Single Unified Safeguarding Review Report

On completion, this form must be published in accordance with the SUSR statutory guidance by the commissioning Safeguarding Board and where relevant, the Community Safety Partnership and then sent to the SUSR Co-ordination Hub. Do not send any photocopies to the Co-ordination Hub, the Report must be in its original format for inclusion in the Wales Safeguarding Repository

To be completed by the Reviewer:

1 Name of Safeguarding Board:

Cwm Taf Morgannwg

2 **Name of Community Safety Partnership**

Cwm Taf Community Safety Partnership

Name of Relevant Review Partners *(where an Offensive Weapons Homicide has occurred).* Delete if N/A:

- West Midlands Police Review Officer
- South Wales Police Review Officer
- West Yorkshire Police Review Officer
- Rhondda Cynon Taf County Borough Council
- Cwm Taf Morgannwg University Health Board
- Birmingham and Solihull Integrated Care Board
- Birmingham City Borough Council

SUSR Reference Number:

SUSR-2024-06/CTM

Pseudonym 1:
Steven

Pseudonym 2:
Person 1 – (P1)

Pseudonym 3:
Person 2 – (P2)

Pseudonym 4:
Person 3 – (P3)

Pseudonym 5:
Person 4 – (P4)

Pseudonym 6: Person 5 – (P5) **Pseudonym 7:** Person 6 – (P6)
Date of incident which led to the Review: If unknown, please state this. **Month: 12** **Year: 2023** **Or:** Choose an item.
Date of death (where applicable): If unknown, please state this. **Month: 12** **Year: 2023** **Or:** Choose an item.
Review's start date (commissioned): 19/02/2024 **Review completion date** 19/03/2025 **Publication date: 15/05/2025** *Explain any reasons for delay in completion (this should include any additional delays other than due to a criminal trial).*

3 Outline of circumstances resulting in the Review:

3.1 The referral was made in relation to an incident, where Steven was murdered in an altercation where a knife was used. It was considered that this incident should be treated as an Offensive Weapon Homicide (OWH) as the deceased was aged over 18 years and that his death was caused by an offensive weapon, namely a knife. This was determined by the circumstances of the incident combined with the supporting evidence and expert opinion.

3.2 Cwm Taf Morgannwg Safeguarding Board were approached by Welsh Government to pilot this review under the Single Unified Safeguarding Review (SUSR) process whilst also being guided by the Offensive Weapons Homicide Review (OHWR) Statutory Guidance . Both the Cwm Taf Community Safety Partnership, and the Cwm Taf Morgannwg Safeguarding Board were fully supportive of piloting this case under this methodology, with the aim to improve engagement with families and bring learning from reviews into action in the most effective way.

The criteria for this Review are met under:

- Offensive Weapon Homicide Review (OWHR) – to be completed in accordance with the Statutory Draft Guidance 2022.[1]
- Single Unified Safeguarding Review (SUSR) process 2024. [2]
- Police, Crime, Sentencing and Courts Act 2022[3]

Core issues to be addressed in the Terms of Reference of the review will include:

- To examine inter-agency working and service provision for individuals through defined Terms of Reference.
- To seek contributions to the review from the individuals and appropriate family members and keep them informed of key aspects of progress.
- To identify recommendations and learning for agencies.
- To produce a report for publication.
- To produce an action plan, to ensure recommendations are progressed.

4 Parallel Investigations

- A Coroner's Inquest has opened and is ongoing.
- There was a criminal investigation which has now concluded.
- No other internal agency investigations have been commissioned.

5 Agencies who Provided Information to the Review

- South Wales Police (SWP)
- West Midlands Police (WMP)

- West Yorkshire police (WYP)
- Birmingham Childrens Trust
- Birmingham & Solihull Integrated Care Board (BSOL ICB)
- Birmingham City Council – Education Safeguarding Team
- Birmingham City Council – Think Family
- Neath Port Talbot Council (NPTC) – Adult Services
- Cwm Taf Youth Justice Service (YJS)
- Rhondda Cynon Taf County Borough Council (RCTCBC) – Children's Services
- Rent Smart Wales
- Red Thread
- Social Housing
- Cwm Taf Community Safety Partnership
- Violence Prevention Unit
- Cwm Taf Morgannwg (CTM) University Health Board
- National Society for the Prevention of Cruelty to Children (NSPCC)
- University of South Wales (USW)

6 Family Tribute

A Tribute to our Son

First of all, I would like to say how difficult it is to express and put into words how we feel about our son. It is near on impossible.

He was 30 when he was brutally murdered, a young man with so much love, intelligence, and vitality. He was a true gentleman, with the biggest heart, and an infectious humour; he was funny and cheeky. He was a ray of sunshine, brightening up any room he was in, and wherever he went, everyone knew him. A popular young man, full of life, oozing charm and charisma and was very popular with the ladies. He was so kind and caring, and you couldn't help but to be drawn to his smile and good looks.

He loved his family dearly, not least his four children, who meant the world to him. He had his whole life ahead of him and he was determined to make a better life for him and his children and be the 'daddy' he longed to be.

He had his struggles and tried so hard to overcome these. Despite his best efforts, he paid the ultimate price in trying to manage his illness. His illness placed a tremendous strain on family at times. The good times were great, but the bad times were heartbreaking, in trying to access and provide him with the support he needed.

[1] Offensive weapons homicide reviews - GOV.UK

[2] https://www.gov.wales/single-unified-safeguarding-review-guidance

[3] https://www.legislation.gov.uk/ukpga/2022/32/contents

He was never 'work shy' and would always seek employment, unfortunately, due to job locations, he moved around and therefore struggled to maintain the support he needed in managing his illness. Furthermore, COVID came upon us and workwise, the hospitality industry shut down, impacting further on his ability to cope and manage.

He was undeniably one of the most genuine people you would ever meet, he wore his heart on his sleeve, with drive and determination and he always strived to better himself. He was desperate to work, but the 'system' did not allow this. Thus, meaning he had too much time doing nothing. He used the time wisely and embarked on gaining a 'personal training' qualification.

Following a meeting with the career's advisor, they advised it may be best to use his A-level in Aviation to follow his passion, and this led him to Wales where he commenced the Aircraft engineering course. He had big dreams, and his ambition and drive pushed him to achieve these, flourishing on his airline-engineering training course at South Wales University. He loved all things in and around aviation and was committed to his studies. Outside of University, unfortunately he struggled to deal with his illness and to source the necessary support he required.

We have heard stories of how he helped fellow students settle in at university, and how he played a key part in bringing people together and forming a cohesive friendship group. His university friends have sent us numerous messages of support, which we have appreciated, and many have shared stories and how he will be missed. We got a lot of comfort from this, they said his presence will be greatly missed, due to his heart of gold, lovely personality, and kindness. He would always go out of his way, checking everyone was okay and this is a testament to his character. Many students said how they miss his positive day to day impact, and was always invested, showing genuine care. He was empathetic, likeable and his loss has had a negative impact on students and tutors alike.

He, most of all, loved his family. He wanted to look after them, protect them and make them proud. He will never be forgotten by those that met him, and he is missed terribly. We will all remember him as a polite, well-mannered young man, with a big heart and a sense of fun. Most of all, he will be remembered with love, every minute, of every day.

We fully embrace this *'Offensive Weapon Homicide'* review and are committed in doing whatever we can to support others in a similar position to our son.

7 Case Background

7.1 This case is about Steven, but includes P1, P2, P3, P4, P5 and P6. Steven was from the Bradford area and had moved to Wales to study as a mature student living in a house of multiple occupancy (HMO) whilst studying at the University of South Wales (USW).

7.2 South Wales Police (SWP) attended a call transferred to them from Welsh Ambulance Service NHS Trust, just prior to 8pm on a Sunday in December 2023. A code red call came through that a 30-year-old male was not breathing, not conscious and had possibly been murdered. The phone call came from another resident at the HMO which Steven shared with four other adults.

7.3 Police officers attended Steven's place of residence, and he was observed to have multiple stab wounds in his thigh area, which caused significant bleeding. Officers did attempt to stem the flow of bleeding, but Steven lost his life because of the amount of blood loss.

7.4 The circumstances appear to be that Steven had a drugs debt and it is believed that P1, accompanied by P2 and P3, has gone to the address to collect the drugs debt and became embroiled in the incident. P4, P5, and P6 became involved following the incident when they assisted in making arrangements to transport P1 who had sustained injuries to hospital for medical treatment.

7.5 Six subjects of interest were arrested and charged in some capacity with the incident.

One Individual - Charged and convicted of murder.

Two individuals were - Charged with murder – acquitted of murder and manslaughter.

One individual – Charged with assisting an offender / perverting the course of justice – not guilty.

One individual – Charged with assisting an offender / perverting the course of justice – Guilty of assisting an offender. Not guilty of perverting the course of justice.

One individual – Charged with assisting an offender / perverting the course of justice – Guilty of perverting the course of justice. Not guilty to assisting an offender.

7.6 The postmortem findings of the Forensic Pathologist concluded that Steven suffered six stab wounds to the left thigh area.

The cause of death was a stab wound to the back of left thigh, involving Profunda Femoris Artery (the Profunda Femoris Artery provides the main supply of blood to the thigh).

8 Time Frame

8.1 This review covers the period from 18th August 2022 up to and including the date of death. This extends beyond the 12-month time period normally used within an SUSR. The decision to extend the time frame was made by the Review Panel to allow a full analysis of events and agencies involvement from the time of Stevens enrolment on to his chosen course at the USW.

9 Methodology

9.1 The first panel meeting took place on Thursday 11th April 2024. Panel members agreed the Terms of Reference (TOR) for the review. The TOR has been reviewed consistently by the panel throughout the process. In total the panel met seven times. Panel meetings were held both via Microsoft Teams and face to face meetings with all panel members, which fostered robust and analytical discussions contributing to the review process.

9.2 The methodology took cognisance of the process contained within the SUSR Guidance and the Home Office Offensive Weapon Homicide Review Draft Statutory Guidance.

9.3 All agencies were asked to provide an analytical timeline of their agency's information within the specified time frame. In addition, summaries in relation to significant events outside the timeline were also completed and submitted, these allowed the Review Panel to have a clearer understanding of the lived experiences of the individuals involved. The Review Panel reviewed the merged timeline and from their discussions in panel meetings agreed Key Lines of Enquiry (KLOE) for the case. All agencies have then undertaken further work in analysing events within their timeline.

9.4 The family were informed of the methodology being undertaken by way of letter through the identified Family Liaison officers. Following the conclusion of the trial the family met with reviewers.

9.5 A learning event was arranged with key practitioners involved with the victim and significant others. Attendees at the learning event were identified by panel members from their respective agencies.

10 Contacts with agencies outside of panel meetings and learning events.

10.1 The chair and reviewers met with West Midlands Police (WMP) outside of the learning event via a Microsoft Team's meeting as WMP were unable to attend on the day. This allowed an opportunity to discuss their involvement, analysis against key individuals, incidents, and receive pertinent information relating to WMP involvement. The reviewers were able to understand from this meeting that WMP had made use of all investigative practices available to them to disrupt criminality and identify concerns, some of which could not be in the report due to the sensitive nature of operational practices. The reviewers also identified good practice.

10.2 Steven's GP was unable to attend the learning event and met with the chair and reviewers to discuss their involvement and analysis against key incidents. As a result of this meeting, both the chair and reviewers identified good practice, and all concerned in the meeting were able to identify an opportunity for learning that will be referenced later in the report.

