Domestic Homicide Review

Overview Report

Gwynedd and Anglesey
Community Safety Partnership

Report into the death of Elizabeth
June 2022

Author – Dr Shonagh Dillon, LLB, DCrimJ

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Glossary

ADAPT - Agencies Domestic Abuse Perpetrator Targeting

AS – Adult Services

AWARE (training) - Appearance, Words, Activity and Behaviours, Relationship and Dynamics, and Environment

BCUHB - Betsi Cadwaladr University Health Board

CCB – Coercive and Controlling Behaviour

CID16 - Criminal Investigation Department report (safeguarding)

CMP - Crime Management Plan

CPS – Crown Prosecution Service

CSP – Community Safety Partnership

DA – Domestic Abuse

DAO – Domestic Abuse Officer

DARA – Domestic Abuse Risk Assessment

DASH – Domestic Abuse, Stalking and Honour Based Violence

DASU – Domestic Abuse Services Unit

DHR – Domestic Homicide Review

DVA – Domestic Violence and Abuse

DVPN/O – Domestic Violence Protection Notice/Order

ED – Emergency Department

EOEL 7 – Occurence Enquiry log within the Police Crime Recording System

ePCR- Electronic Patient Clinical Records

FLO – Family Liaison Officer

GDP – Gross Domestic Product

GP – General Practitioner

HITS - Hurt, Insult, Threaten, Scream

ICAD - Intergraph Computer Aided Despatch System

IDVA – Independent Domestic Violence Advocate/Advocacy

IMR – Independent Management Review

IRISi – Identification and Referral to Improve Safety

MARAC – Multi-Agency Risk Assessment Conference

MHA – Mental Health Act

NHS – National Health Service

NICE – National Institute for Care Excellence

NMO – Non-molestation Order

NTF – National Training Framework

NWP – North Wales Police

ONS - Office of National Statistics

OT - Occupational Therapist

PSED – Public Sector Equality Duty

REDA - Routine Enquiry Domestic Abuse

RMS – Record Management System

SSWW - Social Services and Wellbeing (Wales)

SMS - Substance Misuse Services

VARM - Vulnerable Adult at Risk Management

VAWDASV - Violence Against Women Domestic Abuse and Sexual Violence

UNODC - United Nations Office on Drugs and Crime

WAST - Welsh Ambulance Services NHS Trust

WG – Welsh Government

WHO – World Health Organisation

WVPU - Wales Violence Prevention Unit

DHR Overview Report into the death of Elizabeth, in June 2022.

Preface

The independent author, DHR panel, and the Gwynedd and Anglesey Community Safety Partnership 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 (IMRs); their time and effort enabled 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.

1. Introduction and Background

1.1 This review will examine the circumstances surrounding the death of Elizabeth, aged 83, who died in her home in June of 2022.

1.2 Domestic Homicide Reviews (DHRs) came into force on the 13th of April 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[2].

1.3 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.

[1] Not her real name

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

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 (DA) 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.

1.4 Timescales

This report of a death, where domestic abuse was identified, analyses the agency involvement and responses afforded to Elizabeth, who was a resident in Anglesey at the time of her death.

The review will consider agency contact with Elizabeth, her husband George[3], and her son David[4] for the period of:

- January 2018 until June 2022

The period of time for the review was agreed after due regard was paid to any information that may be held outside of this timeframe. Analysis by the panel revealed the time frame to be appropriate and was agreed by all panel members on 24/01/2023.

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 panel members met on the following dates:

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

[3] Not his real name

[4] Not his real name

1.5 The overview report and executive summary were presented to the Anglesey and Gwynedd CSP board for approval on 17/11/2023 and submitted to the Home Office on 6/12/2023. The report was considered by the Home Office Quality Assurance Panel on 20/03/2024 and approved for publication on 23/04/2024.

1.6 Gwynedd and Anglesey takes the issue of VAWG seriously; the area has an exemplary record of prioritising and commissioning innovative services for victims and survivors of domestic abuse. Gwynedd and Anglesey adhere to the overarching principles outlined in the Welsh Government's Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Strategy[5]. Gwynedd and Anglesey local authorities are members of the North Wales Vulnerability and Exploitation Partnership Board, which have the following VAWDASV priorities:

- PREPARE: To support the Partnership and communities to understanding the scope and breadth of the problem, what risk looks like and understand how to increase safety and promote healthy relationships.

- PREVENT: Commit to a whole systems approach to prevention. Utilise all available resources to protect victims. Increased awareness in children and young people of the importance of safe, equal, and healthy relationships and that abusive behaviour is always wrong.

- PROTECT: Provide the best possible support, intervention and services to victims, survivors, and their families, as well as support to change behaviour of perpetrators where appropriate. Increased focus on holding perpetrators to account and provide opportunities to change their behaviour based around victim safety.

- PURSUE: Respond to perpetrators, holding them to account through enforcement activities. Make early intervention and prevention a priority. Relevant professionals are trained to provide effective, timely and appropriate responses to victims and survivors. Provide victims with equal access to appropriately resourced, high quality, needs-led, strength-based, gender responsive services across North Wales.

1.7 <u>People involved in the DHR:</u>

Name	**Age at time of death**	**Relationship with the victim**	**Ethnicity**
Elizabeth	83	Victim	White British
George	85	Husband	White British
David	56	Son / Alleged Perpetrator	White British

[5] https://www.gov.wales/violence-against-women-domestic-abuse-and-sexual-violence-strategy-2022-2026-html

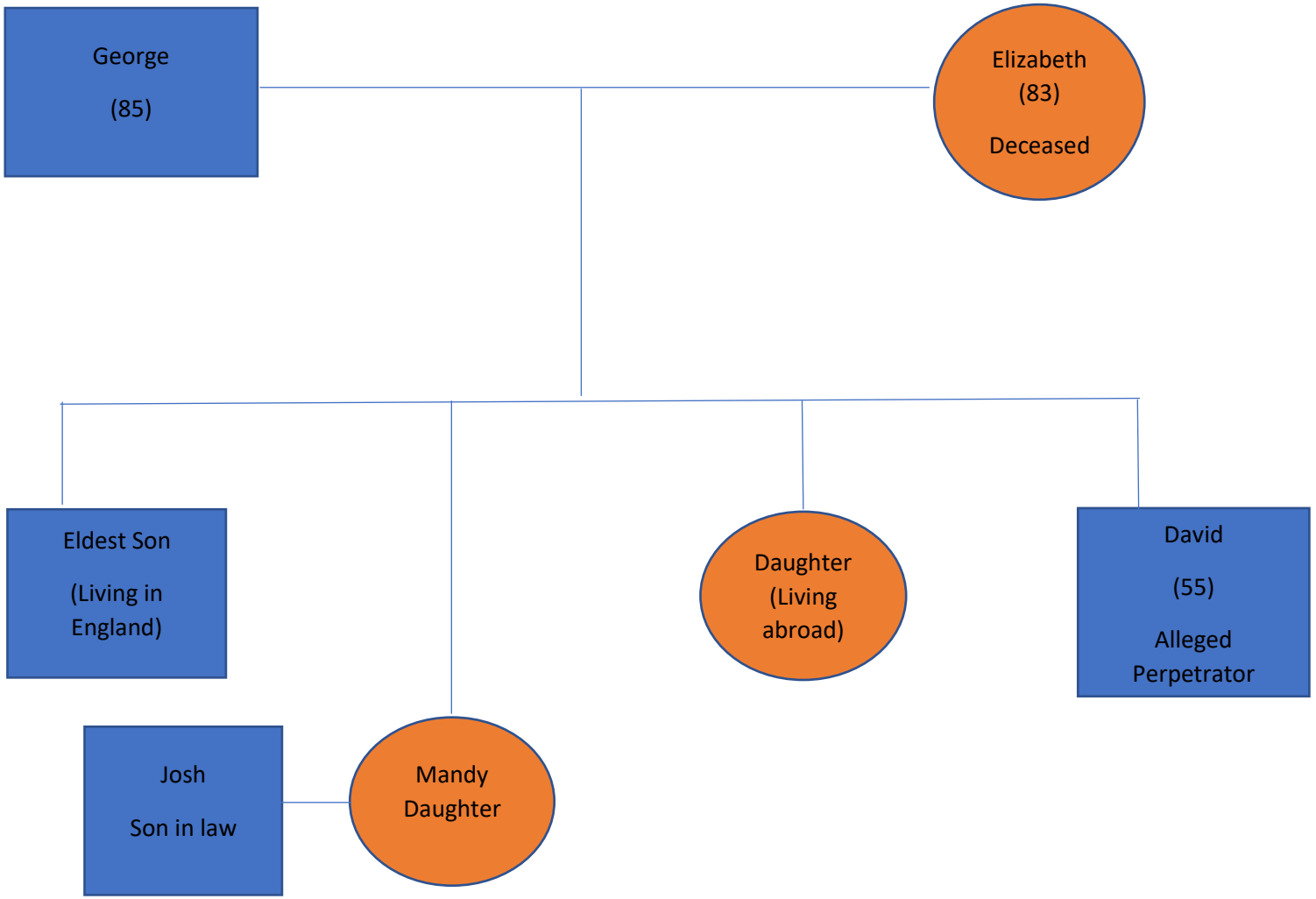
The panel has applied the Home Office guidance and has given the pseudonyms identified above to the family members and the victim. It is hoped this humanises the review process and eases the reading of the report.

