

Domestic Homicide Review of the death of Matthew in September 2022

Executive summary

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Commissioned by:

Carmarthenshire Safer Communities Partnership

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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 assessment¹ 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 MARAC², (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?

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.

- Was anything known about the perpetrator? For example, were they subject to MAPPA³, (Multi-Agency Public Protection Arrangements), MATAC⁴, (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 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.

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.

- 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 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.

5. Equality and diversity

- 5.1 The report also 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 Equality Act duties, to assess if they were relevant to any aspect of this review. The equality and diversity considerations are recorded within section 5 of the overview report.
- 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.

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 of the review 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 AAFDA⁶ 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.
- 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

⁶ 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.

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 provide 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 physics concepts to design and create new ways which can help 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.

7. Background information

- 7.1 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.
- 7.2 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.

- 7.3 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.
- 7.4 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 GCSE⁷ level. There was no reference within the school records of poor behaviour. The school records suggested that prior to September 2017, Jacob was also a very capable pupil with only minor behaviour logs recorded.

8. Narrative chronology

2017

- 8.1 Neath Port Talbot CSC records documented a deterioration of Jacob's behaviour throughout 2017. There were a number of occasions where his use of alcohol or illicit substances, mainly cannabis, are recorded. Jacob's foster carers raised a number of concerns about his use of alcohol, drugs, poor behaviour and lack of respect for boundaries. Although support was provided by CSC, the foster carers requested a change of placement for Jacob.
- 8.12 The foster carers had reported that Matthew's behaviour was good and that he continued to progress well. Although there were concerns about Jacob's use of illicit substances, CSC determined that the boys' supervised contact with their mother would continue.

2018

- 8.2 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. Jacob made an allegation of assault against his foster mother. This was

⁷ General Certificate of Secondary Education, (GCSE).

subject of a professional abuse strategy meeting, (PASM)⁸, which determined that the allegation was not substantiated and that no further action was required.

- 8.21 Jacob's behaviour continued to deteriorate in November and December with CSC records documenting further concerns about his use of cannabis.

2019

- 8.3 In February, Jacob was excluded from school on two occasions, one relating to cannabis use. The Looked After Children⁹, (LAC), health review in March, documented that his health needs were being met. He was emotionally well but he had declined any specialist support regarding his cannabis use, telling practitioners that he had stopped using it.
- 8.31 Over the next few months, there were further concerns about Jacob's use of illicit drugs, this included his arrest having been found in possession of a white powder. The NPT Youth and Justice team assessed his risk of harm to others as low and his risk of reoffending as medium. Jacob attended a one-off drug awareness session as an outcome for his drug related arrest. The records show that Jacob was aware of the consequences of continued drug use.
- 8.32 In September, Matthew secured a place at Swansea University to study aerospace engineering. In October, Jacob enrolled on 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 declined any further support.
- 8.33 In October, concerns were raised about Jacob's low mood. He was subsequently referred to CAMHS¹⁰. However, on 18 October, Jacob was admitted to A&E, Morriston Hospital, having self-harmed. Jacob was subject of a mental health assessment and then discharged back to his placement. The NPT Social Services record stated that a safety plan was agreed. Advice and support was offered to the carers. There was no mention of this in the SBUHB records. Jacob continued to receive

⁸ A professional strategy meeting convened to consider safeguarding concerns made against a practitioner/person in a position of trust.

⁹ A looked after child is a child or young person who is being cared for by their local authority.

¹⁰ Child and Adolescent Mental Health Service.

CAMHS support through October and November. It was noted that Jacob had informed CSC that he was still using cannabis.

2020

- 8.4 During the early part of 2020, concerns continued to be raised about Jacob's attitude and cannabis use. CSC records documented that Jacob was involved in fights with other youths on at least two occasions, he continued to use cannabis, he was not motivated to attend college and he was having thoughts about self-harming. It was also noted that he was having more contact with his mother.
- 8.41 In March, Jacob was moved to another placement after his foster carers demanded he leave due to his drug use and poor behaviour.
- 8.42 The covid 19 restrictions commenced in late March, and although agencies, including CSC and CAMHS, maintained contact with Jacob, this was primarily by phone. In May, Jacob had a telephone appointment with CAMHS. He informed them that he felt mentally well and was discharged from their service. In the same month, he also withdrew from his college course. He had informed his social worker that he intended to apply to join the military.
- 8.43 In June, Jacob was given words of advice by Dyfed-Powys Police after making threats to assault a third party via social media. The victim of these threats did not wish to support a prosecution.
- 8.44 In September, Jacob enrolled on a new college course but later that month, the supported lodgings provider informed NPT Social Services that Jacob had not been attending his course and that when he did, he was under the influence of substances. A referral to specialist drug and alcohol services was discussed but declined by Jacob.
- 8.45 During October and November, there were further concerns reported with respect to Jacob's use of cannabis. NPT Social Services' records documented that Jacob was in a better mood but again, he declined a referral for drug and alcohol specialist support.
- 8.46 In late November, Jacob was taken to hospital on two occasions after using illicit drugs. On the second occasion, he informed staff that he had wanted to overdose on the drugs. When his support worker tried to contact him by phone after his discharge from hospital, Jacob was staying at his mother's address.

