualised thoughts about his mother. Whilst there

was some limited sharing of information between agencies, this was inconsistent and there was no evidence of the risk of domestic abuse having been identified and acted upon. Agencies sought to deal with issues raised in silos rather than in a coordinated and joined up manner with the risk to others, in particular members of his family, not addressed.

10.18 The panel also considered the issue of sibling related domestic abuse and whether front line practitioners would identify threats of harm to siblings as domestic abuse. The IMRs, together with discussions at panel meetings, described a generally good understanding of domestic abuse at practitioner level, but this was really focused on domestic abuse between intimate partners. The panel agreed that there was less understanding of sibling related domestic abuse which is relatively rare in terms of reported domestic abuse. Whilst untested, it is the view of the panel that it was highly likely that practitioners would not have identified the risk to family members, particularly his brother, as domestic abuse and this may explain the limited referrals.

Recommendation 11

The identified agencies should satisfy themselves that frontline practitioners have the skills to identify the risk of sibling related domestic abuse and the confidence, and knowledge, to make referrals where appropriate.

10.19 On 21 June 2022, DP Police investigated allegations that Jacob had made threats to kill his brother and mother and that he also threatened to burn their house down. These threats were reported to DP Police by Jacob's father. The incident was correctly identified as domestic abuse related and a DASH risk assessment completed, albeit each question is marked 'refused'. The risk level was deemed to be standard.

10.20 The assessment of risk as being at 'standard level' for this incident was an issue of concern to this review. Jacob was an individual who had significant mental health concerns, had recently disclosed to practitioners that he had thoughts about causing harm to family members, expressed anger about his family and was known to be regularly abusing substances. During this incident, he had clearly made threats to kill his

brother and mother, as well as the threat to commit arson. If all of the relevant information was not available to the decision makers, a greater degree of professional curiosity could have secured the information held by safeguarding partners. With a more holistic understanding of the available information relating to Jacob, the panel believed that the risk of harm to Jacob's family members, specifically Matthew, would have been assessed at high which would have resulted in the risk Jacob presented being considered at MARAC. It is reasonable to conclude that this would have led to the appropriate sharing of information, a more effective risk assessment and an agreed and coordinated risk mitigation plan being put in place. This was considered by the panel as a significant missed opportunity, less than three months before the homicide.

Recommendation 12

DP Police should ensure that decision makers understand the need to obtain all relevant information when assessing the risk of domestic abuse and the importance of using professional curiosity to achieve this. This is all the more important in cases that involve the making of a threat to kill or cause serious harm in circumstances that would amount to domestic abuse.

10.21 The sharing of information between agencies to enable a more complete understanding of Jacob's care and support needs and the risks he presented both to others and to himself, was a key issue throughout the review. Practitioners had concerns about Jacob's substance misuse, mental health issues and the threats to cause harm to family members but the information was not always shared with other agencies effectively. This resulted in risk assessments and decision-making taking place without being based on all of the available information.

Recommendation 13

Each agency should ensure that they have the appropriate mechanisms in place to encourage practitioners to share or seek information to support risk assessments in relation to adults who they have concerns about, but who do not fit within statutory frameworks for information sharing such as MAPPA, section 126

Social Services and Well-being, (Wales), Act 2014 or other sharing requirements including MARAC.

11. Appendix 1: Table of Recommendations

No.	Recommendation	Theme	Agency
1	NPT CSC should review the design, delivery and timelines for life story work with a particular focus on: • Commencing the work in an age-appropriate manner at a younger age. • Which agencies, or who from the wider support network, should be involved with the life story work or have some input. • How the life story work is communicated with relevant partners or support network members.	Adverse childhood experience.	NPT Children's Social Care.
2	As part of their ongoing review, NPT CSC should consider how wider partners can be encouraged to feed into pathway+ assessments to enable a more holistic understanding of the issues that the young person faces and a more effective response to meeting their care and support needs during adolescence and the transition to adulthood.	Transition to adulthood.	NPT Children's Social Care.
3	NPT CSC should ensure that the background and experiences that carers bring to the role are opened up for reflection during supervision sessions and that all foster carers are provided with training to enable them to be trauma-informed and trauma-responsive.	Transition to adulthood.	NPT Children's Social Care.
4	Where the service user has multiple needs and there is evidence of significant substance misuse, agencies should ensure that front line practitioners understand that risk assessments should be based on effective cross agency information sharing and subject to a joined-up risk mitigation plan. This will mean one agency taking the lead, coordinating the information sharing, risk mitigation planning and then overseeing delivery.	Substance misuse.	System wide.
5	The health boards should satisfy themselves that front line mental health practitioners understand the need to use professional curiosity to explore the risks that an individual may present to themselves and to others.	Mental health.	SBUHB and HDdUHB.