2. Parallel Reviews and Processes

2.1 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.

2.2 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.

Genogram – Elizabeth's Family (no real names used)



Case Summary:

Elizabeth and George had four children together. Elizabeth lived with George and their adult son, David, 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[6], lived close by with her husband Josh[7]. Elizabeth's other daughter did not reside in the UK at the time of her death. Her other son lived in England (see genogram p.7).

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, he was not in employment at the time of Elizabeth's death. Elizabeth had numerous health issues and 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.

There had been previous call outs to the police for DA incidents involving David being aggressive towards both his parents; these will be referred to in more detail in the NWP IMR.

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, to the address. David was at the property and being abusive. As David 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.

[6] Not her real name

[7] Not his real name

3. Domestic Homicide Review Panel

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

The Quality Assurance (QA) panel for the Home Office (HO) noted that Age UK or Dewis choice may have been beneficial panel members given the circumstances of the case. This recommendation will be taken forward by the CSP in any similar reviews.

4. Independence

4.1 The author of this report, Dr Shonagh Dillon, was independent of all agencies. 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 DA, 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. Terms of Reference

5.1 The full terms of reference, which were agreed at the first panel meeting and reviewed at the subsequent meetings, are included in Appendix A of this report.

6. Confidentiality and Dissemination

6.1 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[8].

6.2 The Gwynedd and Anglesey CSP will be responsible for monitoring the individual agencies tasked with implementation of recommendations.

Once clearance has been approved by the Home Office quality assurance panel, the dissemination of the overview report will be published on the Gwynedd and Anglesey Community Safety website[9], and learning will be widely disseminated, including but not limited to:

- The Community Safety Partnership
- Regional Vulnerability and Exploitation Board
- Senior manager of each participating agency
- Police and Crime Commissioner
- Domestic Abuse Commissioner for England and Wales
- North Wales Safeguarding Board
- Local MARAC

7. Methodology

7.1 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 that agencies had with Elizabeth during the specified review period.

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

[8] https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted
[9] https://www.gwynedd.llyw.cymru/en/Residents/Community-safety.aspx

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. However, after data revealed there was no information of significance during this period in England, the panel agreed that the information from the agencies above would form the basis for the review.

7.2 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 2022.

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 fully explored.

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers the 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, and
    - 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 from 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.

- Examine 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.

- Examine 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[10].

7.3 This report is based on:

- The findings of the IMRs
- Further requested information and analysis resulting from the IMRs
- Interactions with community members and professionals based in Anglesey.

The IMRs are set out below (see section 9). Each IMR author offered single agency recommendations which are presented in section 15 of the report. The panel have reflected and amended where they felt that single agency actions needed further clarity, and these are reflected in section 14.

The full recommended action plan is presented in section 15 of this report.

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

The conclusions and recommendations are the collective views of the panel, which has the responsibility, through the participating agencies, for implementation of any improvement recommendations.

8. Involvement of Family and Friends

8.1 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 from 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.

The Quality Assurance QA panel for the HO noted that the family were only contacted by letter – this was the only contact method the family consented to by the chair, and the FLO did alert Mandy and Josh to the potential for them to be involved, but they ultimately chose not to contribute to the review.

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 in the Isle of Anglesey.

8.2 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 the panel understands he 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.

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 Independent Management Reviews

9.1 Independent Management Review – North Wales Police (NWP):

Key Incident Timeline:

NWP received three calls to Elizabeth's address during the review period.

9.1.1 Incident one:

In September of 2020, NWP received a call from a member of the public reporting a domestic incident at Elizabeth and George's home.

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"*.

When the police arrived, there was no ongoing dispute and they found Elizabeth in one room and George and David in another room. The family were unhappy that the police had been called and expressed surprise at the attendance, they said they thought the call had been malicious because they did not mix with the neighbours, and Elizabeth said that George and David had an argument, like any family does. Elizabeth went on to explain that they were having a new kitchen fitted and were on top of each other – the argument ensued because of the smell of the microwave in the living room when cooking food and David had wanted the window open.

When George and David were spoken to, they expressed unhappiness that the police had been called and said that the neighbours were jealous because they were getting a new kitchen and had flowers in their garden. They explained that David was a carer for both his parents and said they got on well. The police found nothing of concern at the property or in the presentation of George and Elizabeth.

It is normal procedure on a DA call out for the police across the UK to undertake a risk assessment after each reported incident. This risk assessment is used across multi-agency partners to assess the needs of the victim and the context of the offending of

any alleged perpetrators. The form is called a Domestic Abuse, Stalking, Honour Based Violence and Harassment[11] tool (DASH):

> *"DASH is a multi-agency risk assessment tool designed to manage risk for victims and co-ordinate safety plans and services. A DASH is completed by a professional who asks the victims a list of between 24 or 27 questions, the information given by the victim is then used to assess the risk the perpetrator presents to the victim and facilitate a safety plan to safeguard against further abuse and violence."*

The DASH was not completed by NWP after this incident as the attending officer did not recognise that the matter was a 'domestic' report. The reviewing officer within the NWP control centre asked for a DASH score, in line with NWP Policy, prior to closing the incident log. The incident log is finalised as *"DASH - not assessed/ declined"*. Positively, however, the attending officer did undertake a thorough report on the incident on the force Record Management System (RMS), which included a supervisory review.

9.1.2 Learning Points – Incident one:

The IMR author reviewed all the documentation relating to the incident above in line with the Crime Management Plan (CMP), which is a document that sets out the expectations for crime investigations and their management. In relation to NWP's response to DA, the document states that a supervisor should:

> *"Dynamically review and manage reports of domestic abuse ensuring that the appropriate resources are put in place to identify, manage, and document the threat, risk and harm to the victim and any children of the parties involved."*

The level of detail the attending officer addressed in the full report was very insightful, including the description of the resistance the family had to police attending the property. Although a DASH was not completed, the report did include a safeguarding report under the 'adult at risk' category. This referral was assessed by the central referral unit team at NWP as a standard risk safeguarding incident, and as such the referral was not shared with external agencies due to Elizabeth and George not consenting.

Unfortunately, a further issue occurred with the linking of the nominals involved in this incident on the RMS database, which created a barrier to identifying previous incidents and this information could have been missed by officers reviewing previous incidents involving Elizabeth and George.

The CMPs in 2020 and 2021 were adequate and should have picked up these issues; helpfully the CMP guidance has been reviewed and is due to be published again in late 2023. The author of the IMR noted that the renewed emphasis on DA in the CMP guidance 2023 will assist moving forward. She also noted that many changes have already occurred since this incident, including the rollout of force-wide training on DA

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11 https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

Matters[1] and the introduction of Appearance, Words, Activity and Behaviours, Relationship and Dynamics, and Environment (AWARE) training.

The author has provided a single agency recommendation in relation to the above incident. These are available in the single agency action plan, section 15.

9.1.3 Incident two:

In November 2021 (14 months after previous incident), NWP received a silent call which was treated as an ongoing suspected domestic incident. 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 describe that 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".*

When officers speak to Elizabeth and George directly, they tell them that David's drinking has worsened over the last year because he is *"unhappy".* They confirm with officers that David lives with them and a number of times they ask officers to "*get him off the drink"*. Elizabeth and George say, *"we're old, aren't we"*. Elizabeth states that nobody has been assaulted but that David "*jostles with his dad"* and describes the physicality as a *"semi push"*. Elizabeth goes on to explain that nobody has been hurt and that she is not afraid.