10.3 The chair and the reviewers also met with SWP at their request outside of the panel meeting. The purpose was to be open and

transparent with the reviewers of the relevant policing methods that had been applied around suspected drug activity which provided reassurance of police activity that could not be divulged in this report, due to the sensitive nature of operational practices. As a result of this police intelligence briefing, the chair and reviewers can record that there was good practice identified.

10.4 The chair and reviewers met with the health representative outside of the panel meeting in January 2025, as due to unforeseen circumstances they were unable to attend the panel meeting that was scheduled in January. This gave health the opportunity to discuss learning identified from a health perspective, which will be added to the report.

Key Lines of Enquiry

- Whether previous relevant information or history about the individuals and/or family members was known and considered in professionals' assessment, planning, and decision-making in respect of any persons at risk, the family, and their circumstances. How that knowledge contributed to the outcome for the individual at risk.

- Whether the actions identified to safeguard the individuals at risk were robust, and appropriate for that person and their circumstances.

- Whether the actions were implemented effectively, monitored, and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.

- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the individual at risk. Whether the protocol for professional disagreement was invoked.

- Whether the respective statutory duties of agencies working with the individuals at risk and family were fulfilled.

- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

Additional Areas of Focus

- To aid and facilitate better understanding and learning about the culture of Organised Crime Groups, County Lines, Exploitation, and the potential for safeguarding of all those involved to identify any barriers.

- Explore and understand from this case both the implications of and the extent of infiltration of illegal drug abuse within the communities and any management prevention or support around the same.

- Consider whether cross border investigations and information sharing are sufficiently robust to manage the risks of organised crime.

- Consider the inter-related connection between varying forms of exploitation including Modern Slavery.

- Any identified links between the feeling of isolation through lack of friends and family resulting in students who are residing away from home becoming vulnerable and susceptible to the use of illegal drugs. Consider how this is identified and what provisions are put in place to support those individuals.

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

- Highlight any relevant changes in practice that have taken place in any organisation since this time of this incident which may have led to a different outcome.

- Impact of COVID 19

11 Equality and Diversity:

Address the nine protected characteristics under the Equality Act 2010[4] to the Review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted, consider the Socio-Economic Duty[5].

Make reference to:

Age

(1) In relation to the protected characteristic of age—

(a) a reference to a person who has a particular protected characteristic is a reference to a person of a particular age group.

(b) a reference to persons who share a protected characteristic is a reference to persons of the same age group.

(2) A reference to an age group is a reference to a group of persons defined by reference to age, whether by reference to a particular age or to a range of ages.

11.1 Steven was 30 years old at the time of his death. At the time of the incident the other principal individuals involved were of ages ranging from 17 years – 36 years old.

11.2 There were four individuals classed as Young Persons (under the age of 25) and two of these were under the age of 18 at the time of the incident that led to this review.

11.3 *"Child criminal exploitation is common in county lines and occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology."* [6]

Disability

A person (P) has a disability if—

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.4 Steven was diagnosed with Irlen Syndrome, this resulted in difficulty in making sense of visual information.

[4] Equality Act 2010. Equality Act 2010 (legislation.gov.uk)
[5] Socio-economic Duty: an overview | GOV.WALES
[6] https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines/criminal-exploitation-of-children-and-vulnerable-adults-county-lines

11.5 Whilst attending USW it was identified that Steven had Dyslexia, and an Individual Support Plan was put in place to ensure the recommended adjustments were made.

11.6 Steven also had an appointment with his GP in relation to his mental health to ascertain a potential ADHD diagnosis, although Steven's family reported to the reviewers he had been displaying classic symptoms of ADHD, which had been confirmed by a private practitioner, however, there had never been a formal diagnosis.

11.7 Steven was also known to be on Anti-Depressants for anxiety. Additional persons included in this review were also identified to be suffering from anxiety.

11.8 One individual was known to be experiencing symptoms of Post Traumatic Stress Disorder (PTSD). The symptoms of which are far reaching and include but are not limited to, hyperarousal, feeling a heightened sense of danger, flashbacks of the traumatic event/s and negative thoughts and emotions.

11.9 *"Cuckooing" (also known as "forced home invasion") – a tactic used by criminals, typically drug dealers, to take over the homes of vulnerable individuals, such as care leavers or those with addiction, physical or mental health issues, and use the property as a base for criminal activity. This is a common characteristic of the county lines business model and can occur in a range of settings such as rental and private properties, student accommodation, prisons, and commercial properties.*[7]

Gender Reassignment

11.10 Not known to be relevant for this review.

Marriage and Civil Partnership

11.11 P6 was known to be Married.

Pregnancy and Maternity

11.12 Not relevant to this review

Race

11.13 Six of the individuals were identified as White British and 1 individual was identified as Black British.

11.14 *Ethnicity: people from all ethnicities and nationalities are targeted and the demographics of victims of exploitation vary across England and Wales. In some areas, there is an over-representation of people from black and mixed ethnic groups, while in others, victims are mainly white*.[8]

Religion or belief

11.15 Not Known to be relevant to this review

Sex

In relation to the protected characteristic of sex—

(a)a reference to a person who has a particular protected characteristic is a reference to a man or to a woman.

(b)a reference to persons who share a protected characteristic is a reference to persons of the same sex.

11.16 The subjects involved in this review consist of five males and two females.

11.17 *Ninety-one percent of those involved in County Lines and Organised Gang Crime (OGC) are male, however females are underrepresented in the data. Females' involvement is less likely to be discovered by services, but we know it does happen, and they may be asked to carry drugs and weapons because they are less likely to be suspected than males.* (htt1)[9]

Sexual Orientation

11.18 Not Known to be relevant to this review

[7] https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines/criminal-exploitation-of-children-and-vulnerable-adults-county-lines

[8] https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines/criminal-exploitation-of-children-and-vulnerable-adults-county-lines

[9] https://www.gov.uk/government/publications/county-lines-exploitation-applying-all-our-health/county-lines-exploitation-applying-all-our-health

12 Involvement of family and principal individuals:

12.1 In accordance with the SUSR guidance and having cognisance of the OWHR guidance there has been contact with Steven's family members throughout the review process.

12.2 The family were informed of the methodology being undertaken by way of letter dated 23rd April 2024 it was agreed they would be contacted post-trial, and they were given the relevant SUSR information leaflet explaining the process. This was undertaken through the identified Family Liaison officers (FLO). The family spoke with the reviewers following the conclusion of the trial.

12.3 An introductory meeting was held in person with Steven's dad and stepmother and another with his mother and stepfather. These meetings took place on 19th September 2024, at the respective homes of the family members. During the meeting the reviewers expressed their sincerest condolences on behalf of the chair and panel. The SUSR and OWHR processes were explained to the family including the purpose of the review process, what it would entail, who would be involved and how it would progress. The family agreed to engage with the review process and confirmed that it was their wish to liaise with the reviewers directly and they did not require advocacy.

12.4 Subsequent contact was made with the family over the review process and at key points, via email, letter, and telephone.

12.5 The family provided the reviewers with a family tribute for the learning event with photographs. The tributes and photographs were shared with panel members and practitioners during the learning event.

12.6 The family also accepted an invitation to meet panel members.

12.7 A Panel Meeting was held on the 28th November 2024. Steven's family including his sister attended via a Microsoft Teams Link. This gave the family an opportunity to meet the panel and pose some thoughts around learning and missed opportunities to the panel through the chair.

12.8 Further meetings took place between reviewers and family on 13th and 14th January 2025 to sit and go through a draft of the report. Reviewers explained to the family that due to unforeseen circumstances, the panel meeting scheduled for December 2024 had to be rescheduled for January 2025. However, not wanting to disrupt arrangements already in place to meet family, the decision was taken to proceed with the meetings to show the family the report as it was, which was close to completion. Reviewers explained that there would still be some potential amendments that they would see in the final draft. All family members appreciated this and were happy to convene.

13 Contact with Others

13.1 P1 was contacted by way of letter in October 2024 through the Prison Service. The letter and additional documentation were to inform P1 that a review had been commissioned. The purpose and process of the review were explained together with an invite to meet with the reviewers and the chair. P1 was also advised that support would be made available throughout the process if required. The Prison Service verbally discussed with P1 the contents of the letter and purpose of the SUSR / OWHR, but P1 declined to look at the information or meet with reviewers.

13.2 All significant others which included:

P2, P3, P4, P5, P6 and identified witnesses who were also contacted by way of letter in October 2024 and invited to meet with the reviewers and chair. The letter and additional documentation provided to the individuals were able to inform all parties of the purpose of the review and the support that would be available to them.

Please consider the Section 6 'Engagement of Victims, Family and Principal Individuals in the SUSR process' in the SUSR Statutory Guidance and refer to it where appropriate. Click on the following link and view Section 6: [https://www.gov.wales/sites/default/files/publications/2023-03/single-unified-safeguarding-review-draft-statutory-guidance.pdf]

Family Engaged well throughout the review process

14 Family History and/or Contextual Information

14.1 Steven was two years old when his birth parents separated. Steven continued to have a relationship with both parents. He continued to live with his mum and saw his dad every weekend. Later, he spent some time living with his dad.

14.2 Steven was diagnosed with Irlen Syndrome as a child, a type of visual or perceptual processing disorder. Someone with a visual or perceptual processing disorder has difficulty making sense of visual information.

14.3 Steven's attention span was also very short, and he struggled to focus for any length of time without distractions, it was an ongoing process to get a diagnosis of ADHD. Family reported that a private practitioner was able to confirm that Steven displayed all the classic symptoms of ADHD but there never appeared to be a formal diagnosis.

14.4 Steven left school with eight GCSE's; he was a very intelligent individual but had to work hard to put the focus in due to his attention span. Having succeeded in getting the grades he had a sponsorship with an aviation airline and worked as Cabin Crew. It was during this time that he formed a relationship and became a father and moved to Scotland.

14.5 The relationship broke down, and Steven moved out of the area. Following the breakup there was a period of time where Steven was unsettled and appeared to find it difficult to settle in any one area for a prolonged length of time and moved around different cities, Steven became a father to three more children during this time of his life, however, relationships with the respective mums broke down.

14.6 Steven was reported to use substances to 'self-medicate' his illness which in turn caused financial difficulties. Steven was homeless at times and also relied on medication for depression and anxiety during some of these times but was always well presented.

14.7 Steven moved to Wales in the summer of 2022 to follow his passion for Aviation and commenced a three-year course in USW, he had lived in Wales for 18 months and was attending University at the time of his death.