8.47 The six-week review meeting on 9 December, identified the main concerns being the delay in a mental health assessment and supporting Jacob in reducing his substance use. Later that month, Jacob was offered a referral to the early intervention psychosis¹¹, (EIP) service but Jacob declined to engage with them.

2021

- 8.5 In February, Jacob's supported lodgings provider informed the support worker that they had concerns about Jacob's mental health and his drug abuse. The information was shared with his social worker and the young person advisor, (YPA)¹².
- 8.51 The concerns about Jacob's drug use continued and in April, he was admitted to hospital following what the Swansea Bay University Hospital Board, (SBUHB), records document as a deliberate overdose. Jacob denied intending to take his own life and was discharged after three days. Jacob had also informed his support worker that he was spending more time with his mother and indeed, was staying at her address.
- 8.52 During May and June, the support worker recorded that Jacob was very positive about his engagement with the adult mental health team and his relationship with family members. It was noted by the review that the SBUHB records documented that Jacob was not attending his mental health appointments and, in early July, he was discharged from their service.
- 8.53 On 20 July, Jacob reported that he had been staying at his mother's address and had fought with his brother Matthew, resulting in Matthew having a black eye.
- 8.54 On 24 August, Jacob was discharged from the EIP service as they believed that there was no ongoing psychotic illness. Jacob was referred to the local primary mental health support service, (LPMHSS), Unfortunately Jacob did not respond to the attempts by the LPMHSS to contact him.
- 8.55 In September, Jacob was interviewed with respect to an offence of criminal damage to a previous foster carer's premises, he admitted the offence. After Jacob failed to comply with an out of court disposal

¹¹ 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.

¹² A YPA works closely with a young person, their carers and a range of agencies to support the young person's transition to adulthood.

resolution, he was summonsed to court where he admitted an offence of criminal damage.

8.56 In December, Jacob's support worker spoke to him by phone. He reported that he was staying at his mother's address. He stated that his mental health was good and that he was no longer engaging with services. He did admit to smoking cannabis at his mother's address.

2022

8.6 At a six-week review meeting in February, it was noted that Jacob was no longer engaging with mental health services. He was still visiting his mother but reported that he was not enjoying the visits as he had in the past.

8.61 Jacob was required to leave his accommodation placement due to his erratic, violent and abusive behaviour. The support worker noted that Jacob had spoken about issues with his family and their 'disgusting behaviour'. Another proposed placement refused to accept Jacob so a safety plan was put in place whilst he stayed at his mother's address.

8.62 Social services' records documented that Matthew, Jacob and their mother, were all using cannabis and staying at the same address.

8.63 On 15 March, Jacob failed to attend court with respect to an offence of criminal damage. A warrant was issued for his arrest.

8.64 On 5 April, Jacob had a mental health crisis. It was clear that there had been some form of falling out with members of his family. Jacob was taken to the Prince Philip Hospital. There had been a falling out within the family and Jacob could no longer stay with them. Jacob was assessed later that day. The Hywel Dda University Health Board, (HDdUHB), mental health records, documented that Jacob was expressing over sexualised thoughts about his mother. He had low mood and his mental health had been declining since he had returned to live with his mother. Jacob was discharged from the hospital with a plan to refer him for support and therapy from the Neath Mental Health Crisis Resolution Home Treatment Team, (CRHTT). Emergency accommodation was arranged for Jacob at Beaufort House which is in the Neath area. A safety plan was put in place and the CRHTT made contact with him the next day. During the rest of April, there was a significant amount of work undertaken by Jacob's support worker, the YPA and by NPT Housing, to resolve Jacob's accommodation issues.

- 8.65 Staff at Beaufort House recorded Jacob stating a desire to kill people and that he had had enough of his family. There was no record of this information being escalated to other agencies.
- 8.66 In June, Jacob appeared at court with respect to the outstanding criminal damage charge and his failing to appear at court. He was sentenced to an 18-month community order¹³.
- 8.67 On 19 June, Jacob had a further mental health crisis, he was threatening to kill himself and claimed to have heard voices telling him to 'go on a killing spree'. Jacob was assessed by the CRHTT but no outcomes were recorded. The records state that Jacob was having thoughts about self-harming but would not act on them.
- 8.68 On 21 June, Jacob's father contacted the Dyfed-Powys Police to report that his son, Jacob, was making threats to kill his brother and his family and to burn their house down. Jacob was arrested but as his mother and Matthew did not wish to support a police prosecution, Jacob was released from custody without being charged. A DASH risk assessment was completed and the risk assessed as 'standard'. Jacob was sign posted to services in NPT as he currently resided at Beaufort House.
- 8.69 Jacob attended his first meeting with the probation service on 24 June. This followed the re-allocation of his case to a probation officer based in Carmarthenshire. Jacob's engagement with the probation service was characterised by his failing to attend appointments, he received two warning letters with respect to non-attendance at meetings in July.
- 8.691 On 2 July, Dyfed-Powys Police inform South Wales Police of the incident on 21 June and the threats that Jacob had made to kill his brother. They also shared the DASH risk assessment. South Wales Police advised Matthew of the threat and put critical information markers on what was then Matthew's current address.
- 8.692 On 20 July, Jacob was again assessed by the CRHTT due to his worsening mental health. They assessed that Jacob understood the consequences of the comments he had made about his family. They