Elizabeth refers to the previous police call out (incident one, 9.1.1), and re-asserts they were just getting on top of each other at the time. Elizabeth and George say that David is aggressive when he drinks, and the officers offer reassurance that they may be able to get him help and that he isn't in trouble.

Police arrest David at the scene for a breach of the peace, he is highly intoxicated and says he has mental health issues.

Officers do not undertake a DASH with Elizabeth and George, they state the reason for no DASH is because the victims declined.

9.1.4 A crime report was generated on the above incident and describes David's presentation whilst in custody. He was very unstable on his feet and very confused, he also had no idea why he was in custody. Custody officers noticed that David had a cut to his head and after medical advice the police transferred him to the Emergency Department (ED). David was de-arrested at the hospital.

David states in custody that he had consumed 12 bottles of larger but denies having an alcohol problem, officers note on the write-up that family members state he does have an issue with alcohol. Due to the safeguarding concerns raised by attending officers, a Criminal Investigation Department report (CID16) report is filed by the

[1] https://safelives.org.uk/training/police

Domestic Abuse Officer (DAO), as per NWP policy. This form is generated and sent to Adult Services (AS).

Ten days later the DAO also emails for a follow up from AS on the case. Concerns are raised about whether there is a warden service for Elizabeth and George; and the DAO also refers to a Vulnerable Adult at Risk Management (VARM) referral and another referral to Substance Misuse Services (SMS).

9.1.5 Learning Points – Incident two:

The IMR author notes that the presentation of Elizabeth and George could have constituted grounds for David to be arrested for assault. Further the IMR author notes that the officers do not complete appropriate information-sharing internally, which prevents the basis for information being shared to AS.

This is the second time the officers have attended the address for a domestic incident, and no DASH was recorded on either incident. The IMR author notes that the DASH can be completed with professional judgement and should not be dismissed just because victims decline to answer the specific questions. Having reviewed the body worn vest footage, the IMR author noted that Elizabeth and George were engaging in conversation with officers, but at no point are any of the questions that assess risk of victims asked of them. There was an opportunity to gain more specific information on any risk posed by David to his parents; for the officers to use this to inform the context of the situation; and subsequently to share information within NWP and multi-agency partners on professional judgement.

Astutely, the IMR author sums up this incident by stating:

> *"The officers articulate the level of fear displayed by Elizabeth and David, but they act upon what they are told and not on what they can see and their professional judgement. David could have been arrested for an assault which would have provided an opportunity to further engage with Elizabeth and David. This would have provided the opportunity for a Domestic Violence Protection Notice/Order[12] (DVPN/O) application to be considered and/or potential bail conditions."*

Further, the IMR author notes that the crime report does not detail the medical assessment of David whilst he is in police custody. The officers do not adequately share information between themselves which means the referral to partner agencies makes no reference to David's mental health issues. During conversations between officers it was noted that David said he had a diagnosis of schizophrenia; however this could not be corroborated by any agency involved in the review and is the first indication of a trend of disclosures of self-diagnosed mental health issues from David.

[12] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

9.1.6 Incident three:

In June 2022, Elizabeth's son-in-law, Josh, called the police stating that his brother-in-law (David) was intoxicated and causing issues at the address. Josh stated that his mother-in-law is 83 years old and is awaiting an ambulance as she has fallen on the floor.

Local police attend the incident to check on the welfare of the residents. David is arrested for a breach of the peace by officers and is described as being *"disruptive"*.

Whilst at the scene officers report back to the custody suite that Elizabeth has disclosed being *"pushed"* by David. David is subsequently arrested for assault and then for murder, after Elizabeth sadly dies in hospital two days later.

9.1.7 Learning Points – Incident Three:

It is noteworthy that the officers attend due to David's intoxication, and the report from Josh that Elizabeth has fallen. There is no suggestion of criminality initially and as such, it appears officers are not thinking about evidence gathering, rather their focus was a welfare check.

Incident three occurred after COVID19 lockdown procedures had ended, but the police were still feeling the effects of the pandemic and were operating in a recent 'post lockdown mode'; the IMR author notes that this frustrated access to support/decision making.

9.1.8 Developments and Good Practice:

Incident two provides evidence that the attending officers follow the NWP DA practice guide and took positive action by removing David from the address.

Further, the DAO intervention and problem-solving is good overall. The review author further noted the good practice of the DAO in following up on the referral made to Safeguarding Adults. This will be discussed further in the IMR for AS (Section 9.4).

Developments since Elizabeth's death have been implemented by NWP:

- There has been significant investment in training around domestic abuse and a force-wide roll out of DA Matters training, which is delivered by Safelives[13]. DA Matters training results in forces appointing 'DA champions', who act as domestic abuse specialists across their force areas.
- Following on from the DA Matters training NWP is focussing on evidence-led prosecutions, recognising that victims of domestic abuse do not always feel able to support a criminal complaint. NWP have a number of workstreams promoting this element of change.
- The Domestic Abuse Risk Assessment (DARA)[14] has also been introduced by the College of Policing which will be introduced in place of DASH as the new

[13] https://safelives.org.uk/training/police

[14] https://www.college.police.uk/article/police-better-equipped-spot-controlling-behaviour

risk assessment tool for frontline officers to better identify CCB. NWP have a task and finish implementation group in place to manage the introduction of this tool. This will be discussed further in the analysis section 10.1.

- In addition to the above, NWP are adopting AWARE training (Appearance, Words, Activity and Behaviours, Relationship and Dynamics, and Environment), and the introduction of this training will further support officers' learning and development around their own professional curiosity (see appendix B).
- Recent NWP data analysis shows an improvement in the use of body worn cameras which highlights good practice.
- Domestic abuse officers review all DASH refused cases to explore history/patterns of behaviour and to make attempts to engage with the victim.
- NWP's response to domestic abuse is governed by the domestic abuse workplace guidance document.

9.1.9 Panel Analysis

The panel agreed with the overall comments made within the IMR by the author, namely:

- It appears that David living at the address has been a barrier to Elizabeth and George making disclosures.
- It does not appear that Elizabeth and George considered themselves to be victims of abuse and normalised David's behaviour.
- Elizabeth and George are also protective of David and are seeking support for him.
- Age and mobility appear to be a barrier to reporting – David is possibly their carer, and they appear conflicted.

These points will be discussed in analysis.

The review author requested further information from NWP on the reason for the de-arrest of David. The panel member from NWP helpfully provided the following legislative guidance for breach of the peace:

> *"Breach of the peace is not a criminal offence in English law, and anyone detained or arrested can be released at any time when the officer is satisfied that a breach of the peace is no longer likely to occur or re-occur. Should it be necessary to detain someone who has committed a breach of the peace, then in the more serious cases they can be taken to a custody office where they should be detained. When necessary, they can be required to appear before a magistrates' court to be bound over to keep the peace. Such a procedure in law amounts to a complaint.*
>
> *There is no power once the breach of the peace has ceased and there is no immediate likelihood of it reoccurring."*

The hospital ED department was 25+ miles from the home address and the breach of the peace was therefore unlikely to reoccur, hence the de-arrest of David at the hospital.

The panel further discussed the issue of the police attendance at the address on incident three. The observations of the IMR author on leading witnesses were reflected in the report; however, it was useful for the panel to understand that the attendance was not in response to a criminal act and that the police were not entering the property for a reported domestic incident. It was only when they were there that the disclosure came from Elizabeth that David had pushed her.

Given the privacy of the family, the panel reflected that this case may never have become a DHR had Elizabeth not mentioned to the officer at the scene that David had pushed her. Although the case resulted in no criminal charges, it is unlikely that a review would have been commissioned on the previous concerning incidents reported to the police, and thus the learning for families with similar issues and demographics in the Gwynedd and Anglesey area would not have been forthcoming.

During discussions relating to the incident prior to Elizabeth's death, panel members reflected that reviewing the case and the context of what had happened had impacted on them - these comments will further be reflected in the analysis section 10.8.

9.1.10 Recommendations:

There were a number of single agency recommendations offered by NWP. The panel agreed with all recommendations, and these are reflected in section 15 of the report.

Following on from the useful observation of the IMR author regarding the use of DVPN/O for this case, the panel noted that SafeLives have provided training to NWP in May 2022 promoting the use of DVPN/O. NWP have since seen a spike in the issue of these orders. In addition, NWP now have a process of recording an occurrence every time a DVPO is issued to allow staff to manage the conditions and victims. This was introduced in 2022, and the panel commend this development.