15 Family Expectations

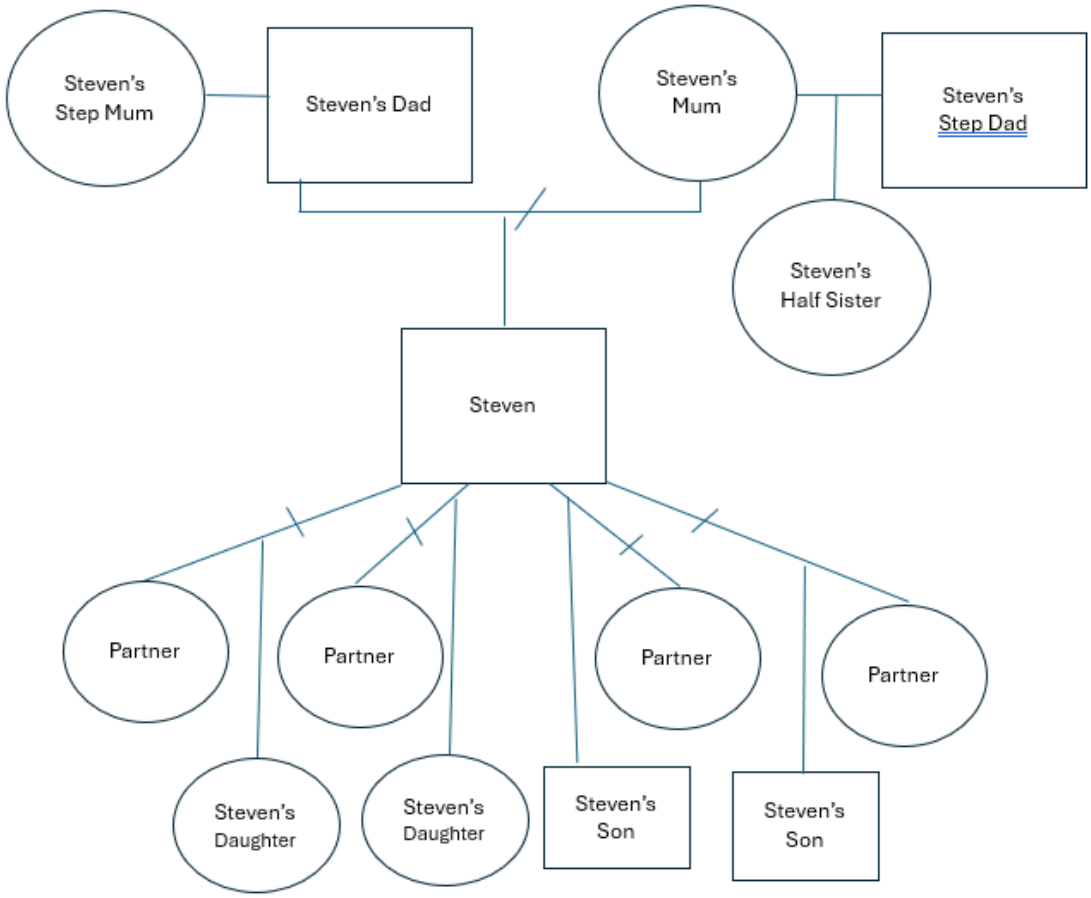
15.1 During the initial meeting with the family members, there was agreement that this process should focus on identifying learning to take forward. The reviewers also discussed and ascertained what the family might like to see resulting from this review. Points raised are:

- What, if anything, can students access outside of term time if they are struggling, especially for students that are residing in the area but are not from the area.

- Reviewing thresholds for individuals who struggle to engage with agencies following an incident. Should agencies look at each individual case in context or is it one strike and out, likely due to service capacity?

- How to save this happening to another family.

16 Genogram –



17 Agency Timeline

17.1 The combined timeline produced a record of agencies information with over 60 entries. The review panel separated the combined timeline into two key time periods, August 2022 to 6th June 2023, then post 6th June 2023 through to December 2023. This method was undertaken to allow the reviewers and practitioners attending the learning events to focus on specific incidents within each time period against the agreed Key Lines of Enquiry.

17.2 The review panel note that the below events are factual entries. The analysis of specific events is captured within the Practice and Organisational Learning Section.

17.3 The review panel acknowledged that there are indications throughout the timeline where witnesses appear intimidated and are fearful to give evidence.

17.4 The review panel acknowledged that there was limited information shared in the review time lines from police forces due to the sensitivity of the information. Both WMP and SWP have met with the chair and reviewers outside the panel as mentioned earlier in the report.

17.5 To aid with understanding the report, it concentrates initially on the victim and the main defendant. Entries on the timeline of the remaining significant others will immediately follow.

Agency Timeline for Steven & P1

17.6 In August 2022, Steven enrolled onto the foundation year of the BSc. Aircraft Engineering and Maintenance Systems Course. The University provided Steven with all relevant information on available support.

17.7 In September 2022 Steven attended A&E following the ingestion of 12 co-codamol 30/500mg he disclosed he was overthinking and felt under a lot of stress attending college and had taken the tablets in an attempt to calm himself down and sleep. Steven denied any thoughts to harm himself or suicide ideation to hospital staff. Staff advised Steven that the tablets taken were not to be used for sleep purposes and advised him to speak with his GP for reassessment if he felt in a low mood and required antidepressants or talkative therapy. Nothing previous was disclosed.

17.8 In September 2022 P1 presented at the hospital, with a gunshot wound, he was transferred to a more specialist hospital due to the type of wound and underwent surgery. Hospital staff enquired as to how the injury was sustained and were curious as to whether he was a young person at risk of exploitation. He was referred to Red Thread* and supported by an exploitation worker, the worker felt that there was a need to establish how/why this incident happened and if there was a further risk posed as well as individual support needs so the hospital could ensure safe discharge. P1 had reported the

gunshot wound as accidental, and further reported he was unable to identify any responsible persons as it had been dark at the time of the incident. **Red thread works with children and young people affected by exploitation, violence, mental and physical health issues, grooming and modern slavery in hospitals and health settings.*

17.9 Social Worker (SW) from Adult Social Care (ASC) had no concerns around care needs and was satisfied P1 had a safe place to go. With P1 being an adult, there were no concerns about his mental capacity, and following discharge P1 was collected by family members. There was no further involvement from the SW.

17.10 Red Thread continued to engage and slowly built a relationship with P1 between 12th September and 29th November 2022.

17.11 P1 attends the Emergency Department (ED) on 22nd September 2022 with generalised weakness but left before being treated.

17.12 In October 2022, two individuals alleged to police that they were victims of a crime, they stated they agreed to meet a mutual friend; however, three suspects have attended a location, armed with weapons, one with a gun and two with machetes. The suspects have forced the victims into the back of the vehicle, forcing them to log into their bank accounts, an amount of £10,000 was transferred from one victims account against their will. The suspects, in possession of weapons, caused injuries to the victims by use of a machete, drove the victims erratically for a number of hours before eventually taking their mobile telephones and leaving them. The victims would not provide statements or name the suspects as they were fearful of repercussions. They appeared to 'know' the suspects, stating they were part of a known Organised Crime Group (OCG).

17.13 P1 was believed to be a subject of interest and was arrested, but subsequently released on conditional bail, while further enquires were conducted. The investigation was closed down due to evidential difficulties, the victims did not support police action. There were no further lines of enquiry that could be followed and all the enquires that were conducted showed that P1 had not been involved.

17.14 In October 2022, P1 disclosed to a Red Thread youth worker of struggling with their mental health and described symptoms of PTSD which suggests that P1 had been affected by trauma.

17.15 In November 2022, following on from P1's disclosure in October, Red Thread called P1 to discuss counselling. They discussed expectations and symptoms that was being experienced. Counselling consent given. It was agreed that telephone contact to be maintained whilst finding a suitable and safe venue. P1 remained open to Red Threads counselling service and was closed to Red Threads Youth Violence Intervention Team.

17.16 In November 2022, Steven engaged with the University's Disability Team, to seek support for learning. An Individual Disability Support Plan was agreed with examination adjustments whilst awaiting an assessment for a Specific Learning Difficulty (SpLD). It was confirmed in January 2023 that Steven had Dyslexia.

17.17 In January 2023, WMP received a report from an anonymous source of an adult male running naked in the Birmingham area, it was further reported that this male had been kidnapped and beaten. The victim was transported to hospital for injuries sustained and was treated for 3rd degree burns to his feet, a head injury, and an amputated fingertip both caused by a machete. It was established the victim had been kept under duress for 5 days without food, tied up and denied toilet facilities. The Police investigation established the reporting person and victim were known to each other. The victim was involved in County Lines activity and that he would hold firearms for the reporting person, the reporting person was associated with a known 'drugs line' and a known OCG. It was believed that a cloned vehicle was involved in the kidnapping incident. The victim's family received an initial ransom demand of £3 million, lowering to £50K and requested that no contact was to be made to the police. An extensive police investigation took place, P1 was arrested for a kidnapping offence together with four other males. Whilst in custody, intelligence was shared to say that a threat to life had been made against P1 and the other arrested persons in retaliation to the kidnap. P1 denied his involvement during interview, stating he had an alibi at the time of the incident. He was initially bailed, following extensive enquiries there was insufficient evidence to meet the Crown Prosecution Service (CPS) threshold for charge and no further action was taken.

17.18 At the time of the arrest for the kidnap a lawful search of P1's address was conducted. Cannabis Buds and other drug paraphernalia were discovered including, dealing bags, weighing scales, a small amount of cash and mobile phones. P1 was interviewed and stated that the cannabis was personal use only. No further action taken as there was no realistic chance of prosecution.

17.19 P1 was in regular contact with a Red Thread counsellor over the telephone between November 2022 and March 2023. The counsellor offered support and booked appointments, but P1 did not engage, due to psychological anxiety. It was agreed collaboratively with P1 that this was not the right time to access counselling, he was provided with information on other agencies and informed he could get back in touch in the future if he felt he needed the support.

17.20 In February 2023, Steven's GP made a referral to mental health services. Steven disclosed a concern that he believed he was suffering from ADHD. Steven disclosed to the GP that for a long time he was unable to sit still, his mind races and he found it hard to concentrate. He said he had impulsive behaviour and increased energy/hyperactivity. He described his mood as up and down, and he advised that he was on medication for depression. He felt symptoms were affecting his studies.

17.21 Following on from the referral from the GP, the mental health team wrote to Steven on two occasions, but they received no response from Steven and as such there was no further action taken by the team.

17.22 In Early May 2023, SWP received intelligence that Steven was supplying controlled drugs, namely cannabis and cocaine to other students at the USW. The received intelligence further records Steven would take orders via a mobile telephone number and then arrange to meet students locally.

17.23 SWP submitted a Data Protection Access (DPA) request, liaison and intelligence work was undertaken with USW to confirm his details. Response provided with requested information the same day. The Intelligence was added to the Daily Intelligence Daily Summary (DIDS) for Officer's awareness and noted by the Local Intelligence Officer. Mobile devices were subsequently linked to Steven and a warning marker for drugs was updated on the police system in relation to Steven.

17.24 At the end of May 2023, SWP received further intelligence (second strand) that Steven was continuing to supply cannabis and cocaine to other students at the University using a mobile telephone number (as previously shared). This was shared with the appropriate Neighbourhood Policing Team for Officer awareness, targeted patrols, sightings, intelligence requirements and stop checks.

17.25 In June 2023, The Foundation year results were published. Steven Passed.

17.26 In July 2023, Steven was a passenger in a motor vehicle that was involved in a Road Traffic Collision (RTC) where it was reported that Steven had caused damage to another vehicle and issued threats to kill the driver of another vehicle following a failure to stop. Steven was later found to be in possession of Class A controlled drugs, he was arrested on suspicion of causing criminal damage, threats to kill and possession of controlled drugs. During interview, he admitted being in possession of drugs for his own personal use. He declined to comment on any other charges.

17.27 In August 2023, Steven was stopped whilst driving a motor vehicle and found to be without insurance and arrested on suspicion of driving whilst impaired by drugs. A blood sample was taken and found to show the presence of Cocaine and Cannabis however, both detections were below the legal limit therefore no further action was taken.

17.28 In September 2023, Steven attended A&E with a crush injury to hand, believed to have been caused by a car door, resulting in pain to outer hand. However, Steven left department without being assessed.