No.	Recommendation	Theme	Agency
6	The health boards should ensure that front line practitioners understand the need to keep accurate and detailed records of assessments and that feedback from those assessments is shared appropriately to better support cross agency, and where appropriate, cross border, risk mitigation planning.	Mental health.	SBUHB and HDdUHB.
7	The local PDU should ensure that risk assessments are reviewed with respect to individuals under their supervision, when circumstances change or where cases are reallocated across borders. This will include carrying out the appropriate domestic abuse and safeguarding checks to support the risk assessment process.	Probation Service supervision.	Probation Service.
8	The local PDU should quality assure their new transfer policy after an agreed period of time to satisfy itself that the policy is delivering the required quality of service and that it enables the appropriate level of senior management oversight of complex cases.	Probation Service supervision.	Probation Service.
9	The local PDU should review its case allocation practices and the recording of related decision making to ensure that complex cases are managed by practitioners with the appropriate levels of skill and experience. Allocation decisions should be clearly recorded and auditable.	Probation Service supervision.	Probation Service.
10	The identified agencies should ensure that they have measures in place to ensure that practitioners complete domestic abuse and safeguarding training relevant to their roles.	Domestic abuse.	System wide.
11	The identified agencies should satisfy themselves that frontline practitioners have the skills to identify the risk of sibling related domestic abuse and the confidence, and knowledge, to make referrals where appropriate.	Domestic abuse.	System Wide.
12	DP Police should ensure that decision makers understand the need to obtain all relevant information when assessing the risk of domestic abuse and the importance of using professional curiosity to achieve this. This is all the more important in cases that involve the making of a threat to kill or cause serious harm in circumstances that would amount to domestic abuse.	Domestic abuse.	DP Police.

No.	Recommendation	Theme	Agency
13	Each agency should ensure that they have the appropriate mechanisms in place to encourage practitioners to share or seek information to support risk assessments in relation to adults who they have concerns about, but who do not fit within statutory frameworks for information sharing such as MAPPA, section 126 Social Services and Well-being, (Wales), Act 2014 or other sharing requirements including MARAC.	Sharing information.	System Wide.

12. Appendix 2: Terms of Reference

1. Background

1.1 On a date in early September 2022 police officers were called to an address in Ammanford, Carmarthenshire. The body of Matthew was found in the garden of the address. Matthew had suffered multiple stab wounds and a knife was recovered at the scene. Present at the address was the victim Matthew's mother, and his brother Jacob.

1.2 Jacob was arrested for murder and was subsequently charged and remanded in custody.

1.3 In June 2023, having previously entered a guilty plea to the offence of murder, Jacob was sentenced to life imprisonment with a minimum tariff of 18 years before he can be considered for parole.

1.4 In accordance with section 9 of the Domestic Violence, Crime and Victims Act 2004, a meeting of representatives from the Carmarthenshire Safer Communities Partnership, (SCP), including the Chair of the SCP, was held on 10 October 2022, it confirmed that the criteria for a DHR had been met.

1.5 The Home Office have been informed.

2. The Purpose of the DHR

2.1 The purpose of the review is to;

i. to establish the facts, and produce a comprehensive and balanced analysis of the information to inform organisational learning and influence change.

i. establish what lessons are to be learned from the domestic homicide of Matthew with regard to the way in which local professionals and organisations work individually and together to safeguard victims;

ii. 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;

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

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

v. identify potential gaps in service provision and/or potential barriers to accessing services;

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

vii. highlight good practice.

3. The Focus of the DHR

3.1 This review will establish whether any agency or agencies identified potential and/or actual domestic abuse that may have been relevant to the death of Matthew.

3.2 If such abuse took place and was not identified, the review will consider why not and how such abuse can be identified in future cases.

3.3 If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to assess risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and best practice. The review will examine how any pattern of domestic abuse was recorded and what information was shared with other agencies.

4. DHR Methodology

4.1 This review will be based on independent management reports, (IMRs), provided by the agencies that were notified of or had contact with Matthew or Jacob in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g., mental health, alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not had any direct involvement with Matthew or Jacob, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

4.2 The IMRs must be submitted using the approved templates current at the time of completion.

4.3 Each IMR will include a chronology, a genogram, (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and unsatisfactory practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will also provide context through including information relating to resourcing, workload, supervision, support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about Matthew or Jacob from 1 January 2017 to the death of Matthew in September 2022. If any information relating to Matthew as the victim or Jacob as the perpetrator, or vice versa, of domestic abuse before 1 January 2017 comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol or substance misuse, or mental health issues relating to Matthew or Jacob. If the information is not relevant to the circumstances or nature of the homicide, a brief precis of it will suffice.