The panel has further reflected multi-agency recommendations for all agencies in Section 14 of this report.

9.2 Independent Management Review – Welsh Ambulance Services NHS Trust (WAST)

George and David did not consent for their medical records to be shared therefore the information below is limited to Elizabeth only.

For reference, during part of the review timeline period WAST used 'Routine Enquiry'. Routine Enquiry was introduced as a screening tool which recognised that asking patients routinely in some specialised health care is considered good practice. It

involved "*asking about the experience of domestic violence of all people within certain parameters*" regardless of visible indicators of abuse. This tool was appropriate for the prehospital emergency setting at this time. WAST would ask questions associated with whether anyone hurt, insulted, threatened, or screamed at them (HITS) and if there was a positive disclosure, they would offer support and signpost to specialists.

The National Institute of Health and Care Excellence (NICE, 2014) and the World Health Organisation (WHO, 2013) had launched recommendations to consider a targeted approach to enquiry for these circumstances across Health and Social Care. This was further supported by the Welsh Government VAWDASV (Wales) Act 2015. This required the WAST to review the use of '*Routine Enquiry'* and consider that a principles-based approach to '*Targeted Enquiry'* be implemented across the organisation.

WAST's launch of '*Targeted Enquiry'* was governed by the requirements of the Welsh Government's National Training Framework and principles of 'Ask and Act', where individuals are questioned if there are indicators of possible domestic abuse. There is no exhaustive list of indicators, they could be: visual signs (potential outward and physical signs someone is experiencing DA), symptoms (of abuse or associated impacts), cues (presence of some other information which suggests the experience of abuse.) Targeted questioning is based on the premise of professional judgement and professionals are encouraged to be alert to the dynamics of DA and the different ways in which victims will present. Victims/survivors can be referred directly to the Live Fear Free Helpline[15] via a bespoke pathway[16] (consent must be provided). Victims/survivors can be signposted to the helpline to access support themselves, WAST staff can initiate contact for them, or a digital referral can be made where the Helpline calls the individual back at a safe time to discuss.

Key Incident Timeline: WAST had contact with Elizabeth six times within the review period. It is worth noting that several contacts occurred during the COVID19 lockdown period, which may have had an influence on responses.

9.2.1 Incident one:

In July of 2018, WAST attended Elizabeth's address after a 999 call was made regarding chest pain.

The analysis of the attendance noted that WAST attended the property in good time and adhered to the appropriate protocols. The IMR author comments that during the call there were several times when Elizabeth appeared not to be able to hear what the call handler was saying, each time the call handler gave Elizabeth the expected level of care.

The relevant clinical history was noted on the system, however, there is limited social history for Elizabeth. The records do contain shared information that Elizabeth lives

[15] https://www.gov.wales/live-fear-free

[16] https://www.southwalesargus.co.uk/news/19742465.welsh-ambulance-service-app-launched-support-domestic-violence-victims/

with George and her son David. The IMR author notes that the social history and context for Elizabeth should have been expanded to include aspects such as whether she cared for herself independently or relied on family support.

9.2.2 Learning points incident one:

The IMR author notes the importance of contextual information on social history for patients, based on the documented information there was no indication that targeted enquiry should have been completed. WAST make organisational recommendations in section 15 of the report.

9.2.3 Incident two:

In November of 2018, a 999 call was received from an out of hours GP requesting a hospital admission for Elizabeth, who had chest pain. Elizabeth was attended by WAST and transported to hospital.

When the IMR was submitted, the author was unable to locate the call and this was reported internally. Since the IMR submission, the call was found and the IMR author was able to review it prior to report completion. The call was prioritised in accordance with policy. A four-hour response was requested, and an ambulance was there within 90 minutes. On the information available it is ascertained that Elizabeth received the appropriate clinical care. The social history evidences that Elizabeth stated she lived with her husband, but there is no mention of her son, David. Elizabeth reports that she lives independently and does not have a carer.

The IMR author notes that the targeted enquiry was not completed. There is nothing documented in the presentation of Elizabeth to indicate a prompt for professionals to undertake targeted enquiry.

9.2.4 Learning Points incident two:

The IMR author again notes the value of WAST staff to remember:

> *'…the importance of including appropriate contextual details on documentation. Information such as the rationale for decisions made or reasons for taking/not-taking actions can provide further explanation regarding a situation.'*

9.2.5 Incident three:

In May 2019 WAST received a 999 call for Elizabeth when she had chest pain. An ambulance responded and she was transported to hospital.

There is information again (see 9.2.1) to suggest that Elizabeth struggled to hear on the 999 call. The call handler dealt with this in the appropriate manner and clinical guidance was adhered to.

In terms of social history, the information documented is limited. Records state that Elizabeth lives with her husband and son and the IMR author notes that there should

have been more information sought on the contextual information. As with incident two, targeted questions were not completed but there is nothing to indicate they should have been.

9.2.6 Learning Points Incident three:

See incident two (section 9.2.4) and organisational recommendations in section 15.

9.2.7 Incident four:

In February 2020, Elizabeth was again transported to hospital by WAST. Elizabeth was referred to 999 via her General Practitioner (GP) as she was short of breath.

The incident follows a similar pattern to the previous logs. Clinical guidance was adhered to, but it was noted that social history and information on family support was limited.

9.2.8 Learning points incident four:

See incident two and three, and organisational recommendations within section 15.

9.2.9 Incident five:

In August 2020 WAST received a 999 call for Elizabeth when she had chest pain and shortness of breath. An ambulance responded and Elizabeth was transported to hospital.

The same issues of Elizabeth experiencing difficulties in hearing the call taker are noted in the records and the call taker responded appropriately.

On this incident the IMR author notes that the social history is taken alongside the targeted enquiry (HITS questions), which evidences good practice. There was a negative response to the HITS questions which did not equate to a referral to the Live Free Fear Helpline. The social history records are ineligible and the analysis is limited.

9.2.10 Learning points incident five:

The IMR author notes:

> *"At the time of the incident WAST utilised Digi pens to complete patient clinical records. Since then, WAST have transferred to a new digital system with electronic patient clinical records (ePCR) being completed on iPads."*

9.2.11 Incident six:

This is the incident that preceded Elizabeth's death in June 2022. WAST were called to Elizabeth's property. The incident was reported as a fall.

999 was called several times and 111 was also contacted. It took some time for WAST to get a resource on scene to Elizabeth and the IMR author notes that WAST were experiencing a significantly high volume of calls across Wales on that day. Apologies and reassurances were given to the family during all phone contact.

The patient clinical record is limited but does note that the patient, Elizabeth, was:

"…pushed across the room by a family member".

Given the nature of this record the IMR author asserts that more information should have been gathered, including, but not limited to: whether the alleged perpetrator was still on the scene, whether the Live Fear Free helpline[17] was discussed, and/or whether the police were on the scene. Although not documented, we know that NWP were on the scene before WAST arrived.

The IMR author also notes that although Elizabeth had capacity:

> *'…consideration for an adult at risk safeguarding report should have been documented due to the assault/physical abuse and her known physical needs for care and support.'*

The IMR author notes that some of the clinical information is unclear on the provision of analgesia, this has been referred internally for review by the WAST Clinical Directorate, and any findings will be shared with clinicians for developmental purposes.

9.2.12 Learning points incident six:

The IMR author notes the importance of reminding WAST colleagues to document their consideration of, and reminding them of their duty to report, safeguarding concerns.

9.2.13 Developments and Good Practice:

The review author further noted the good practice on incident four when the HITS questions were completed by the attending WAST colleagues. Most of the interactions with Elizabeth were emergency responses with no indications of DA. There was evidence to show that WAST colleagues can refer victims of DA to external agencies, including statutory bodies.

The IMR author noted the developments at WAST in November 2021 when they:

[17] https://www.gov.wales/live-fear-free

"Digitalised the referral pathway with the Live Fear Free helpline for all colleagues with iPads. Since the introduction of this digital referral pathway, we have witnessed a steady increase in the number of monthly digital referrals to the Live Fear Free helpline. During 2023/2024 work will be completed to digitalise the pathway for WAST colleagues who work within the 999 and NHS111 Wales call centres."

Although this change occurred prior to Elizabeth's death, it was seven months prior and thus the full impact of these changes may not have been evident.