17.29 In September 23, Steven contacted Student Services at the University using an on-line self-referral form asking to speak to someone. The Duty Officer spoke to Steven on the telephone and booked a follow up appointment with a Well-being Adviser for a week later. Steven attended this appointment and was further referred to mental health support and counselling teams within the University by the Well-being Adviser. A follow up email was also sent to Steven with relevant support options.

17.30 Toward the end of September 2023, SWP received a third strand of intelligence that Steven was supplying cannabis as a student at USW. As previously shared, this also linked Steven to a mobile number and in addition a physical description, including that of a tattoo. The assessing Local Intelligence Officer recorded that both the Neighbourhood Policing Team and Response teams policing the area were aware of Steven and that the Organised Crime Unit were tasked for information purposes.

17.31 In October 2023, SWP received a call from a house mate of Steven's reporting that he was smoking 'weed' in the house and had refused to stop when asked and had issued threats to the house mate. Officers were deployed despite a further call to cancel by the original caller. SWP did attend, carried out a house search and spoke to both parties confirming no criminal offences had occurred.

17.32 In October 2023, following the summer break, Steven enrolled on the first year of the Aircraft Maintenance Engineering course at the University. Steven e-mailed the course leader to request a meeting. The course leader responded the same day offering to meet in person which they did that day. Steven followed up in an email to the course leader that evening thanking them for the reassurance provided during the meeting.

17.33 In November 2023, Steven booked another appointment with the Student Services Team and met a Progression Adviser. Steven discussed his concerns about attendance on the course due to family issues but that he remained committed to succeed in his studies. Advice and support options were provided, including how to access the Extenuating Circumstances process and Interruption of Studies. The previous Well-being Adviser was contacted and referred to the Student Money Team for further advice. A follow up appointment was booked with Steven to review the situation. The Student Adviser emailed Steven with an update, confirming he was on the waiting list for counselling and mental health support and would hear in due course. Steven met with a Student Money Adviser and discussed the possibility of a reduction of course credits. The Student Money Adviser fedback their advice and guidance to the original Adviser. Steven did not attend the follow up meeting with the Progression Adviser, they emailed Steven and gave the link to rebook an appointment and invited further email correspondence with questions.

17.34 In December 2023, SWP received further intelligence that Steven and another known male were using a local man to store and distribute controlled drugs on their behalf. Intelligence was assessed and evaluated with all three individuals being electronically linked as associates.

17.35 SWP contacted the University Facilities Manager requesting details of Steven following an incident that resulted in Steven's death. Information was provided to SWP on the same day.

17.36 In December 2023, P1 attends hospital with lacerations to the hand, and reported they had been messing around with a kitchen knife. P1 had multiple lacerations to left hand, and was referred to the hand

specialist, where they were subsequently admitted for surgical intervention. Due to the presentation hospital staff informed WMP of P1's admission. Hospital staff were briefed that if P1 was to be moved, police were to be informed immediately, in addition to this staff were not to disclose P1's location with any person.

17.37 Following surgery, P1 was subsequently arrested. Red Thread visited P1, and he agreed to work with them, going forward. P1 was discharged to Police Custody with wound care advice given.

Agency Timeline All Other Parties

17.38 In October 2022, SWP dealt with a reported crime where an unattended purse containing a large sum of money was stolen from a street bench. Following investigative enquiries and CCTV footage, P2 and a male is identified and arrested. P2 admitted to the offence of theft and was referred to a Youth Bureau Panel, due to previous clean character, P2 later received a Youth Restorative Disposal (YRD). *(A YRD is an out-of-court option for the police to deal with minor crimes and disorder committed by 10–17-year-olds)*

17.39 Youth Justice System (YJS) worked with P2 on the Out of Court Disposal (OoCD) between June 2023 and October 2023, for the offence. Work completed and early discharge of intervention given as a result of engagement and good behaviour.

17.40 In November 2022, SWP receive a report, it transpires that P2, and a group of underage youths are in possession of alcohol, appearing to be intoxicated, and engaging in anti-social behaviour. P2 was taken home to parents and an anti-social behaviour referral form is completed and submitted. Anti-social behaviour Stage 1 First Warning letter subsequently sent to parents.

17.41 In May 2023, NSPCC contacted Emergency Duty Team (EDT) in Children's Services disclosing an anonymous caller had reported concerns regarding a male relative residing at a family home where young persons are present. The male was allegedly smoking cannabis, taking cocaine, has an attraction to 15-year-old girls and has a history of domestic abuse. Due to the limited information around identification of the persons concerned the NSPCC were advised to make immediate referral to police and follow up referral to The Information Advice & Assistance Team (IAA).

17.42 Children's Services established that the identified male did have a significant history and was a risk to his own children who had been open to Children's Services. The address provided was different to that recorded. There was no history of sexual harm present, and the substance misuse was historic. No action taken. NSPCC shared information with SWP and it was recorded 'await PPN for updated information'

17.43 Email received by SWP from NSPCC in May 2023, in relation to the concerns regarding the male relative. Officers attended and spoke with the family concerning the information. The family said it

was a malicious call but accepted that the male did smoke cannabis but not in the house or around the children. The parent of the children is P5, but the children reside with grandmother. Officers made a thorough check of the house and was satisfied there was no evidence of any drug use. All concerned individuals have separate bedrooms in the well-kept property. No concerns for the children's safety or welfare. Officers spoke with the children who confirmed that the male has never been inappropriate towards them and does not smoke drugs around them.

17.44 Police submitted a PPN which was received by Children's Services and linked to NSPCC referral above and noted the police considered the call as malicious and no concern identified. No further action taken. SWP were unaware that NSPCC had already emailed Children's Services, if known Police would have liaised with Children's Services.

17.45 In September 2023, PPN received by Childrens Services regarding a Missing Persons (MISPER) report for young male who was located at P2's home. There were no offences disclosed by young male who stated he missed curfew. No safeguarding concerns shared. No action taken.

17.46 In May 2023, Project Worker for P6, made a referral to Mental Health Team. P6 was diagnosed with Bipolar Disorder previously in England. P6 admitted to struggling to manage their emotions and had stopped taking medication several months ago having felt better without it. P6 made a disclosure to staff in relation to historic child abuse and disclosed being beaten as a child on a regular basis.

17.47 In June 2023, P6 had an assessment with the Mental Health Team, this showed that in 2014 – 2015 P6 had admitted themself into hospital where medical staff diagnosed P6 with Borderline Personality Disorder. P6 was also awaiting to be assessed for Autism. P6 disclosed regular use of cannabis and reported this helped to maintain focus and reduce anxiety. P6 had also been involved with police on a few occasions over the years, with all offences being of a violent nature. Previously arrested for Criminal Damage and Actual Bodily Harm (Domestic Abuse which included non-fatal strangulation). P6 was sentenced for ABH and received 12 months custody, suspended for a period of 18 months. Signposting and guidance offered in relation to managing emotions and substances, P6 said he would go to the GP and accepted an offer of support regarding substance use. A physical assessment was also completed.

17.48 In October 2023, P6 did not attend an appointment with the Primary Care Mental Health Team. Letter sent to GP and P6, to advise of missed appointment and subsequent discharge. Advised to re-refer if service still required.

17.49 In November 2023, P6 was offered and allocated a new tenancy and moved from the Hostel. P6 was offered Tenancy Support but declined.

17.50 In June 2023, SWP arrested P4 and a male who was known to deal drugs at a residential address in the local vicinity. SWP searched the property, and a quantity of cannabis was located within the address, resulting in both persons being arrested for possession with intent to supply. A large quantity of cash was later found at P4's address which supported the criminal offence. Both subjects denied a criminal offence, and both were released under investigation pending expert evidence and CPS advice. USW received notification of P4's arrest by email. Risk Assessment Panel (RAP) convened by USW and outcome communicated to P4.

17.51 In September 2023, USW had a further update from SWP regarding P4 via email, to state that P4 was Released Under Investigation (RUI). A University RAP was convened. The outcome of the RAP, which restricted access to some parts of the campus, including the student union and halls was communicated to P4.

18 Learning Event

18.1 A learning event was held which brought together front-line practitioners from agencies involved in the case across the counties. Attendees at this event were identified by panel members for their respective agencies.

18.2 The learning event provided an opportunity for professionals to reflect on their involvement with the victim and any significant others with the hope of identifying any systems and organisational learning. The learning event was led by the reviewers and chair.

18.3 Prior to the learning event, professionals were provided with a copy of the combined timeline, and information on the circumstances of the case and the review process being undertaken. Professionals attending the learning events were briefed by their relevant panel member in accordance with SUSR guidance.

18.4 In order to facilitate the learning event, the reviewers separated the timeline into two key time periods. Each time period identified key events to be considered and discussed by practitioners during the learning event. The learning event provided additional information which has been captured within the report.

18.5 The reviewers would like to thank all practitioners that attended the learning events and their contribution to identified learning in the review process.

19 Practice and organisational learning:

19.1 Within the following section, the review panel were looking at events that occurred between 18th Aug 2022 and the date of death. The Review Panel were informed that analysis of these events would need to consider that they occurred in different counties across England and Wales and could potentially have differing policies, procedures, and legislation.

Offensive Weapons / Knife Crime

19.2 Steven was the victim of a homicide by an Offensive Weapon. He was stabbed several times in the thigh area, which fatally resulted in a significant amount of blood loss. It was clear from Steven's presentation following the incident and from the evidence in the criminal hearing that Steven had received a significant threat of harm prior to the incident of the assault that led to his death. What is clear is that he tried to protect himself from injury by improvising wood as body armour to protect his torso. It is not known why Steven did not alert any agency of any significant threats. This would appear to be a theme through this review.

19.3 From September 2022 through to December 2023 this review has identified several incidents across the counties concerned, utilising offensive weapons and causing significant harm to individuals. All

incidents had police involvement, including an out of county area incident where P1 himself was the subject of a serious threat to his life, so much so the police in that area served a threat to life notice upon him. A threat to life notice is issued by police when intelligence is identified of a real and immediate threat to an individual and despite police involvement the threat remains. It is clear in this review that despite the individuals being victims of significant threats of serious violence and P1 receiving significant injuries including a gunshot wound, they did not and would not report incidents or engage in any investigation. What is also significant is that witnesses to these very violent attacks did not wish to engage in police investigations which result in no criminal proceedings due to lack of evidence.

19.4 P1 was considered a subject of interest in all incidents, including one where it was later identified that there was threat to P1's own life. Due to evidential difficulties, no action was brought against P1, until the incident in December 2023 which resulted in an arrest and subsequently a conviction.

19.5 P1 was identified as a person with significant propensity for Urban Street Gangs (USG), Organised Crime Groups (OCG) and violence but wasn't individually mapped to OCG. He was mapped by WMP as a subject in USG, based on his associations, incidents that he was involved in and clothing that he wore. The panel identified that P1 was a victim in his own right and likely coerced into recruiting others or acted on others instruction, which is a common theme in OCGs.

19.6 WMP had recognised P1 as a subject of interest as both a perpetrator and victim and there were markers on his home address to safeguard and manage potential risk to him.

19.7 It is evident that differences are apparent between police force areas, on what they may consider to be low level incidents and crimes, due to higher volumes of serious criminality involving offensive weapons, gang crime and charges / arrests in the areas concerned. It was clear in this review that WMP deal with a higher level of crime than SWP involving OCGs and USGs that carry a higher propensity to include criminality in relation to offensive weapons. A consequence of dealing with a high volume of serious crime relating to offensive weapons within gang cultures means that WMP may deem other aspects of criminality such as drug related crimes within the OCGs and USGs a lower threshold.

