Domestic Homicide Review

Executive Summary

Gwynedd and Anglesey
Community Safety Partnership

Report into the death of Elizabeth
June 2022

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1. Executive Summary

The independent author, Domestic Homicide Review (DHR) panel and the Gwynedd and Anglesey Community Safety Partnership (CSP) wish to offer their deepest condolences to everyone who was affected by Elizabeth's[1] death.

In addition to this, the author of the report, and the panel, would like to extend our thanks to all professionals who responded to the Independent Management Reviews (IMR), their time and effort enabled some robust analysis and recommendations.

Finally, the author of the report would like to extend her sincere thanks to the panel members for their professionalism and the considered manner in which they approached this review.

Facts

Elizabeth and George[2] had four children together. Elizabeth lived with George and their adult son, David[3], on the Isle of Anglesey. Elizabeth and George's three other adult children consisted of two daughters and another son. One of Elizabeth's daughters, Mandy[4], lived close by with her husband Josh[5]. Elizabeth's other daughter did not reside in the UK at the time of her death. Her other son lived in England.

Elizabeth was an elderly woman of 83 years, her husband George was 85 at the time of her death, and her son David was 56. David had lived with his parents all of his adult life. David was reported to have substance misuse issues and mental health problems, and he was not in employment. Elizabeth had numerous health issues, these combined with her age, made her vulnerable. George also had a number of health issues.

Elizabeth and George had lived in England for a period of time some years prior to her death, but they relocated back to Wales with the family. From all the information gleaned by the panel, the family were intensely private, they did not converse with neighbours and were not involved in community life on the Isle of Anglesey.

Prior to Elizabeth's death, there had been two previous calls to the police for domestic abuse incidents, involving David towards both his parents. In September 2020, a member of the public called the police stating they wanted to *'report a domestic'*. The caller stated that *'an elderly couple'* 'and *'their son'* were at the address. The member of the public stated: the son *'is a known drinker'* and that they can *'hear him shouting at them and is very threatening'*, the caller stated that this '*isn't the first time'* they had '*heard this'*.

[1] Not her real name
[2] Not his real name
[3] Not his real name
[4] Not her real name
[5] Not his real name

The second recorded incident was in November 2021 when a silent call from the property was answered by the police. Police hear a female on the call, and a male in the background shouting and behaving aggressively, he was thought to be intoxicated. Police record the male saying: *"you're gonna [sic] pay for this"* and *"you fucking shit".*

On attendance at the property officers described Elizabeth and George appear to be *'hiding'* from David, who is very intoxicated. Whilst the officers are outside the room Elizabeth and George are hiding in, they can be overheard talking to each other saying:

"he's very, very angry", and *"I'm very, very scared".*

In June 2022, police received a call in the early hours of the morning, from Elizabeth's son in law, Josh, stating that his mother-in-law had fallen. George had been resting on his bed because he was feeling unwell, and he heard a scream. When he went to check he found Elizabeth on the floor of the living room in significant pain. George called his daughter Mandy for help, and she sent her husband, Josh, over. David was at the property being abusive; when he would not calm down George asked Josh to call the police. By the time the police arrived, Elizabeth had been on the floor for approximately three hours.

Whilst the police were on the phone to Welsh Ambulance Services NHS Trust (WAST), Elizabeth disclosed to an officer that she had been pushed by David. David had already been arrested for a breach of the peace at the scene, and he was further arrested for assault of Elizabeth after her disclosure. Elizabeth died in hospital two days later, and David was subsequently arrested for the murder of his mother.

After a full investigation by NWP, the Crown Prosecution Service (CPS) reviewed the evidence and concluded a decision of no further action to be taken against David.

2. Domestic Homicide Review

2.1 The referral from North Wales Police (NWP) was sent to the CSP on the 24/06/2022. The decision to undertake a DHR was made by Gwynedd and Anglesey CSP on 29/06/2022. The Home Office was subsequently informed on 06/07/2022. In September 2022 the CSP commissioned Dr Shonagh Dillon, to undertake the role of independent author and chair to the panel, and the DHR panel was convened.

The review considered agency contact with Elizabeth, her husband George[6], and her son David[7] for the period of:

- January 2018 until June 2023

[6] Not his real name
[7] Not his real name

The panel members met on the following dates:

- 24/01/2023
- 15/06/2023
- 20/09/2023

2.2 Domestic Homicide Reviews came into force on the 13/04/2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a DHR should be a review of the circumstances in which 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 she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death[8].

2.3 The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

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

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

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice

3. Terms of Reference

[8] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office - December 2016

3.1 The Terms of Reference guidance set out the purpose and the scope of the review and the panel focused specific questions to each agency whilst undertaking the analysis of their involvement with Elizabeth, George, and David between January 2018 until June 2023.