The majority of WAST interactions with Elizabeth were made in line with policies. However, there was no documented consideration of completing an adult at risk safeguarding report on incident six, which preceded Elizabeth's death. The IMR author recognised this falls short of the expected practice under safeguarding duties and has sent a reminder to all WAST colleagues regarding their duty to report, even if other agencies are already on scene.

There was a delay in the ambulance arriving at Elizabeth's address on incident six. Although the clinical response model was followed and regular contact made with Elizabeth's family, the IMR author noted that this issue is not unique to this case:

"Hospital handover delays can impact our ability to respond to patients in the community. This is a UK wide problem with significant pressures on the whole health and social care system. WAST executive management team are working hard with Health Board colleagues to redress these issues and have escalated to Welsh Government."

More generally the IMR details the robust policies, procedures, and strategies in place for WAST staff, including, but not limited to:

- There is evidence to demonstrate that when disclosures are made to WAST that the organisation will signpost victims/survivors to appropriate specialist support and/or Local Authority.

- WAST have a specific VAWDASV policy which supports patients, service users and WAST employees who may be victims/survivors of DA, domestic violence, or sexual violence.

- WAST is committed to ensuring all colleagues complete appropriate VAWDASV training. VAWDASV Ask and Act Group 2 training is provided for all new colleagues who respond to 999 calls and to clinicians who undertake telephone triage. The training is delivered during induction which is outside the yearly mandatory CPD programme.

- WAST work in collaboration with the Live Fear Free helpline. This enables WAST colleagues to signpost or support victims/survivors of DAV in accessing specialist help.

The IMR author noted that some of the record-keeping was not at the expected level for WAST and this will be referred to in the WAST single agency recommendations in section 15.

9.2.14 Panel Analysis

The panel noted the quality of the IMR report. They also commented on the good practice of the call handler when Elizabeth had trouble hearing instructions on the phone during 999 calls.

The panel noted the positive findings of the change to '*Targeted Enquiry'* in relation to the questioning of possible DA victims/survivors. In addition, the panel were supportive of the developments regarding reminders of a duty of care to report safeguarding issues.

9.2.15 Recommendations

The panel accepted the WAST single agency recommendations in full. There will be further recommendations for WAST within the multi-agency responses put forward by the panel (see section 14).

9.3 Independent Management Review – Betsi Cadwaladr University Health Board (BCUHB)

Within the timeframe BCUHB had contact with Elizabeth, George and/or David on 35 occasions, of which two were related to domestic abuse. One of the incidents resulted in the commissioning of this DHR.

Key Incident Timeline Elizabeth:

There were 12 occasions that BCUHB had contact with Elizabeth. Some of the incidents relate to routine medical appointments in line with Elizabeth's age and health issues. The review author has not included all appointments/incidents recorded within the IMR so as to preserve the confidentiality of Elizabeth's health data. All relevant information pertaining to the review process and subsequent analysis are referenced.

9.3.1 Incident's corroborating WAST IMR:

The BCUHB IMR corroborates the data already presented within the WAST IMR, incidents one to five (see 9.2.1 to 9.2.9).

The IMR author notes that after emergency hospital admission by WAST in November 2018 (see 9.2.3) Elizabeth stayed in hospital for the night under observation. Whilst in hospital it was noted that Elizabeth was with her husband, George; social history and support networks were explored but no concerns were raised.

Elizabeth was admitted to the ward within the hospital on two other occasions after emergency services had responded to a call for chest pain, in February and August of 2020 (see WAST IMR 9.2.7 and 9.2.9).

The following incidents relate to data held for Elizabeth with BCUHB only and are relevant to the review process.

9.3.2 Incident one:

In February of 2019 Elizabeth was seen in the pain clinic at the hospital. Records state that Elizabeth was present with George at this appointment, and they disclosed there was:

"Lots of stress at home with the son"

Although Elizabeth did not want to go into the detail of what was happening with her son, she described the situation as causing George and herself a lot of stress and anxiety. Both George and Elizabeth explained they wanted to try different techniques to help. They were advised by staff members to do slow breathing exercises. The panel and review author had detailed discussion on this disclosure and response from the pain clinic – the analysis of this is offered in section 10.5.

The IMR author notes that although a letter was sent to Elizabeth's GP about stresses at home, staff did not explore the situation further and domestic abuse was not highlighted as a potential issue of concern for Elizabeth and George.

9.3.3 Incident two:

Following on from the above appointment, Elizabeth contacted the pain clinic in April 2020, stating that she no longer wanted support from the clinic. Elizabeth was discharged from the clinic but there was no exploration of why Elizabeth was declining the intervention. A letter was sent to the GP informing them of the discharge.

9.3.4 Incident three (Elizabeth's death):

Elizabeth was admitted to hospital via WAST. Elizabeth had disclosed that she had been pushed across the room by her son. On admission a safeguarding adult at risk form was completed by hospital staff.

Elizabeth subsequently died in hospital two days after the incident. The post-mortem concluded that, in addition to other health factors - she died of multiple skeletal injuries, may she rest in peace.

9.3.5 Learning Points for Elizabeth's timeline:

The IMR author has referred to the importance of routine health screening for victims of DA in both their analysis and recommendations.

> *"There were 5 attendances to ED and no evidence of Routine Enquiry Domestic Abuse (REDA). Had* DA *been explored, and a disclosure made there would have been an opportunity to undertake a SafeLives Risk Assessment in line with the BCUHB policy*: *VAWDASV Service User Procedure."*

The IMR author also notes a number of attendances at the ED during the COVID19 lockdown period, and this may have had an influence upon how services were accessed.

Key Incident Timeline David: (David presented once to BCUHB).

9.3.6 Incident one:

BCUHB identified the referral from NWP after they noticed David had sustained a head injury when he was in custody (see NWP IMR, 9.1.4). This was following an arrest for a domestic incident involving Elizabeth and George.

On assessment, the health records evidence intoxication and note that NWP were concerned about alcohol dependence. A breathalyser test recorded a measurement of 61, which is just under twice the legal alcohol limit to drive.

David was asked the HITS questions by health staff, and David answered no to all questions.

9.3.7 Learning Points Incident one (David):

The IMR author noted that although the use of the HIT questions evidence good practice by staff, there was a lack of professional curiosity. David had been admitted after a domestic incident and the fact he proffered all negative responses to the HIT questionnaire should have prompted staff to utilise professional judgement and possible referrals to external agencies would have ensued.

Key Incident Timeline (George): George presented 21 times to health services during the review period.

All incidents were for routine or emergency referrals due to various health issues. None related to any DA incidents, and George did not present with any injuries.

9.3.8 Learning Points:

Out of the 21 appointments, George attended ED 4 times and the IMR author noted that on attendance he was sometimes alone. This would have been an opportunity for routine screening to take place and any issues relating to stress at home could have been explored.

The IMR author again noted that COVID19 could have had an impact on the responses to George's attendance during some of the incidents in the review period.

9.3.9 Developments and Good Practice:

The IMR author noted the excellent clinical and empathetic practice of health staff in relation to Elizabeth, and George. In relation to David, the IMR author noted that he received the appropriate level of care, and the HIT questions were asked in line with policy.

On the incident preceding Elizabeth's death, the IMR author noted the referral to adult social care included all relevant information using detailed body maps of injuries. Alongside this the notes were clear, and the referrer's details were shared on the correspondence, which facilitated good communication between the hospital and the local authority.

More generally the IMR details the robust policies, procedures, and strategies in place for BHUHB staff, including, but not limited to:

- BCUHB supports the Welsh Government VAWDASV (Wales) Act 2015[18] in being committed to the resolution of domestic violence, abuse and sexual violence (VAWDASV (Wales) Act 2015).

- VAWDASV Training is mandatory for all BCUHB employees. A Safeguarding Data Analyst and Safeguarding Practice Development Lead support targeted intervention and identification and appropriate escalation for areas or services reporting lower than required compliance.

- The BCUHB Safeguarding Practice Development Lead reviewed the Group 2 VAWDASV Training Package, and this has since been adopted as a National Training Package across Wales for all Health Boards and Trusts to use.

- All forms of DA are robustly detailed within the training package, which is developed by BCUHB Corporate Safeguarding.

- The Corporate Safeguarding Team have developed a VAWDASV Service User Procedure which has been operational since 2013 (SCH05b) and reviewed in line with governance and quality activities.