19.8 Section 28 of the Youth Justice and Criminal Evidence Act 1999 introduced Special Measures to facilitate the gathering and giving of evidence by vulnerable and intimidated victims and witnesses during court proceedings in certain circumstances. This review has identified potential barriers to victims and/or witnesses reporting serious threats of harm, actual serious harm to themselves and reluctance to engage in police investigations.

This could be for many reasons, but it would appear from this review that fear, and intimidation can prevent individuals from engaging.

19.9 The UK Protective Persons Service (UKPPS) can protect witnesses in cases that involve serious and organised crime which has been identified in this review. In particular, in the out of county police force serious and organised crime is daily business. However, it is extremely difficult for people to agree to these measures. Perpetrators also have a right to know their accuser and whilst applications can be made for a court order preventing disclosure, the accuser can keep re applying so witnesses can never be given assurance that they will not be identified. There are a number of interoperable parts to the legislation covering these issues, but panel consider the chief aspect was that the criminal justice system is adversarial.

19.10 The panel were made aware of charities funded by local Violence Reduction Units who work with hospitals where there is criminality and offensive weapon injuries in some areas, namely cities where there are growing numbers and concerns of this type of crime. Redthread are a national charity and are based in the West Midlands delivering transformative work in hospitals and health settings. They work with young people affected by exploitation, violence, mental and physical health issues, grooming and modern slavery. Redthread work alongside NHS staff and other professionals in Emergency Departments to engage with and support young people with the aim to reduce serious violence. Redthread were based at the hospital where P1 was admitted following a serious incident. P1 was allocated an exploitation worker that provided support and made a referral for counselling which they commenced.

19.11 The South Wales Violence Prevention Unit (VPU) established a hospital navigator scheme in the Emergency Department in both Cardiff and Swansea. These Violence Prevention Teams consist of nurses and youth practitioners who are based in Emergency Departments and support young victims of serious violence at critical moments, providing ongoing community care to prevent re-victimisation and retaliation. An analysis of data sourced from Operation Sentinel from January to December 2024 revealed 3,918 incidents of violence with injury, robbery, and bladed article offences across the CTM region. Of these, 2,166 incidents (55.3%) was the accumulative figure for three of the Local Authority areas, one of which includes the area where this incident that led to the review took place, highlighting the acute demand in these areas. Professionals at the learning event voiced that that they consider this was good practice in both West Midlands, Cardiff and Swansea. Cardiff is the Trauma Centre for Mid Glamorgan so referrals can be transferred from Mid Glamorgan to Cardiff Emergency Department; however, the scheme only operates in Cardiff & Swansea.

19.12 This review has recognised clear links of vulnerability between Adverse Childhood Experiences (ACEs), mental health, substance misuse, engagement with USGs, OCGs, exploitation and cuckooing all of which were elements supporting the infiltration of drugs, both locally and across borders leading to individuals getting into debt for

drugs, commonly referred to as 'debt bondage'. The recovery of the debt is often enforced with the threat of serious harm and in this case, the use of extreme violence with weapons. It is also evident in this case that those who fall victim of a drug debt are aware of the propensity of violence towards them. Despite the extreme measures victims will go to, with a view to protecting themselves from the risk of harm, the consequences can be fatal as it was in this case. (Society, n.d.)*Criminals may use a tactic known as "debt bondage" which is where a real or perceived debt is used as a method to exert control over individuals, to provide the use of their properties for the preparation and/or dealing of drugs*[i]

19.13 The review panel were advised of a Campaign on Knife Crime, this campaign highlights the dangers of carrying knives, specifically aimed at the likelihood that you are more likely to be a victim of knife crime if you carry a knife. It is believed by some that carrying a knife aids protection, but statistics show that if you carry a knife, you are more likely to be hurt. Furthermore, the Government has also recently set out a mission on plans for change: Safer Streets. It is recognised that community policing has diminished with neighbourhood police officers undertaking other tasks due to resource shortages. This has led to weakening connections with local communities. The Government's mission is to reduce serious crime and increase public confidence. One specific priority is knife crime, banning lethal weapons and working to remove dangerous blades from the wrong hands. Effective local policing has been identified as being required for the safer streets mission to succeed. The Government has guaranteed additional resources to ensure visibility in communities to deter/prevent crime and respond to emergencies. This reform aims to see a neighbourhood policing team in every local area, providing intelligence-led, visible patrols and a named contactable officer in every neighbourhood to respond to local problems. This review identified that over half of the persons that were a subject of this review were known to carry knives or bladed weapons and some from as young as 14 years old.

19.14 During the learning event it was established that there is a Community Officer who works with USW. Practitioners were supportive of the reinforcing of the importance of Community and Neighbourhood officers to the local communities and expressed a view that they make a positive difference.

19.15 This review has identified and reinforced the links between those vulnerable individuals who are targeted and exploited into criminality to support demand in the supply of illegal drugs. Furthermore, it has identified the propensity of those individuals to use significant violence using weapons, including knives.

19.16 Whilst the number of recorded violent weapon related crimes are higher in England, this review demonstrated that serious organised crime including the exporting or importing of illegal drugs within the UK is prevalent within all regions and as such comes the risk that individuals will be exploited by force, manipulation or coercion into transporting drugs, weapons or money.

19.17 Whilst there have been numerous campaigns including early intervention and proactive initiatives such as 'Not the One' Knife campaign run by SWP and the VPU, this review identifies a continued need of awareness raising within communities about the serious and fatal consequences of knife crime on both victims and perpetrators. In this case the victim died.

19.18 The Head of the VPU has commissioned the USW to conduct an evaluation of the 'Not the One Knife Crime Prevention and Early Intervention Campaign'. The purpose of the evaluation is to provide critical insight into what is working well, what needs improving and whether the messaging resonates with the intended audience.

19.19 Following the findings from that evaluation which are expected in March 2025, the campaign will be developed further, and cognisance will also be taken of the findings within this review. This will ensure that the approach of the VPU continues to be a campaign that is evidenced based, effective and targeted in the right way.

19.20 SWP is committed to Neighbourhood Policing. They have implemented the Neighbourhood Policing Guidelines and Standards provided by the College of Policing. The focus of neighbourhood teams is to provide meaningful engagement, targeted activity and to put resources behind sustainable community problem solving.

19.21 SWP has always been committed to having named local officers in each Ward whether they be Neighbourhood Beat Managers or PCSOs. The focus being to respond to local needs where necessary and provide a focal point for local engagement. This has been recently reinforced by the introduction of the national Neighbourhood Guarantee which has been supported by South Wales Listens where members of the public can access contact details of all local officers and be informed on local priorities and problem-solving activities.

19.22 The Major Crime Unit (MCU) in WMP who more frequently deal with serious crime and violence have processes and mechanisms in place to pass over lower-level crimes to other teams via the Detective Chief Inspector (DCI). In this instance there was an oversight, therefore, this remains a missed opportunity and there is individual organisational learning. However, it needs to be recognised that processes and mechanisms are in place and are for the most part adhered to. Where drug related crimes are linked to higher level crimes, the drug related aspect can be deemed as lower level and therefore not always proceeded with, opportunities are missed to intervene and potentially disrupt criminality and exploitation. This prevents further opportunities for statutory intervention and partnership working between agencies.

Good Practice

QEH Military based hospital specialises in the treatment of wounds inflicted by offensive weapons such as knife and gunshot wounds. They work collaboratively with WMP.

WMP have demonstrated good practice with an effective Gang Offender Management Team. Local response officers link in with the Gang Offender Management team, providing named case workers assigned to individuals for consistency.

Redthread national charity provided support and counselling services following a serious incident. They are based at the hospital and engage with individuals involved in serious violence incidents. They were able to develop a relationship and engage over a 6-month period.

Drugs and Substances

19.23 SWP received intelligence on three separate occasions to indicate a concern that Steven was both using and allegedly supplying Cannabis and Cocaine to other students in the University.

19.24 Following the second strand of Intelligence, SWP put in a Data Protection Act (DPA) application and shared with USW that they were investigating a concern of drugs supply from two students at the USW. SWP requested information on two students one of which was Steven. Upon receipt of this request, USW responded with the information requested. There was a missed opportunity between USW and SWP to collaborate and coordinate further a multi-agency response to explore disruptive and preventative activities for the persons involved. The USW Risk Assessment Procedure details that a panel should be convened where a student poses a risk to self/others or where action is required where a student could cause serious risk to the wellbeing of the university community or reputational damage to the institution.

19.25 The DPA application would not trigger a RAP until such time that they were informed by the police around subsequent police action. A basis for this is that the individual is required to be informed which could compromise an investigation.

19.26 The panel determined through the review process that there were clear links between Birmingham and South Wales in relation to drugs supply. This was not known or identified at the time. There are persons who remain in the area with links to the University and have been identified as being involved in drug activity with other students. It was evident from police records that information was recorded effectively on the Police National Database (PND) for all forces.

19.27 There was an arrest in June 23 of two individuals, for 'concern in the supply of class B drugs' (Cannabis). Both individuals were believed to be students at the University, with one originating from Birmingham and is understood to have had previous involvement with illegal drugs. As a result of this incident, one individual was charged and there was no further action relating to the other individual. A RAP was convened by USW for both the individuals demonstrating effective use of the process.

19.28 P1 was arrested (January 2023) in Birmingham in connection with an alleged kidnap offence. In response to this, WMP conducted a search of his home address where a quantity of cannabis was found. This resulted in no further action as he indicated the drugs were for personal use and the quantity found was unlikely to meet the CPS threshold to prosecute.

19.29 P1 later came to South Wales to link up with other individuals originally from the Birmingham area. WMP were unaware that P1 had moved out of area and were unaware of potential familial connections in Wales. SWP were also unaware that P1 was in the area. Therefore, there was no intelligence or information held by either Police Force area to indicate or establish that P1 was involved in County Line drug activity and travelling between Birmingham and South Wales.

19.30 WMP identified that P1 had gone off the radar from February 2023 following his arrest in January 2023 concerning the kidnap allegation but believed him to be laying low due to the serving of a Threat to Life Notice. WMP had no reason to believe otherwise as there were no reports of P1 being involved in criminality during this time, neither were there any reports of concern linked to P1 to suggest any welfare checks were required.

19.31 The review identified that the USW Student Union Night Club was attributed by some to be problematic in terms of drug activity and where some students were introduced to drugs for the first time. The panel were advised that non-students could also access these venues as members are allowed to invite 2-3 friends. The USW panel member has advised the Student Union Night Club and other premises, operates within licencing guidelines and that the Night Club has since closed down due to reduced demand.

19.32 Although the review identified that information and support in relation to drug and substance use appeared to be limited in the University, the University was able to provide panel with information that details the resources and support available to students should they wish to access it. In 2022-2023, the USW also launched an E-learning course on drugs and alcohol.

19.33 Drug misuse and supply is an issue for all communities, and it is recognised in this review there are particular circumstances surrounding university students which increase vulnerability to unlawful activity, including the transient student population and pressures of undertaking study.

19.34 The review identified that some students lack an understanding around county lines, illegal supply of drugs and are unaware of support / resources to address drug misuse.