¹³ 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.

also commented on his poor insight and his ongoing use of cannabis. He was discharged for ongoing home treatment.

- 8.693 Matthew was arrested on 31 July whilst driving his car on suspicion of driving whilst under the influence of controlled drugs, a blood sample was taken and Matthew was released under investigation. Jacob was a passenger in the vehicle and found to be in possession of a small amount of cannabis. No further action was taken with respect to this.
- 8.694 On 1 August, NPT Social Services reported a pathway assessment that recognised that Jacob and Matthew were not getting on well and that Jacob had previously made a threat to kill Matthew. It was noted by the review, that South Wales Police had not been invited to contribute information to the assessment.
- 8.695 Later the same day, Jacob had a mental health crisis. This included his making strange comments about his brother sleeping with his mother in a telephone conversation with the CRHTT. He then self-harmed and was taken to hospital by South Wales Police Officers. He was discharged with no recorded safety plan or clear discharge planning process.
- 8.696 Throughout August, concerns were recorded about Jacob's drug use and his continued failure to attend probation service appointments. On 25 August, Jacob's case was re-allocated to a Swansea based probation officer.
- 8.697 On 3 September, Jacob had a mental health assessment at Moriston Hospital having attempted to hang himself with a bed sheet. He was assessed as having no evidence of psychosis and no thoughts of harming others. He was discharged with a further appointment planned. There was no recorded evidence of any discharge or safety planning, or any information shared with other agencies.
- 8.698 On a date in early September, Matthew was killed by Jacob at their mother's home address.

9. Key findings and recommendations

- 9.1 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. This resulted 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 completed at a later stage.

9.2 Life story work¹⁴ 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 but 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 suggest 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 is 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 Children's Social Care 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.

9.3 The review considered how NPT CSC and ASC discharged its responsibilities for Jacob and Matthew through the pathway+ team.

¹⁴ Life story work means telling the story of a child's life history to enable the child to understand their past.

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.

- 9.4 The records suggested 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 was 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. 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. The records of these meetings are important in terms of capturing other elements of what was 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.
- 9.5 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.

- 9.6 The scope of the review starts after Matthew had left school but it is very clear that Jacob's behaviour and performance at school deteriorated in 2017. This coincided 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 indicate 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.

- 9.7 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.
- 9.8 The review period also coincided with 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 was 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 is likely that drug use became 'normalised' for Jacob, particularly as his engagement with his family increased.

- 9.9 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.

- 9.10 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, but 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 the main 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.
- 9.11 The review also identified that although there were a number of referrals to mental health services with respect to Jacob, there is 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 documented a significant level of 'did not attend' 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.

- 9.12 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.
- 9.13 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, based on the information available at the time. 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 accept 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.

- 9.14 Jacob's case was a complex matter when 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 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.
- 9.15 The complexity of the case, including the fact that Jacob was vulnerable in his own right with mental health issues, substance misuse issues 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 would 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.

- 9.16 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.

- 9.17 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 when 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.

9.18 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 is 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 is 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.

9.19 On 21 June 2022, DP Police investigated allegations that Jacob had made threats to kill his brother and mother and he had 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.

9.20 The assessment of risk as being at 'standard level' for this incident is 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 relevant 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.

9.21 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. However, information was not always shared with other agencies effectively, resulting 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 don’t 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.

10. Appendix 1: Table of recommendations

| No. | Recommendation | Theme | Agency |
|-----|--|-------------------------------|-----------------------------|
| 1 | <p>NPT CSC should review the design, delivery and timelines for life story work with a particular focus on:</p> <ul style="list-style-type: none"> 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. | Adverse childhood experience. | NPT Children’s Social Care. |

| No. | Recommendation | Theme | Agency |
|-----|---|--------------------------------|-----------------------------|
| | <ul style="list-style-type: none"> How the life story work is communicated with relevant partners or support network members. | | |
| 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. |
| 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. |

| No. | Recommendation | Theme | Agency |
|-----|--|--------------------------------|--------------------|
| 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. |
| 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 don't 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. |

11. 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, a knife was recovered at the scene. Also 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 were informed of the intention to commission a DHR on 11 October 2022.

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 services 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 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.

5. 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.

7. 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.

8. 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 appropriately?
- 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?

9. 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.