- The BCUHB (5b) VAWDASV Service User Procedure identifies processes to support staff in the identification and management of DA and sexual violence, and seeks to:

    - Ensure that staff are aware and alert to the signs of domestic violence, abuse and sexual violence.
    - Ensure that staff are confident to make appropriate and timely reports and referrals to support services within BCUHB, and externally to other partner agencies to ensure that those at risk of harm are protected.
    - Enable staff to apply consistent, co-ordinated, evidence-based approach to domestic violence, abuse and sexual violence whilst ensuring that perpetrators are prevented from instigating further harm.

[18] https://www.legislation.gov.uk/anaw/2015/3/contents/enacted

- Ensure the needs of people from disadvantaged or under-represented groups are properly considered and that the services of BCUHB are fully accessible and culturally sensitive with regards to policy access, advice, and language needs when working with individuals who face additional difficulties.
- The procedure applies equally to all genders of service user above the age of 16 years who seek support, advice, or assistance in relation to DA and sexual violence.
  Systems of enquiry include:
- **Routine Enquiry:** refers to the process of asking all service users over the age of 16 years direct questions about their experiences, if any, of DA regardless of whether there are signs or symptoms of abuse.
- **Selective Enquiry**: refers to the process of asking individuals directly about their experience, if any, of DA where there are concerns or suspicions, including the presence of signs or symptoms.
- **Ask and Act**: The VAWDASV (Wales) Act 2015 legislated in reference to Ask and Act as a statutory obligation.

➢ All BCUHB staff members and managers are required be conversant with routine, selective enquiry, and the requirements of Ask and Act (VAWDASV (Wales) Act 2015)[19] where there are concerns or suspicions regarding DA.

Helpfully, since April 2022 the North Wales Police and Crime Commissioner[20] and third sector colleagues in both Domestic Abuse Services Unit (DASU)[21] and Gorwel[22] have worked alongside the health board to incorporate a health-based Independent Domestic Violence Advocacy (IDVA) service. IDVAs operate across three District General Hospitals in North Wales, and staff can access the IDVA service for general advice and or contact with the victim; they also utilise the Live Fear Free helpline service. Although this service was very new at the point of Elizabeth's death, it is a welcome development for current and future victims of domestic abuse across Gwynedd and Anglesey.

Out of the 34 interactions with BCUHB, only David was ever asked the HITs questions. There was no information to evidence that Elizabeth or George were ever asked the HITs questions by professionals in BCUHB, neither was routine enquiry explored. There were therefore missed opportunities to assess risk or provide further support to Elizabeth and/or George. This will be discussed further in the analysis section 10.5.

9.3.10 Panel Analysis

The panel noted the good quality on the IMR report. There was discussion regarding a possible focus for health staff on trying to ascertain if domestic abuse is a feature for patients by presentation of a physical injury. This will be discussed further in the

[19] Welsh Government Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
[20] https://www.northwales-pcc.gov.uk/
[21] https://dasunorthwales.co.uk/contact-us-refer-to-our-services/
[22] http://www.gorwel.org/eng/

analysis section on Coercive and Controlling Behaviour (CCB) and Routine Screening (RS) (sections 10.1 and 10.5).

In addition, the panel had a good discussion with the Health Board representative regarding the difficulty of formatting and analysing the IMR data due to the fact that some health IT systems do not link to each other. This is problematic for health data and compounds the already limited resources health staff have when responding to death and serious case reviews.

9.3.11 Recommendations

The panel accepted the BCUHB single agency recommendations in full (see section 15). There will be further recommendations for BCUHB within the multi-agency responses offered by the panel.

9.4 Independent Management Review – Isle of Anglesey County Council Adult Services

Records evidence that Elizabeth had ten contacts (with one follow up contact) within the review timeline period, some contacts for Elizabeth were outside the timeline period, but they have been included due to their relevance.

George and David had seven contacts with Adult Services (AS). The records for George and David fall just outside the review timeline, covering a specific period after Elizabeth's death. These have been included due to their relevance in relation to the review.

Key Incident Timeline Elizabeth:

Elizabeth's contacts with AS are largely in relation to assessments required for equipment for her health issues, but there are two contacts directly relating to DA.

9.4.1 Incident one:

In September of 2016 Elizabeth was referred to AS in relation to the pain she was experiencing from her health issues, it was noted that this was having an impact on her daily life. The referral had come from a nurse, and they had asked for an assessment for equipment. The records show that George was Elizabeth's carer and they live with their son David, who had mental health issues. The referrer did note that she had never met David, so she was *"unsure how much of an issue this was"*.

9.4.2 Learning points incident one:

There was a delay in AS responding to this referral for four months, and there was no reason for this delay recorded on the system.

9.4.2 Incident two:

A follow up to the referral above was responded to by an Occupational Therapist (OT) in January of 2017. The discussion was extensive and covered the struggles Elizabeth had and what equipment she may need to assist her in the house. The records are very detailed and focus on Elizabeth's needs and barriers to meeting her outcomes and independence. It is noted that Elizabeth has a very positive attitude and wants to maintain an independent life for as long as possible. By the time AS responded to the original referral, Elizabeth had sourced some of the equipment she needed herself. At this appointment George was offered a needs assessment as a carer, but he declined.

Four days later the OT followed up on the visit to Elizabeth regarding a conversion for her shower and bathroom. The offer of support was declined as Elizabeth and George stated their son-in-law would assist them in anything else they needed. Elizabeth was given contact details should she need assistance in the future.

9.4.3 Learning points incident two:

Family support is recorded but there was no mention of David in the assessment. The records do show that Elizabeth's wishes were prioritised in terms of her desire to manage the situation herself.

9.4.4 Incident three:

There was a referral in February 2020 for another OT assessment for Elizabeth. The IMR author has not been able to gain access to these records because they are password protected.

9.4.5 Learning points incident three: The IMR author notes that whilst protecting documents is common practice for the transfer of data between organisations, the password should have been removed for the internal recording system. The panel are therefore unable to review any pertinent information relating to this contact with AS.

9.4.6 Incident four: A further contact with AS and Elizabeth occurred in December 2020, this was for a discussion around equipment Elizabeth may need due to poor mobility. The records evidence a *What Matters*[23] conversation. 'What Matters' conversations were introduced in Wales as part of the Social Services Well-being (Wales) [SSWW] Act 2014:

> *"A 'what matters' conversation is a targeted conversation relating to any assessment process. It refers to a skilled way of working with individuals to establish their situation, their current well-being, what can be done to support them and what can be done to promote their wellbeing and resilience for the better. It's not an assessment in itself: it's a way of carrying out the assessment, with the practitioner having the right type of conversation to identify with the individual:*
>
> - *how they want to live their life*
> - *what might be preventing that and*
> - *what support might be required to overcome those barriers."*

[23] https://socialcare.wales/resources-guidance/improving-care-and-support/care-and-support-at-home/what-matters-conversations-and-assessment

9.4.7 Learning points incident four:

The IMR author notes that the records state Elizabeth lived alone, but previous notes record Elizabeth living with George and David. There is no evidence to suggest this discrepancy was picked up or followed up at a later date.

9.4.8 Incident five:

In November 2021 AS received a referral for Elizabeth from NWP, this was following on from a domestic abuse incident in the family home where David was arrested for a breach of the peace, following a silent 999 call (see IMR NWP 9.1.3). Elizabeth and George were described by NWP as hiding from David and can be overheard saying they are *"very, very scared"*.

On the referral to AS, NWP state that when officers arrived at the property, Elizabeth presented as not being able to catch her breath (she was waiting for her angina medication to kick in) and she was *"shaking like a leaf"*. Both George and Elizabeth had tears in their eyes when talking to police officers and it took a lot of persuasion for them to finally disclose that David had a drinking problem and they wanted him to get help. The NWP referral records stated that David disclosed he hated his father as George saw him as a "*failure"*. It was noted that clearly Elizabeth and George needed further support to manage David's behaviour.

Following on a duty social worker calls Elizabeth the same day as the referral is received. The notes record this as a *'courtesy call'* and the purpose of the call is unclear.

Six days later NWP followed up with AS via email, chasing the referral. The DAO from NWP asked whether anyone had spoken to Elizabeth and George as they were concerned that David appeared to have alcohol issues and Elizabeth and George were afraid of him.

9.4.9 Learning points incident five:

The IMR author notes that the referral from NWP indicates clear evidence relevant to AS and domestic abuse, which should have triggered a section 126 enquiry under the Social Services and Well Being Act 2014[24].