19.35 The review was informed that SWP and the USW collaborate on initiatives and awareness raising, providing education to students relating to safety and drugs, and are supported by a dedicated PCSO. However, this review identified that the information available did not reach all students and it is acknowledged there is an opportunity to do more.

19.36 WMP have identified that there was a missed opportunity in relation to P1. They identified that there was sufficient evidence to pursue an investigation in relation to the supply of Cannabis that was discontinued. This was a potential missed opportunity to proceed with a prosecution which could have led to statutory agency involvement with P1. Although, the outcome of such a matter cannot be known and would be determined by a Court of Law through a range of sentencing options.

19.37 This review identified the importance of responding to and pursuing low level offences by WMP. There is a need to see the bigger picture where this activity is concerned and the potential opportunity for early identification and prevention regarding criminality and exploitation and the potential for statutory services involvement and intervention.

19.38 WMP have a process in place whereby Serious Crime Investigators can pass low-level crimes identified in serious crime investigations to another investigation branch to deal with. There was an oversight during this incident.

19.39 When reviewers met with the GP, they asked whether consideration had been given to signposting Steven to the support services at the Universities. The Doctor confirmed that they had not because they were unaware of the support or resources available that the University would provide to students, including support for substance misuse. GP Practices who support students need to be aware of services and support that Universities can offer to students so they can discuss this with patients and effectively sign post them to appropriate services.

19.40 The University of South Wales have confirmed they are working to develop a referral pathway and Information Sharing Agreement (ISA) with Cwm Taf Morgannwg Health Board.

Good Practice

SWP evidenced that additional policing methods had been applied for and legally authorised to develop intelligence concerning suspected drug activity. As a result of this Police intelligence briefing, the chair and reviewers can record that there was good practice identified.

The University of South Wales has established a harm reduction approach and governance mechanism which aligns with the recommendations and proposed

framework of a recent Higher Education Sector report by Universities UK. The University has piloted a peer led substance use service in partnership with Barod and promotes to all students, a reputable on-line drug and alcohol education programme "staying safe", as well as an integrated support service mechanism focused on early intervention. The University is committed to further enhance provision relating to the challenges associated with drugs including tackling supply, reducing demand and improving support. They seek to do this in partnership with police and other specialist organisations.

Exploitation (County lines / Coercive Control / Grooming / Cuckooing / OCG)

19.41 Intelligence indicated that Steven was supplying drugs to other students, but there was no record of concerns with risks in relation to Organised Crime Gangs and/or County Lines. It appeared from intelligence identified that the alleged supply of drugs was on a local level.

19.42 Following a thorough review of all the information and intelligence held by agencies, the panel were satisfied that there was no evidence during the timeline that would have raised a concern or that flagged a missed opportunity of children being involved in trafficking, modern day slavery or county lines. There is however a need to consider contextual safeguarding given the peer networks of the young people involved and their vulnerability to becoming victims of criminal exploitation.

19.43 Criminal Exploitation was identified involving the two local teenagers with little criminal footprint who become embroiled into the incident that led to this review. They had accompanied P1 who was supplying drugs and had responsibility for collecting the debt incurred for the drugs supplied. This resulted in not only those individuals witnessing a murder, but their presence also implicated them in the crime which resulted in them being charged with murder. They were later acquitted of both murder and manslaughter charges; however, the incident and the subsequent action is likely to have a traumatic effect on them.

19.44 There is clear evidence of cuckooing in this review although the victims may not have identified such exploitation. This property was owned by social housing, reports suggest that the accommodation was in a poor condition and in need of repair.

P1 was involved in the supply of illegal drugs from England into Wales. It would appear that P1 was then introduced into the area and retrospectively into places of residence by a person whom they knew and who had previously managed to effectively house themselves.

The individual whose position they replaced resided in local accommodation with other individuals whom they had befriended within the community, having frequented local licenced establishments as well as the Student Union, through visiting the Student Union bar.

The individuals who were cuckooed were vulnerable, residing in a deprived area, with poor mental health, feelings of social isolation and / or a drug habit, but all had their own accommodation rented or otherwise.

19.45 Invariably those who exploit vulnerable people through means of cuckooing from across the border to infiltrate both the community and the University with illegal drugs will have more than one place to stay as a network that relies on having multiple accommodations available which was evident in this review.

19.46 The review identified that P1 had previously been exposed to not only witnessing but had also been a victim of extreme violence himself having been the victim of exploitation.

19.47 It is clear in this review that both children as well as adults have been a subject of exploitation albeit they may not have identified this themselves at the time.

19.48 Exploitation is an area that is of concern across the UK and has a detrimental impact on both children and adults within communities.[10]

19.49 Panel shared that whilst the area where this incident occurred had a protocol in place for managing children at high risk of exploitation, this has been identified as a key priority for the CTMSB, and the development of a Regional Exploitational Strategy in partnership with the CTM Community Safety Board has been developed using a contextual safeguarding approach. In April 2025, Phase 1 (Children and Young People) of the strategy will be implemented and Phase 2 (adults) will be developed. Whilst panel members welcome this, there is no national strategy in place to allow for a consistent approach across Wales and the UK.

19.50 Both the recently completed 'Jay Review of Criminally Exploited children' and 'Children on the Margins Report' made significant recommendations from the learning which were mirrored in this review. [11] [12] Panel supported the recommendations from both.

19.51 As a result of the Jay Review, the 'Crime and Policing Bill 2025' Crime and Policing Bill - Parliamentary Bills - UK Parliament was published in February 2025 that creates a new standalone and specific offence to prosecute adults exploiting children into criminal activity. In addition, it will also be an offence to 'takeover' a person's home also known as 'Cuckooing'. Panel is in support of these decisions.

19.52 It is recognised that a National Strategy for exploitation would provide National Leadership with a consistent approach across the UK. This would ensure implementation of effective policy procedure and protocol. It would provide opportunities to gather the data and intelligence to allow prevention to be put into place to protect vulnerable adults and children.

19.53 Safeguarding Children and Adults at Risk is everyone's responsibility, as set out in the Wales Safeguarding Procedures.[13] Panel recognised the plethora of legislation and procedures to support the statutory intervention to protect children and adults at risk under the defined categories of Physical, Emotional, Sexual,

[10] https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines/criminal-exploitation-of-children-and-vulnerable-adults-county-lines
[11] https://www.actionforchildren.org.uk

[12] https://senedd.wales/media/xmhhaypg/cr-ld16844-e.pdf

[13] https://www.safeguarding.wales/en/

Financial Abuse and Neglect. However, it was acknowledged that when defining an adult at risk it may be assumed that one had capacity or consented and therefore may not be identified 'at risk'. Panel agreed that no one can consent to being exploited, it is abuse, and therefore in the absence of a category of exploitation in its own right for both children and adults it was felt that guidance for adults should be reviewed and sit alongside Wales Safeguarding Procedures so that all agencies and professionals can ensure children and adults alike are protected and safeguarded from exploitation.

19.54 The panel are aware that the Welsh Government Modern Slavery/Exploitation Team will be updating the children practice guides.

19.55 To strengthen the regional response to serious violence and child criminal exploitation, the CTM Community Safety Board has recently established a Violence Prevention Board as a dedicated sub-group. This board will provide a strategic platform, ensuring a coordinated and evidence-based approach to violence reduction, particularly amongst children and young people. This work will closely align to the CTMSB Exploitation Strategic Objectives.

19.56 Bringing together senior decision-makers from policing, local authorities, health, education, youth justice and community organisations, amongst others, the Board will promote cross-sector collaboration to develop and deliver targeted interventions to support children and young people affected by violence. By analysing regional data and emerging trends, the board will identify common challenges and opportunities, enabling a proactive and preventative approach.

19.57 The Violence Prevention Board will also drive the local implementation of the Serious Violence Duty, ensuring a structured and sustainable response that aligns with national priorities while being tailored to the needs of CTM communities. Through shared learning, resource alignment, and joint action, this collaborative approach enhances accountability, innovation, and long-term impact, providing communities with the confidence to report concerns creating safer communities and reducing the risk of harm, particularly among vulnerable young people.

19.58 Established since the beginning of this OWHR, this Board along with the implementation of the CTMSB Exploitation Strategy gives an opportunity to drive a number of the recommendations identified throughout the review, particularly those that require multi agency collaboration.

19.59 Social Housing were aware of and informed about concerns with the accommodation that needed work. The house was reported to be in an appalling condition, damp ridden and should have prompted an earlier response. An earlier response or attendance to this report may have allowed Social Housing to identify repairs to the property and potentially identify further concerns in relation to the potential signs of cuckooing and illegal activity at a social housing property.

19.60 With the recent changes in the Renting Homes (Wales) Act 2016, landlords can now take civil action through the courts via an injunction

to access a property. This provides landlords with legal authority to access properties where there is little or no engagement from tenants.

19.61 Although recent research has shown that students are less likely to have used drugs in the last twelve months compared to general population 16 – 24 year olds, students can be vulnerable when they attend university for the first time which can be compounded by social isolation. In this review, it also led to students being influenced and involved in criminal activity. This review identified that not all students were aware of the available resources and support from the University which are intended to mitigate feelings of isolation, in and out of term time. The USW is committed to reviewing peer mentoring, buddying schemes, and other initiatives within university settings to help new students, particularly from outside the area, to feel settled and less isolated

Mental Health

19.62 Both Steven and his family had concerns in relation to ADHD, as an adult Steven was awaiting an ADHD assessment and the panel learned from family that there had been a private consultation where it was suggested that Steven displayed classic symptoms of ADHD, but they were still pursuing a confirmed medical diagnosis. Some of Steven's behaviours such as acting without thinking about consequences and difficulty coping with stressful situations were consistent with symptoms of ADHD. The panel learnt that Steven exhibited maladaptive behaviours, and it was reported by family that he felt the need to 'self-medicate' with drugs to manage and calm his mind. It must be recognised that long-term misuse of drugs can be indicative of an addiction or reliance on substances. Panel agree that consideration also needs to be given to the impact of long-term Cannabis misuse as this could have had a significant impact on Steven's mental health. There is evidence that suggests where individuals are taking Cannabis to calm their mind or help them sleep that Cannabis can have the opposite effect.

19.63 The review identified that following referral for mental health assessment/support, healthcare practitioners would endeavour to contact patients by way of letter. A symptom of avoidance can be classic in some people with poor mental health, and in turn can lead to mail not being opened. In addition, students often live in HMOs and correspondence in the way of letters won't always be a guaranteed form of delivery. This learning was identified in a previous review SUSR01/2022 where CAMHS accepted the importance of developing alternative methods of communication with patients. Since that time, they have embedded SMS text messaging in respect of alerting children of appointments and a similar process is being progressed for adults and is expected to be implemented in the near future.

19.64 The panel identified that Steven had stopped taking his medication of anti-depressants. Whilst the GP records confirm that the

medication was prescribed from August to November2022, the decision to stop was sudden and was not in consultation with his GP. There is no mechanism in place to flag this as a concern, for the GP to follow up and discuss risks or to provide advice, unless the patient presents on a further occasion when the flag would alert the doctor that the patient had stopped medication without consultation. The panel realise that this is not unique to this GP Practice and will be a wider issue. This meant that Steven had ceased his prescribed anti-depressant medication without advice and guidance from his GP in relation to the impact of sudden cessation from such medication and/or alternative treatment/support.

19.65 The panel also learnt through this review that P1 struggled with and displayed symptoms of Post Traumatic Stress Disorder (PTSD) due to previous incidents, including a gunshot wound to his torso and a known threat to his life as referred to earlier in the report. The panel identified that this was potentially one of the significant factors in P1 moving from England to Wales.