The questions were as follows:

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers victim or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.
    - In regard to vulnerability and age and any potential impact this had ensuring the safeguarding of any children during the review.

- Examine the events leading up to the incident, including a chronology of the events in question.
- Review the interventions, care, and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether practices by all agencies were sensitive to the sex, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.
- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

The authors of the IMRs are independent in accordance with the Home Office guidance[9].

The full Terms of Reference are available in Appendix A of the overview report.

4. Independence

The author of this report, Dr Shonagh Dillon, was independent of all agencies involved in the panel. She had no previous dealings with the initial inquiries and no contact or knowledge of the family members.

Dr Dillon is a Home Office accredited DHR chair and has nearly three decades of professional experience in the male violence against women sector supporting victims and survivors of domestic abuse, sexual violence, and stalking.

All IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. None of the panel members were the immediate line managers of anyone who engaged with Elizabeth, George, or David.

5. Parallel Reviews

A Home Office post-mortem was conducted and concluded in June 2022. Elizabeth's death was recorded by the coroner as one related to various health conditions, including traumatic skeletal fractures.

Discussions were undertaken as to whether the death of Elizabeth should be reviewed under an Adult Practice Review, ultimately it was decided that a Domestic Homicide Review would take precedence. There were no other parallel review processes arising from Elizabeth's death.

6. Methodology

6.1 Following the decision to conduct the review, NWP provided the panel with a timeline of the investigation and the proceeding case. Subsequently, several other statutory and voluntary sector agencies were asked to return a chronology of their involvement to help the panel understand and analyse any interactions agencies had with Elizabeth during the specified review period.

Having considered the chronologies, the following Individual Management Reviews (IMRs) were requested:

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9 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf (Section 7)

a) North Wales Police (NWP)
b) Welsh Ambulance Services NHS Trust (WAST)
c) Betsi Cadwaladr University Health Board (BCUHB)
d) Isle of Anglesey County Council Adult Services

The panel undertook further research regarding a period of time that Elizabeth and George had lived in England, after data revealed there was no information of significance during this period in England, the panel agreed the information from the agencies above would form the basis for the review.

6.2 The DHR panel consisted of the following agencies and professionals:

Name	Job Title
Dr Shonagh Dillon	Chair of panel/Author of review
	Senior Operational Officer, Gwynedd and Anglesey Community Safety Partnership
	Senior Operational Officer, Gwynedd and Anglesey Community Safety Partnership
	Safeguarding Specialist Paramedic, Welsh Ambulance Services NHS Trust
	Head of Services and Survivor Engagement, Welsh Women's Aid
	Domestic Abuse/MARAC Detective Inspector, North Wales Police
	Service Manager (Safeguarding and Quality), Isle of Anglesey County Council
	Service Manager – Community Housing, Anglesey

6.3 The chair would like to thank all professionals involved in this review, their time, effort, and cooperation was exemplary.

7. Confidentiality

The Individual Management Reviews (IMR) will not be published but the DHR report will be made public.

The contents of this report are anonymised to protect the identity of the deceased, family, friends, staff, and others to comply with the Data Protection Act 2018[10].

8. Involvement of Family and Friends

7.1 Victim

After speaking with the Family Liaison Officer (FLO) from NWP, the chair of the panel wrote to Elizabeth's family in February 2023. The contacts included two of her adult children living in the UK, and her husband George. Unfortunately, there was no address for Elizabeth's daughter who lived abroad, therefore no contact was made with her. Another letter was sent at the end of March 2023. After receiving no response, the chair wrote to Mandy and Josh separately in May 2023. Mandy was the daughter who lived closest to Elizabeth, and she, and her husband Josh, had the most contact with Elizabeth, George, and David. Mandy had expressed to the FLO that she would be interested in contributing to the review. Unfortunately, no response was received on any of the correspondence sent out to the family, therefore this review is limited in terms of the views of the victim and her family.

It would be normal practice for the chair to contact friends or neighbours of the victim to see if any of them would be willing to contribute to the review process, however, Elizabeth and the family were incredibly private and there were no avenues available for the chair to pursue.

Unusually this means that we know very little about Elizabeth, who she was, and what she enjoyed in life. From the little we do know about her we can confirm she was married to George for many years and was very close to her family.

Although we have no further information about Elizabeth, it was important for the panel to ensure her voice was not lost in the bureaucracy of the review. We have therefore done our best to honour her and design the review based on the culture, demographic, and specific needs of an indigenous elderly and isolated woman living on the Isle of Anglesey.