4.6 Any issues relating to equality, for example disability, cultural and faith matters, should also be considered by the author of an IMR. If none are relevant, a statement to the effect that these have been considered must be included.

4.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR panel and an overview report will then be drafted by the chair of the panel. The draft overview report will then be considered at a further DHR review panel meeting before a final, agreed version is submitted to the chair of the Carmarthenshire SCP.

4.8 The report author will conduct relevant research and include lessons learned from previous DHRs where similar issues are identified.

Family Involvement

5.1 Engagement with the family of Matthew is an important part of this review. They will be given the opportunity to make a meaningful and effective contribution to the process and where appropriate, specialist support to enable them to fully engage with the review.

5.2 The chair will ensure that there is an effective communication strategy in place to keep the family informed, if they so wish, throughout the process, being sensitive to their wishes, support needs and any existing arrangements in place to do this.

6.Timescales, Report Author and Final Report

6.1 Home Office guidance requires the review to be completed within six months of the first review panel meeting, it is our intention to meet this requirement.

6.2 The report will be a transparent, honest and thorough analysis of the circumstances to inform learning and influence change as appropriate.

6.3 Any learning points will be considered and agreed by the review panel before being included in the final report and subsequent action plans. Should any urgent learning points or issues to be addressed be identified, they will be brought to the attention of the SCP Chair to enable sharing prior to Home Office approval of the final report.

6.4 The SCP Chair will send a copy of the final report, together with any action plan, to relevant agencies for comment before sign off and submission to the Home Office. Following Home Office approval, the SCP Chair will provide a copy of the overview report, executive summary and any action plan to the relevant senior manager of each participating agency.

6.5 The SCP Chair will send a copy of the final report to all relevant forums/stakeholders to share learning and where appropriate, influence priorities and work programmes.

6.6 The SCP Chair will publish the overview report and executive summary on the SCP website.

6.7 The SCP will be responsible for monitoring the delivery of any action plan in line with the guidance.

6.8 Subject to the recommendations of the review panel, the SCP Chair will hold a learning event if appropriate.

Parallel Reviews

7.1 The probation service have completed a serious further offence review with respect to their supervision of Jacob. The review lead will liaise with the Independent chair for this process and contribute to the DHR by sharing their findings.

Specific Issues to be Addressed

8.1 Specific issues that will be considered, and if relevant, addressed by each agency in their IMR are:

- Were practitioners sensitive to the needs of Matthew or Jacob, and were they knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to deliver against those expectations?
- Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment, (DASH), risk assessment and risk

management for domestic abuse victims and perpetrators? If so, were those assessments correctly used in the case of Matthew or Jacob? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective?

- Were Matthew or Jacob subject to MARAC, (Multi-Agency Risk Assessment Conference), or another multi-agency forum?
- Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?
- Were there missed opportunities for intervention? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in light of the assessments, given what was known or what should have been known at that time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they sign posted to other agencies?
- Was anything known about the perpetrator? For example, were they subject to MAPPA, (Multi-Agency Public Protection Arrangements), MATAC, (Multi-Agency Tasking and Coordination) or any other perpetrator intervention programme? Were there any injunctions or protection orders that were, or had previously been in place?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration of vulnerability or disability necessary? Were any of the other protected characteristics relevant in this case?
- Had Matthew or Jacob disclosed to any practitioners or professionals and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were senior managers or other agencies/professionals involved at the appropriate points?
- Did staff involved have the necessary skills and training?
- Are there lessons to be learned from this case relating to the way in which an agency, or agencies, worked to safeguard Matthew or Jacob and promote their welfare? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies or resourcing?
- Did agencies respond effectively to substance misuse by Jacob and Matthew? Were there missed opportunities to do more?

- Was Jacob a mental health service user and if so, were his treatment/support needs being met appropriate?
- How accessible were services to Matthew or Jacob?
- Did any restructuring take place during the period under review and if so, is it likely to have had an impact on the quality of service delivered?
- Did the covid pandemic impact on the services provided to Matthew or Jacob?

Confidentiality

9.1 All information discussed or shared through the Domestic Homicide Review is **strictly confidential** and must not be disclosed to third parties without the prior agreement of the SCP Chair/DHR Panel Chair—in line with the confidentiality agreement that panel members and other participating individuals will be required to sign.

9.2 All documentation should be marked **Confidential - not to be disclosed without the consent of Carmarthenshire Safer Communities Partnership.**

9.3 Each agency is asked to adhere to their own data protection procedures, including the security of electronic data.

9.4 The draft overview report will remain a confidential document until it is approved for publication by the Home Office Quality Assurance Panel.