19.66 There was no alert mechanism in place to notify the GP that prescribed anti-depressant medication had been discontinued and therefore, treatment had ceased. This meant that there was no follow up from the GP with the individual to explore the reasons for this and to provide advice and guidance to minimise/prevent a deterioration in mental health. The panel acknowledges that under medical ethics and law, a patient has the right to make informed decisions about their treatment, which includes the right to discontinue medication. However, Healthcare providers are responsible for ensuring that patients understand the purpose of prescribed medication, the potential benefits, the risks, or consequences of suddenly stopping medication and potential alternatives to the prescribed medication.

19.67 We know from previous reviews (Child Y CTMSB 04/2022 & CV SUSR 01/2020) that inconsistencies in relation to medication not being collected or continued with has been problematic, indicating that a potential flag system for health alerting practitioners may be a solution.

19.68 The review is aware that the non-taking of medication has been identified as an emerging theme for consideration by the Single Unified Safeguarding Review Support Network and that work is ongoing to explore this area in more detail. The learning from this review will add to the evidence base for ongoing work.

19.69 There is an over reliance by GPs and other healthcare professionals to take patients words at face value and has been identified in this review. Whilst it is acknowledged that healthcare professionals need to be respectful of what patients disclose, there is a need for practitioners to take a more holistic approach to gather and understand a patient's history especially where that person is from a different area.

19.70 More could be done by healthcare professionals to consider the impact of individuals presenting with classic symptoms of ADHD or a confirmed diagnoses for individuals. There should be consideration

of problematic coping mechanisms and maladaptive behaviours that could be adopted by individuals as a coping strategy and how this could be linked to substance misuse and have a detrimental impact on an individual.

Sharing Information

19.71 There is an active information sharing process operating between the Police and the University, albeit not formalised in a standard operating procedure.

19.72 SWP had not been informed and were unaware that NSPCC had emailed Childrens Services. If known, Police would have liaised directly with Childrens Services and worked together with this. SWP completed a PPN based on the information they had received from NSPCC which led to a duplication of work.

19.73 It should be recognised that there is still an opportunity to improve the comprehensive sharing of information and intelligence with Universities, Colleges, and Schools across Wales with the implementation of the Wales Accord on the Sharing of Personal Information. There was also similar learning identified in a previous review SUSR01/2022.

19.74 It was identified by panel that in some cases, Information Sharing Protocols (NSPCC) were missed as the police were not informed that Childrens Services had already been informed some concerns raised in relation to children and could have prevented duplication of work. There is a need for them to be robust when there are safeguarding concerns. Consideration should be given to how intelligence is handled and used to ensure safeguarding.

Good Practice

The University offers comprehensive and integrated support opportunities to students throughout their learning. Students joining USW are informed of opportunities through pre-entry communication, induction, welcome programmes and on-going contact with academic/support staff and the student portal and virtual learning environment. These schemes include but are not limited to, Mentoring; Peer Assisted Student Support; Student Navigators; and Togetherall – a 24/7 online peer support community; This review has demonstrated Steven effectively engaged with a variety of support at USW who worked cohesively, sharing information appropriately to offer the best interventions.

Impact of COVID

19.75 This review identified that it was during COVID that the younger persons were brought together. P3 and P2 resided on the same Local Authority Housing estate as P5. During COVID they formed relationships due to P5's children being of similar age groups.

19.76 It was identified by both the review panel and at the learning event that COVID impacted on victim support services, going into hospitals

to assess and support victims face to face when appropriate to risk manage and effectively engage individuals.

19.77 The review identified that COVID, also impacted on individuals losing jobs during this time and being further isolated from support in the way of colleagues, family, and support services. This would have had a detrimental impact on resilience and coping strategies leaving individuals more vulnerable.

19.78 This review also identified that during COVID with the timeline of both national and local lockdowns there was a significant impact on children and young people around safeguarding. The ramifications of schools not seeing changes in behaviours of individuals and the lack of face to face and in person contact with young persons, meaning early identification and intervention could be missed.

Process and Communication

19.79 The NSPCC were very prompt in reporting a safeguarding concern for two children to the Emergency Duty Team (EDT) and on the advice of that team also to the police.

19.80 Social services did their own checks on the limited information and established the male person was a risk to his own children and open to the services and had no information he was residing at their address.

19.81 Police confirmed they were not made aware by EDT of the NSPCC's initial contact with Children's Services. Had they known that contact had been made they would have linked in with the agency.

19.82 Having attended, Police were satisfied there were no safeguarding concerns and accepted the maternal grandmother's opinion that it was a malicious call. The parent of the children was not spoken to by police. There was an over reliance on the information provided by the grandparent.

19.83 During the learning event it was acknowledged that there was a seven-week delay in the submission of the PPN to Children's Services which is outside of usual policy and procedure.

19.84 There was also a missed opportunity by Children's Services and the Police to triangulate the information with each other to determine any risk and for Children's Services to have a 'What Matters' discussion with P5 who had parental responsibility.

19.85 In October 2022 Police arrested P2 for the theft of a purse. During the learning event practitioners voiced their concerns around the 6 months delay between the allegations of the theft and the subsequent interview of P2. Following his interview there was a further 3 months delay before YJS became involved with P2 for an out of court disposal. He worked with YJS from the 9th of June 23 to 4th October 23.

19.86 Practitioners felt that there was a missed opportunity to do early intervention work with P2 sooner because in November 2022 his behaviour had escalated into an incident of anti-social behaviour and

in December 2023, he was arrested in relation to the incident leading to this review.

19.87 If individuals who commit low level crime are going to be referred to YJS by way of out of court disposal (OoCD), then that referral needs to be expedited to ensure that early intervention with a view to deterring the individual from committing further offences. The review identified that there was a delay in the referral to the YJS for OoCD, however the review has been informed that delays are not usual and that the process works well between YJS and SWP and as a general rule are processed swiftly.

19.88 During Panel meeting and at the Learning Event, it was identified that Rent Smart Wales could be a valuable resource to safeguarding partners. However, until this review the capability around the sharing of information from the privately rented accommodation perspective was not widely known. The agency is keen to make better connections with other agencies and are prepared to engage with CTMSB.

20 Improving Systems and Practice (National, Regional and Local):

To promote the learning from this case the review identified the following actions and anticipated improvement outcomes:

20.1 This Review has identified that all agencies including statutory, and third sector agencies have a role to play in tackling violent crime to ensure communities within the region are a safe place to live and work.

Recommendation 1 – CTM Safeguarding Board and Community Safety Partnership must strengthen the multi-agency response to serious violence and exploitation in the Region. This should be done by:

- A contextual safeguarding approach
- An understanding of the prevalence of the issues within the region, and
- A strategic platform

This will create a coordinated and evidenced based approach to violence reduction, whilst preventing and protecting individuals and communities from serious violence and exploitation, a key focus of which must be pursuing and disrupting offenders whilst providing reassurance and confidence to communities to report any concerns.

20.2 This review identified incidents of serious assaults and drug related offending not being reported or being progressed through the legal process due to the lack of evidence as a consequence of the reluctance of witness and victim participation in the investigative process.

Recommendation 2 – SWP must satisfy the Regional Safeguarding Board that current legislation around section 28 The Youth Justice and Criminal Evidence Act 1999, as well as witness protection which was introduced to protect vulnerable and intimidated witnesses and victims of violent crime is being consistently used. In addition, there is a need to establish the barriers for non-engagement to identify if the current protection measures in place provide sufficient reassurance to allow fearful and intimidated witnesses to want to engage in investigations.

This will either support current legislative measures are sufficient and effective enough to support engagement of vulnerable and intimidated witnesses through investigations or it will identify a need to escalate the identified concern via the National Police Chief Council to the Home Office to review and strengthen the measures under the legislation.

20.3 This review has identified relatively high levels of violent crime, and that County Lines and Organised Crime Groups are moving into and operating within the local area.

Recommendation 3 – Consideration should be given to the VPU expanding the Hospital Navigator Scheme in the local ED Department to support individual victims of serious injury.

This will ensure a more robust and rapid intervention and support for victims of serious violent crime and exploitation. In the same way as it operates in the city areas, which is recognised as good practice.

20.4 This Review has identified that USW has a plethora of resources available and support services within house for students, however, not all students and other professionals appear to be aware of the significant amount of support that is available.

Recommendation 4 – USW to continue to work with Health, including local GPs and Police to increase awareness and improve engagement with available resources and support for students. This is to be facilitated by existing and new networks, partnerships and agreements which can review existing materials and mechanisms and develop new opportunities for engaging students and raising awareness on drug misuse, cuckooing, knife crime and debt.

This allows the USW an opportunity to review and evaluate how well-informed students are of services and support and will enable health and police alike to understand the USW intervention and support available for students, enabling a more holistic approach to community safety. This is building on the existing provision and is intended to increase the number of students actively seeking advice and support if required.

20.5 It was recognised in this review there are particular circumstances surrounding university students which increase vulnerabilities to unlawful activity, such as drug use and supply.

Recommendation 5 - USW and Student Union should continue to review and evaluate current methods of monitoring risk and the potential for criminality and the illegal supply of drugs on premises.

This will ensure all methods are robust and mitigate further the risk of criminality and illegal drug supply to students who may be feeling vulnerable.

20.6 A more robust response from Social Housing Providers could have potentially identified concerns in relation to both the property and the vulnerability of the tenant being a victim of exploitation.

Recommendation 6 – Social Housing Providers should review and refresh training for all front-line staff, to ensure they are aware of processes and procedures to highlight property concerns and recognise potential signs that make tenants vulnerable to and/or at risk of exploitation and or cuckooing.

Recommendation 7 – Social Housing Providers should conduct a review and audit on property checks and maintenance checks to ensure they are robust and regular enough to highlight these concerns.

This will upskill and develop existing staff and ensure processes are in place to safeguard vulnerable tenants from exploitation of this kind. The maintenance checks on the properties will help to mitigate some of that vulnerability and adhere to acceptable standards.

20.7 It was highlighted in this review that individuals will and do 'self-medicate' when they are symptomatic of a condition, in this case ADHD and struggle to get a formal diagnosis.

Recommendation 8 - CTMHB and the USW to collaborate to enhance understanding of professionals to best support individuals' presenting with ADHD symptoms with an intention of achieving timely diagnosis and reducing maladaptive behaviours.

This will develop and upskill staff in these areas, allowing a better response and understanding to individuals with maladaptive behaviours and coping strategies, ensuring a better-informed intervention.

20.8 In the absence of a specific category for exploitation in the Child and Adult Statutory Protection Procedures, whilst it is expected that no one can agree to be exploited. When identifying an adult at risk It may be assumed that they have capacity or consented and therefore may not be identified 'at risk' which could impact on decision making intervention and safeguarding opportunities.

Recommendation 9 - The Wales Safeguarding Procedures Board should develop a practice guide to cover all forms of adult exploitation. This will support the Statutory Guidance for the Safeguarding of Adults for adoption by each of the safeguarding boards.

This will provide practitioners with the guidance to apply a robust and consistent approach to reported incidents or identification of exploitation involving adults, enhancing opportunities for safeguarding and protecting identified adult victims.

20.9 This review identified that students were using cannabis to help calm their minds or help them to sleep however due to high potency forms

of cannabis this could have the opposite effect as well as worsen pre-existing mental health conditions.