7.2 Alleged perpetrator

The chair of the panel wrote to Elizabeth's son David in February 2023 and again in March of 2023. David resided at home with his parents, and as the panel understands is still residing with his father, George. The panel placed due regard in relation to safeguarding in these matters, and from the information contained in the IMRs we understood it was very unlikely we would be able to gain the views of George or David.

[10] https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Every attempt was made to gain the perspective of David and any others who knew him for this review, but due to the lack of information this review is limited on its analysis from the perspective of the alleged perpetrator.

In response to the lack of information about David or anyone who knew him, the panel have used demographic information available and the voice of community members in the Isle of Anglesey to describe the issues relating to employment and multiple disadvantages of Anglesey residents. It is hoped that this input can inform the recommendations for Gwynedd and Anglesey moving forward.

9. Key Findings and Conclusions

8.1 Coercive and Controlling Behaviour

Signs of Coercive and Controlling behaviour is often difficult for professionals to identify. Victims may not overtly be telling us what is going on within a relationship, and many have lived with controlling behaviour for so long that they do not understand what is happening to them is a criminal offence. The ways in which victims present can tell us a lot about what is going on for them. These presentations can widely vary, especially dependant on the compounding factors and diverse nature of victim's culture and protected characteristics. In Elizabeth's case her age and sex were an important factor. There is not a neat list that professionals can be given to understand how victims display their 'trauma' as they are not a homogonous group. Equally the presentation and narrative of perpetrators provides us with insights into what may lay behind a situation that is being fed to us as professionals. Tools like the DASH and assessment forms within health and social care provide professionals with useful prompts for identifying CCB, however frontline professionals should be supported to better understand the complexities of Coercive and Controlling behaviour, they should also be given permission by training departments and supervisors to follow their instinct and probe further when something doesn't 'feel' right. This is particularly important in terms of perpetrators who exert power and control over vulnerable victims – it may be hard to 'engage' those victims, as that is the purpose of the control.

8.2 Filial Abuse

Filial abuse is the abuse of parents by their dependants and is inadequately researched, therefore difficult to respond to for professionals. The ways in which victims of filial abuse will access support, disclose the abuse they are being subjected to, and respond to support will be very different. Victims of filial abuse will often be perceived as not taking 'action' to support themselves, and this can reinforce the

feelings of powerlessness and isolation they are experiencing. We need to have national conversation about filial abuse, and the focus of research must also incorporate adult dependents who reside in households with elderly parents.

8.3 Older people as victims of abuse

Although older people as victims of domestic abuse on the whole is better researched than filial abuse, the lack of training and awareness amongst professionals in how to respond to the intersecting needs of elderly victims was concurrent throughout the analysis into Elizabeth's case.

Fortuitously just prior to submission of this report the Wales Violence Prevention Unit (WVPR), published their data on abuse against older people[11]. The data evidences an increase in domestic abuse and sexual offences against older people across the country. Although it is harrowing to see the numbers of offences recorded increase, it could be viewed as a positive development as more victims are coming forward to report. Professionals need the infrastructure and support to respond adequately to domestic abuse victims who are older.

Further upskilling up an already compassionate multi-agency workforce will not be difficult, and throughout the analysis the chair noted that professionals acted with care and kindness towards Elizabeth, despite the presentation of the family as one being of a closed book that needed little outside support. The key aspect needed for Gwynedd and Anglesey to move forward in this area of knowledge is good investment in terms of training, promotion and awareness raising of older people as victims of domestic abuse.

The National Training Framework (NFT)[12] incorporates the Ask and Act training. This training framework is already well established in Wales:

- One of the key mechanisms for delivering the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act is the National Training Framework.
- Offering proportionate training to strengthen the response provided across Wales to those experiencing these issues.
- It will formalise the requirements of those offering specialist and universal services and raise awareness and understanding of such violence and abuse.

Wales has made significant progress in developing the workforce with regards to domestic abuse and sexual violence. This in turn provides a great conduit for incorporation of the learning from this review to ensure filial and elder abuse form key drivers for the framework moving forward.

[11] https://mcusercontent.com/af96e5bc7dd21d56d7a30afc0/files/0fbcecea-5119-4888-b7f1-ce515d88c540/OFFICIAL_Violence_Against_Older_People_in_Wales_Report.pdf
[12] https://senedd.wales/laid%20documents/sub-ld10514/sub-ld10514-e.pdf

8.4 Rural Communities and Domestic abuse

The Domestic Abuse Commissioner provided a detailed survey mapping[13] service provision across England and Wales in November 2022. The results of the survey evidence a patchwork of service provision for victims. This is even more apparent when exploring service provision for victims in rural communities. Research by the Rural Crime Network in 2019[14], revealed the difficulties and compounding factors for victims in rural areas, in both trying to access services and in the culture of complicity in close knit communities.