On the follow up from NWP, there was no record of AS re-considering whether an Adult at risk process should be implemented or a referral to the Multi-Agency Risk Assessment Conference (MARAC) should be completed.

The IMR author also notes that AS were not aware of the previous call out to NWP, this could have precipitated a different decision on the second referral because relevant information-sharing provides a full picture of what is going on for a family.

9.4.10 Incident ten:

In March 2022 (prior to Elizabeth's death in June 2022), there was a referral from Elizabeth's GP to AS regarding Elizabeth's health care needs and vulnerabilities and

[24] https://www.legislation.gov.uk/anaw/2014/4/section/126

a wheelchair was requested. There was a timely response to this referral from AS. Shortly after the referral, Elizabeth contacted AS to cancel the intervention and the case was closed.

9.4.11 Learning points incident ten:

There were no recorded learning points specifically for AS with this incident. However, the review author notes that the analysis section responds to the importance of professional curiosity and routine enquiry where people who are experiencing DA may cancel interventions or appointments. Given the previous reported incident (four months prior) to AS was related to DA, this is an important point to analyse for learning and development.

NWP and BCUHB both referred to AS regarding the incident prior to Elizabeth's death.

Key Incident Timeline, George, and David:

Following on from Elizabeth's death a number of referrals were made to AS in relation to David as a vulnerable adult due to alcohol and mental health issues. Subsequently George was referred to AS after David moved back home with him.

9.4.12 Combined analysis of interventions for David and George:

The review author presents the interventions of David and George together for the period June – November 2022.

9.4.13 Shortly after Elizabeth's death in June 2022, David went missing. A concern for welfare was raised in regard to David and he was located very quickly. The notes do state that David disclosed he has issues with alcohol and had suffered a recent bereavement. He explained that he had nowhere to live and was isolated from his family with no support network. The records state that whilst David was in custody, he mentioned he had previously been sectioned under the Mental Health Act (MHA) 1983[25]. Similarly to incident two in the NWP IMR (section 9.1), this appears to be a self-diagnosed disclosure, which is not an uncommon trait for some perpetrators of domestic abuse, this will be analysed further in section 10.6.

A strategy discussion was organised by NWP to discuss an assessment for David's risk due to the above issues. The strategy meeting concluded that David did not meet the threshold as an adult at risk, as defined by the SSWW Act 2014[26].

9.4.14 Following on from the CPS' decision not to prosecute David, a further strategy meeting was held with regard to him returning to the family home to live with George. A referral was made to MARAC on professional judgement and the MARAC concluded that a warning marker was to be placed on David and George's address. It was

[25] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
[26] https://www.legislation.gov.uk/anaw/2014/4/contents

recommended that David be referred to Agencies Domestic Abuse Perpetrator Targeting (ADAPT)[27], for support to change his behaviour:

> *"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).*

On a recorded discussion with David over the phone, he stated he needed to live with George because he was George's carer. He rejected the support for ADAPT, and George could be heard in the background getting irate and shouting that they (the family), do not want outside agency involvement. The case was closed after David and George declined support, and it is noted that both had capacity to make this informed decision. The police did share on the internal bulletin that David and George were living together again.

9.4.15 AS had a separate conversation with George to ascertain his wishes on David residing at the family home. George stated he was alone and could talk, he said everything was fine and that he could manage well. George was also offered support from a DA service, Gorwel, and he declined this offer. A final follow up was actioned in November 2022 with George. He reported that everything was well; he was going out, driving, and shopping; and was managing to look after himself.

The case was closed with George following this conversation.

9.4.16 <u>Learning points David and George:</u>

The IMR author noted that David was not known to AS prior to Elizabeth's death. Despite references to mental health issues there was no record of any contact with community mental health teams in the local area. The IMR author further notes that in both Elizabeth and George's notes there were references to them asking for help for David, yet no records evidence this was followed up by AS. In addition to this there was no record of David being considered as an individual with his own care or support needs prior to Elizabeth's death; nor was his position of 'carer' of Elizabeth and George assessed given the disclosures made about David's issues.

The IMR author noted that there was a previous incident where NWP responded to a DA call out and George was harmed by David (see 9.1.1). There are no records for AS on this incident and we subsequently know that this is because NWP did not refer Elizabeth or George to AS after an assessment deemed the incident to be standard and there was no consent to share.

9.4.17 <u>Developments and Good Practice:</u>

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

Through the analysis of information, the IMR author noted that Elizabeth's requests for support in her health needs had been responded to with the appropriate care. The OT assessment was written well, with due diligence paid to Elizabeth's needs and her wishes. There are good descriptions of how Elizabeth presented, describing her positivity and her lived experience.

The 'What Matters' conversation was noted as good practice and the IMR author further commented that it is difficult to get a good record of person-centred conversation on written notes. However, there was no evidence in the records that the conversation led to any further conversations or prompts about other issues Elizabeth may have been experiencing either at home or with her wider support network.

Interestingly, the IMR author notices the pattern of Elizabeth requesting support for care equipment and then declining the support. There were two occasions where this happened regarding equipment in the home. These were in September 2016 and March 2022. The IMR author commented that following the police incident in 2021, Elizabeth refused to take the number for AS support services. It is important to note that Elizabeth had capacity to agree/refuse services to meet her own care and support needs, therefore AS had no grounds to be involved with Elizabeth. These points will be discussed further in the analysis section 10.3 - Older People as Victims of Domestic Abuse.

The IMR author took time to analyse the safeguarding report that was sent to AS via NWP. There were three areas of learning highlighted:

- Compliance with the Wales Safeguarding Procedures 2019[28].
- Recognising filial abuse.
- Domestic abuse and older people.

The extensive analysis the IMR author provided in relation to DA and older people has been incorporated into the analysis section 10.3 of the full report as they are key themes throughout the review. In addition, the IMR author has analysed the impact of COVID19 on services and responses to individuals. This will be discussed further in the analysis section 10.7.

In highlighting the learning and development points in relation to compliance with the Wales Safeguarding Procedures 2019, the IMR author detailed the issues. When Elizabeth was referred by NWP in 2021 after an incident where David had been aggressive in the home, Elizabeth consented to sharing her contact details. The response from AS was recorded as a *'courtesy call'*. This reference lacks any clarity and is not in line with safeguarding procedures.

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

David was described as possibly suffering from alcohol and substance misuse issues, and his parents were described as *"fearful"* of him. NWP were also proactive in asking whether there was a 'warden service' available for Elizabeth and George.

Given the details we now know, the panel agree with the following summary provided by the IMR author:

> *"There is no record that this report was considered under Wales Safeguarding Procedures 2019. There was no record that the duty to undertake a S126 enquiry under the Social Services and Wellbeing Act 2014 was considered. There is no record of a management decision or supervision in relation to this report or the further call by the police. Whilst hindsight is a position of privilege it is our view that the threshold for consideration of safeguard action was warranted.*
>
> *The definition of an adult at risk under the Social Services and Wellbeing Act 2014 is that an adult is:*
>
> - *experiencing or is at risk of abuse or neglect.*
> - *has needs for care and support; and*
> - *as a result of those needs is unable to protect themselves against the abuse or neglect or the risk of it."*

The review author lists the context of the referral, e.g. the descriptions given of David's behaviour, the fear expressed by Elizabeth and George, and the compounding factors of Elizabeth's age, health conditions and the intersections of filial and elder abuse. The IMR author further notes:

> *"…the local authority had reasonable cause to suspect that Elizabeth was an adult at risk, and the defendable decision would have been to make (or cause to be made) whatever enquiries it deemed necessary to enable it to decide whether any action should be taken (whether under this Act or otherwise) and, if so, what and by whom."*

The IMR author further comments that it is notable that this referral was only opened in Elizabeth's name and not George's, as they could both have been deemed to be adults at risk.

In addition, some of the record keeping made data analysis difficult in ensuring safeguarding had met the balance of person-centred care versus management of risk. The panel agree with the author that this is a difficult balance for professionals. The case presented and referred to AS would have met the threshold to undertake a safeguarding enquiry under the SSWW Act, 2014[29]. Further, the IMR author noted that overall the data evidenced a lack of detailed record keeping with too much reliance on copying and pasting of emails. It is essential that the requirements of professionals in safeguarding to provide: context of visits and contacts, outcomes, actions, and what difference has been made for the individual, are routinely adhered to in order to inform

[29] https://www.legislation.gov.uk/anaw/2014/4/contents

good decision-making. Given there was a direct contradiction of information on the records stating at one intervention that Elizabeth lived alone, and then another stating she lived with George and David, the IMR author has recommended consideration of chronologies to be used by professionals.