Recommendation 10 – CTMHB to work with the University to ensure they have resources that support and educate students who may use cannabis, to ensure they are aware of the impact use can have on their mental health.

This will allow students to be fully informed of all the risks associated with cannabis misuse with a view to prevent and deter individuals allowing for allowing for informed decision making and with a view to deterring students from using the same leading to healthier lifestyles and better mental health.

When the SUSR meets the Offensive Weapons Homicide criteria: set out in Section 28 (2) and (3) where it is considered that it may be appropriate for a person to take action in respect of those lessons learned, indicate if they have informed that person – personal details should not be included, see 7.13 of the OWHR statutory guidance.

Tap to enter text.

21 Dissemination

List of recipients who will receive copies of the Review Report (in line with guidance and due to the recommendations of this Report):
Please copy and paste the appropriate number of instances.

Date circulated to relevant policy leads: 15.04 2025

Organisation	Yes	No	Reason
CTMSB	☒	☐	Click or tap here to enter text.
NSPCC	☒	☐	Click or tap here to enter text.
SUSR	☒	☐	Click or tap here to enter text.
Rent Smart Wales	☒	☐	Click or tap here to enter text.
Red Thread	☒	☐	Click or tap here to enter text.
WMSB	☐	☐	To be shared upon publication.
University of South Wales	☒	☐	
Home Office	☒	☐	

22 Single Unified Safeguarding Review process

To include here in brief:

- The process followed by the Board and the services represented on the Review Panel
- A Learning Event was held and the services that attended
- Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them where appropriate. Where this was not appropriate, an explanation should have been provided.

This area has been captured between sections 9 through to 16 of this report.

23 Final confidence check

This Report has been checked to ensure that the Single Unified Safeguarding Review process has been followed correctly and the Report completed as set out in the statutory guidance.

I can confirm that this Report section is at a standard ready for publication
☒

Does this Report include aspects which meet the following requirements of completing a Domestic Homicide Review? *The death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by—* *a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or* *b) a member of the same household as himself* If yes, upon completion and ratification by the Safeguarding Board Chair, in consultation with the Community Safety Partnership Chair, the Single Unified Safeguarding Review Report needs to be forwarded to the Home Office Quality Assurance Panel.	☐

For Welsh Government use only

Date information received: Click or tap to enter a date.

Date acknowledgment letter sent to Board Chair: Click or tap to enter a date.

Date circulated to relevant inspectorates/Policy Leads: Click or tap to enter a date.

Agencies	Yes	No	Reason
CIW	☐	☐	Click or tap here to enter text.
Estyn	☐	☐	Click or tap here to enter text.
HIW	☐	☐	Click or tap here to enter text.
HMI Constabulary	☐	☐	Click or tap here to enter text.
HMI Probation	☐	☐	Click or tap here to enter text.

24 Statements of Independence

Statement of Independence by Reviewer(s): Please read and sign the following statement. Consider the section on independence in the SUSR Statutory Guidance before completing. Single Unified Safeguarding Review (SUSR): draft statutory guidance | GOV.WALES
Reviewer 1: Wendi Briggs
Statement of independence from the case *Final check statement of qualification* I make the following statement that prior to my involvement with this learning review: • I have not been directly involved in the case or any management or oversight of the case. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. Therefore, I have met the criteria of an Approved Chair/Reviewer. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies. • I have read and understood the 7 Nolan Principles and will apply accordingly.
Where a Domestic Homicide has occurred, please set out below how you meet Section 4, paragraph 37 of the *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* *Guidance: Explain the independence of the Reviewer and give details of their career history and relevant experience. Confirm that the Reviewer has had no connection with the Community Safety Partnership. If they have worked for any agency previously state how long ago that employment ended:* Tap to enter text.
Signature: W Briggs **Name: Wendi Briggs** **Date:** 14/03/2025

Statement of Independence by Reviewer(s):

Please read and sign the following statement. Consider the section on independence in the SUSR Statutory Guidance before completing. Single Unified Safeguarding Review (SUSR): draft statutory guidance | GOV.WALES

Reviewer 2: Kirsty McDowell

Statement of independence from the case
Final check statement of qualification

I make the following statement that
prior to my involvement with this learning review:

- I have not been directly involved in the case or any management or oversight of the case.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. Therefore, I have met the criteria of an Approved Chair/Reviewer.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies.
- I have read and understood the 7 Nolan Principles and will apply accordingly.

Where a Domestic Homicide has occurred, please set out below how you meet Section 4, paragraph 37 of the *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*

Guidance: Explain the independence of the Reviewer and give details of their career history and relevant experience. Confirm that the Reviewer has had no connection with the Community Safety Partnership. If they have worked for any agency previously state how long ago that employment ended:
Tap to enter text.

Signature: K McDowell
Name: Kirsty McDowell
Date: 14/03/2025

Statement of Independence by Chair of the Review Panel:
Please read the following statement and sign below. Consider the section on independence in the SUSR Statutory Guidance before completing. Single Unified Safeguarding Review (SUSR): draft statutory guidance | GOV.WALES

Final check statement of qualification

I make the following statement that prior to my involvement with this learning review:

- I have not been directly involved in the case or any management or oversight of the case.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. Therefore, I have met the criteria of an Approved Chair/Reviewer.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies.
- I have read and understood the 7 Nolan Principles and will apply accordingly.

Where a Domestic Homicide has occurred, please set out below how you meet Section 4, paragraph 37 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

Guidance: Explain the independence of the Chair of the Review Panel and give details of their career history and relevant experience. Confirm that the Chair of the Review Panel has had no connection with the Community Safety Partnership. If they have worked for any agency previously state how long ago that employment ended:

Tap to enter text.

Signature: S Hurley
Name: Susan Hurley
Date: 14/03/2025

25 Review Panel Members

(Delete if not relevant)

Number of times the Panel met: Click or tap here to enter text.

Role and job title	Agency	Confirm Independence
CSP Manager	Cwm Taf Community Safety Partnership	☒
Head of Partnerships	RCT Children's Services	☒
Head of Violence Reduction Unit	Violence Prevention Unit	☒
Head of YJS	Cwm Taf Youth Justice Service	☒
Head of Safeguarding	Cwm Taf Morgannwg Health Board	☒
Statutory Review Manager	South Wales Police	☒
Review Officer	South Wales Police	☒
Senior Investigation Officer	West Midlands Police	☒
Director of Student Services	University of South Wales (USW)	☒
Business Manager	CTM Safeguarding Board	☒
Corporate Director	Trivallis, Housing	☒
Operational Manager	Rent Smart Wales	☒
Harm Reduction Coordinator	RCTCBC / Substance Misuse Area Planning Board	☒
Service Manager	Substance Misuse Service Provider	☒

26 Terms of Reference

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were outcome focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress. Panel also agreed that the parents of the deceased should be allowed to provide a pseudonym for their son for the purpose of the report.
- In addition, seek contributions from principal individuals including all perpetrators and any identified witnesses to the incident that led to this review.
- Take account of any parallel investigations, reviews or proceedings related to the case ensuring that where there are criminal proceeding the OWHR should progress in a way which does not jeopardise the integrity of, or undermine, the criminal investigation or criminal justice proceedings.
- Hold a learning event for practitioners and identify required resources to establish what lessons are to be learned from the incident.
- This review has identified a potential link to an organised crime group. Panel members agreed that there is a responsibility to protect the identity of any perpetrator who may have agreed to contribute to this review process. The reason being there is a possible risk of harm to them from other person/s. Consequently, to eliminate the risk perpetrators will be referenced with the prefix letter P (Perpetrator) followed by a number.
- Produce a report of the findings of the review.
- Identify clearly in an action plan what the lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

    - Apply these lessons to service responses including changes to the policies and procedures as appropriate.
    - Improve future outcomes to safeguard victims and support perpetrators and Prevent Offensive Weapon Homicides through improved intra and inter-agency working.
    - Highlight good practice.

In addition to the review process, to have regard to the following:

- Whether previous relevant information or history about the individuals at risk and/or family members was known and considered in professionals' assessment, planning, and decision-making in respect of the adult at risk, the family, and their circumstances. How that knowledge contributed to the outcome for the individual at risk.

- Whether the actions identified to safeguard the individuals at risk were robust, and appropriate for that person and their circumstances.
- Whether the actions were implemented effectively, monitored, and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the individual at risk. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the individuals at risk and families were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the Review Panel in accordance with guidance.
- Agree the time frame.
- Identify agencies, relevant services, and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline on each of the 7 individuals included in this review, initial analysis, and hypotheses.
- Plan with the reviewer/s a learning event/s for practitioners/managers and have, to include identifying attendees (who must have had previous involved with one of the 7 persons involved in this review or had been involved with decision making around the same) and arrangements for preparing and supporting them pre and post event, and arrangements for feedback. Details of the attendees will be expected to be produced at the second panel meeting.
- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft SUSR report to ensure that the Terms of Reference have been met, the initial hypotheses addressed, and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan and make arrangements for presentation to the Board for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Additional Areas of Focus

- Include with a view to better understanding culture of organised Crime Gangs and the potential for safeguarding of those involved to identify any barriers.
- Understand from this case both the implications of and the extent of infiltration of illegal drug abuse within the communities and any management prevention or support around the same.
- Identify if there are signs of criminal exploitation amongst individuals featuring in this review.
- Are cross border investigations and information sharing sufficiently robust to manage the risks.
- Are there identified links between the feeling of isolation through lack of friends and family resulting in students who are residing away from home becoming vulnerable and susceptible to the use of illegal drugs. How is this identified and what provisions are put in place to support those individuals.
- Are there any examples of outstanding or innovative practice arising from this case.
- Highlight any relevant changes in practice that have taken place in any organisation since this time of this incident which may have led to a different outcome.

Timeframe for the OWHR

The timeframe set for the Review is from 18th August 2022 the date of his death.

Agencies will provide summary reports of any significant events occurring either prior or after this date. In these summaries it would be beneficial to highlight any changes in policy procedure or practice relevant to this review.

Learning Event

The learning event will ensure that the voice of practitioners directly contributes to the review and that practitioners can hear the perspectives of the family and other relevant individuals. Practitioners and managers are expected to attend if asked. All practitioners will reflect on what happened and identify learning for future practice.

The Review Panel has responsibility for supporting the reviewers in carrying out an effective learning event.

At the outset it was anticipated that the Learning Event would be held on 25th September 2024. However, since the criminal trial in this has concluded with sentencing taking place on 26th September it was felt that the Learning Event would be moved to 15th October 2024.

Completion Date

The target completion date set for the Review is March 2025.

Tasks of the Safeguarding Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Ensure the Review Panel completes the report and action plan.
- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government (and in cases of Offensive Weapon Homicide Reviews the Home Office).
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored, and reviewed.
- Plan publication on Board website and SUSR Co-ordination Hub website and submission to the SUSR repository.
- Agree dissemination to agencies, relevant services, and professionals.
- The Chair of the Board will be responsible for overseeing all public comment and responses to media interest concerning the review until the process is completed.

When the Single Unified Safeguarding Review includes and Domestic Homicide, please refer to the Terms of Reference guidance in the *Multi-agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016)*[14].

[i] https://www.kirkleessafeguardingchildren.co.uk/wp-content/uploads/2022/09/Debt-Bondage-in-a-Criminal-Exploitation-and-County-Lines-context-A-support-resource-for-professionals.pdf

[14] Multi-agency Statutory Guidance