It is essential that devolved governments respond to victims of domestic abuse in rural areas in unique and creative ways. What works for urban areas may not work for rural areas and adequate resources need to be allocated to ensure rural communities are supported to deliver bespoke services to reach victims in their communities.

In addition, the response to perpetrators who also present with mental health and substance misuse issues needs to be a focus for rural areas, especially those with severe economic disadvantage. Service provision and or community responses towards perpetrators with compounding issues are already a postcode lottery in urban areas, meaning the interventions delivered and resources given to professionals in rural areas can be even more restrictive.

8.5 Health routine screening

Health services were the main agency to have contact with Elizabeth, and this is a concurrent theme with other DHRs the author of the review has undertaken. Routine screening and targeted enquiry are well-established mechanisms within health agencies to identify victims of domestic abuse, however, the practice of screening victims, or asking targeted questions can still be patchy and information sharing is not always consistent. Health agencies need to be supported to continuously remind and reinforce the importance of routine screening to all staff. In addition, support, training, and awareness raising should be routine for the intersecting needs of victims where age is a protected characteristic.

8.6 Impact of fatal deaths of victims of domestic abuse on professionals

The author of this report is now routinely asking panel members on all reviews to feedback the experiences of team members of the impact of a death related to domestic abuse from someone they worked with, this includes where professionals have reviewed a case, where a victim has died. As professionals we are rightly expected to focus on the recommendations needed to ensure victims like Elizabeth are supported better in the future. All panel members came to the review with valuable information, with detailed IMRs and with an energy to want to change anything that did not work for Elizabeth. However, in order to foster change professionals, need to be offered support in ways that ensure their learning or development is not curtailed

[13] https://domesticabusecommissioner.uk/wp-content/uploads/2022/11/DAC_Mapping-Abuse-Suvivors_Long-Policy-Report_Nov2022_FA.pdf
[14] https://www.northyorkshire-pfcc.gov.uk/wp-content/uploads/2019/07/Domestic-Abuse-in-Rural-Areas-National-Rural-Crime-Network.pdf

by the emotional impact that losing a victim has on themselves. Professionals working in emergency services, social care, health, and voluntary sector agencies are largely people who want to help, they want to assist people at a time when they need the most help. When a death related to domestic abuse occurs it is imperative that support is offered to professionals by specialists who understand the complexities of domestic abuse. A supported multi-agency workforce ensures victims receive better services, not to mention the fact that many professionals will be victims themselves.

10. Recommendations

Single Agency Recommendations

9.1 All single agency recommendations were accepted by the panel and are reflected in the action plan (section 15 of the overview report). Where the panel felt there were further recommendations for agencies, they have added these to the action plan.

Multi-Agency Recommendations

9.3 North Wales Vulnerability and Exploitation Partnership Board to update VAWDASV priorities to include older victims of domestic abuse.

9.4 Awareness raising on Isle of Anglesey:

- Promote materials that inform community residents on the importance of reporting domestic abuse within the Isle of Anglesey, including anonymous reporting. (*See it say it campaign*)
- Re-promote NWP target hardening campaign materials, and NWP *'Call the police if you see this'* campaign.
- Sustained financial support for the Agencies Domestic Abuse Perpetrator Targeting (ADAPT)[15] model and the perpetrator programmes across Anglesey and Gwynedd:

  The overarching objectives of ADAPT are to safeguard adults and children at risk of domestic abuse by changing or disrupting offender behaviour and to reduce the offending of domestic abuse perpetrators. (DA Practice Guide, NWP, 2021).

9.5 Consider the learning from this review and ensure relevant matters (specifically older people as victims of domestic abuse and filial abuse) are built into local training as part of the implementation of the National Training Framework and Ask and Act.

9.6 Explore funding options to sustain the IRISi project in Denbighshire and the proposed further roll out of the service in North Wales, including Anglesey.

[15] https://www.leaderlive.co.uk/news/20205738.police-work-perpetrators-tackle-domestic-abuse/

9.7 Track and monitor increase in referrals of older people to Gorwel domestic abuse services, once above actions have commenced.

National recommendations

9.9 Commission extended research into older victims of domestic abuse ensuring filial abuse is considered within the context of older victims.

9.10 Provide more focused promotion and research into the issues faced by victim/survivors in rural areas across Wales. Providing an understanding through research of the culture, demographics and issues that are unique to Wales.

9.11 Commission research into the impact of domestic homicide/suicide on professionals in emergency services, health/social care, voluntary, and CJS sectors.