The IMR author notes that the sharing of information between multi-agency partners and internal colleagues could have been more thorough. The review author agrees with the IMR author on this point. It is often hindsight, after tragic events occur, that offers us an awareness of the full picture. However, the transfer of information between professionals holds a vital key to protecting victims of domestic abuse and people with safeguarding needs and risks. On the referral from NWP, the IMR author helpfully notes that the consent was given by Elizabeth to the contact from AS, but it would be useful for professionals to know what outcome Elizabeth wanted from this contact. The review author notes that this can facilitate better engagement for victims of domestic abuse, especially victims with the types of intersecting needs presented in Elizabeth's case. In addition, the lack of referral from NWP in the first police call out removes the context of the pattern of abuse Elizabeth was being subjected to from her son.

9.4.18 Panel Analysis

The panel noted the excellent quality and detail of the IMR. There were further detailed discussions at panel regarding the means of contact and the types of support available for potential victims of domestic abuse (locally and nationally) that have the intersecting needs of women like Elizabeth, both in terms of her age and the rural area she lived in, these will be discussed further in the analysis sections: 10.1, 10.3, and 10.4.

Recommendations

The panel accepted the AS single agency recommendations in full (see section 15). There will be further recommendations for AS within the multi-agency responses offered by the panel.

NB: The QA panel recommended that the report would have been easier to follow had the author produced a combined chronology. The author of the review will take this suggestion forward in future reviews, but note the reproduction of chronology and IMR data often results in repetition in reports.

10 Analysis

The benefit of hindsight enables the Chair and the panel to assess where different decisions or actions could have been a catalyst for support and/or intervention for Elizabeth. This analysis is based on information provided in the IMRs and further

conversations with panel members and community members about the social context of the Isle of Anglesey.

Chair Summary:

There is no doubt that the lack of involvement of family and friends limits the voice of Elizabeth as a victim of domestic abuse. However, through the data provided in IMRs about Elizabeth, George, and David, we are able to offer a narrative on what differences we can make for victims of domestic abuse, and potential perpetrators with the same presenting needs.

Elizabeth was a vulnerable adult as a result of her age and her health issues. She also lived with her husband George who had his own vulnerabilities. The fact that Elizabeth resided in a property with her adult son, who had alcohol dependence and self-reported mental health issues, compounded and exacerbated the safeguarding risks to all three adults in the family home.

The family generally did not welcome outside agency involvement, neither were they active members of their community. The chair passes no judgment on that personal choice; however, it is important to analyse where we as professionals can better reach families and/or victims who are reticent and dubious about outside support. There may be reasons for that reticence, and it may be a direct result of the abuse they are experiencing. In Elizabeth's case, the evidence we have is that the family preferred life that way. What we don't know is if, or when, David's behaviour became more problematic, whether the fear of outside agencies compounded Elizabeth's ability to reach out.

It is not outside the realms of possibility to suggest that David's behaviour was something that the family wanted to 'manage themselves', they may have tried to do this for a long period of time. There were indications in both Elizabeth and George's interactions with agencies that suggest there were windows of opportunity to support them - they were asking for help for their son - and this may have been an opportunity to get them support.

10.1 Isle of Anglesey

Due to the lack of information from family and friends, the chair of the review spoke with panel members and a member of the Isle of Anglesey community to get a picture of what life is like on the island. It is hoped that this analysis fosters a more personalised view of where Elizabeth was living, what life is like on the island, and where barriers may have prevented Elizabeth from engaging with services. Equally, it is hoped this provides a picture of what life may be like for a person like David on the island, and the common traits he may share with other males his age.

Anglesey is a Welsh island with a rich and vibrant history. It is connected by bridge to the mainland via the A5 and A55 corridor. Both Britannia Bridge and the Menai Bridge

enable residents to access the county of Gwynedd. Anglesey is a beautiful part of Wales, enjoying 125 miles of coastal paths and 21,500 hectors of designated areas of natural beauty. The island is small, comprising 275 square miles.

The population of Anglesey from the 2021 census is 68,900, with further details as follows[30]:

- 33,700 males.
- 35,200 females.
- The average age for the island is 48, compared to the average age of the rest of Wales being 42.
- 76% of people of average working age are economically active.
- 67% of people on the island are of Welsh heritage.
- 26.5% are aged 65 and over.

Interestingly since the last census in 2011, data from the Office of National Statistics (ONS), shows us that the population of Anglesey has declined by 1.3%. The area is vastly rural with a comparison of 0.7 people per football sized pitch of land. Anglesey is now the sixth least densely populated area out of 22 local authority areas in Wales[31]. Anglesey also has an increasingly ageing population, with the share of residents between the ages of 65 to 74 years increasing by 1.9% in the last ten years. In addition, we know from 2011 to 2021; *"The proportion of the Isle of Anglesey residents (aged five years and over) that provided at least 50 hours of weekly unpaid care increased from 3.1% to 3.3%"*[32].

On speaking to a community member, the review author was able to establish that the biggest impact to the island community is the loss of all five of its major manufacturing/ production employers over the past 20 years. The community member noted:

> *"Arguably the biggest loss of all was the closure of the 2 Sisters Chicken Factory in Llangefni on 31.3.23, with the loss of 700 jobs. This factory was established in the early 1970s and had provided countless job opportunities for many unskilled [people] and those with lower than average, to having no, academic qualifications. The vast majority of the workforce were local and indigenous population, many of whom will now struggle to find employment which offers similar rates of pay.*
>
> *The loss of these industries particularly, Anglesey Aluminum and Wylfa has had a huge impact on the island's Gross Domestic Product (GDP)[33], and it is now recognised that it is amongst the lowest in Wales and on par with that of the poorest countries within the European Union." (Community Member, Isle of Anglesey, June 2023)*

[30] https://www.anglesey.gov.wales/documents/Docs-en/Council/Governance-and-Performance/council-plan/Council-Plan-2023-to-2028.pdf
[31] https://www.ons.gov.uk/visualisations/censusareachanges/W06000001/
[32] https://www.ons.gov.uk/visualisations/censusareachanges/W06000001/
[33] https://www.varbes.com/economy/isle-of-anglesey-economy

As a result of the loss of economic infrastructure, Anglesey's unemployment rate of 4.2% is 0.6% higher than the unemployment rate for Wales (3.6%)[34]. The community member was also able to explain the current housing crisis that is apparent on the island.

> *"In comparison to the pre-COVID period when we were supporting between 600-650 people at risk of [being], or already, homeless, we are now supporting between 950 and a 1,000, which for an island with a population of circa 70,000 is extremely high and worrying." (Community Member, Isle of Anglesey, June 2023)*

Despite the levels of deprivation Anglesey faces, the community member was able to give the author of the review a unique insight into how well the networks and relationships work on the island when they need to. Anglesey residents genuinely care for each other, and they enjoy the spirit of a community that doesn't readily exist in more suburban areas of Wales.

As an indigenous member of Anglesey, the community member was able to explain that the rich and vibrant tapestry of life and culture on the island is made up of a community of kind and caring people, who look after each other and connect with each other, despite difficulties. They were able to explain that the evidence of the positive culture of Anglesey came to fruition during the COVID19 pandemic where members of the community, alongside third sector organisations and the council, all pulled together to ensure vulnerable people felt less isolated and got the support they needed. There is a feeling from residents of sometimes being left behind and forgotten by the Welsh Government and/or more suburban areas in terms of the needs and specific cultural knowledge of Anglesey. But the active networks of people on the island offer us an opportunity to ensure victims of domestic abuse that share the same characteristics as Elizabeth understand what is available for them. In turn this can reduce isolation and enable victims to access support services more readily.

> *"It is one of those places where you can't go out without someone knowing you, stopping you and saying hello. People really do care, and we can do more to make sure victims of domestic abuse, particularly those that are older, feel less isolated and are able to come forward for support." (Community Member, Isle of Anglesey, June 2023).*

10.2 Coercive Control

An absence of physical injury does not equate to an absence of risk. Coercive control legislation came into effect in the UK on the 29th December 2015 and was therefore in force as a crime when Elizabeth died. To understand domestic abuse holistically we

[34] https://www.varbes.com/economy/isle-of-anglesey-economy

must understand that coercive and controlling behaviour acts as the backdrop to physical and or sexual violence[35].

The cross-government definition of domestic violence and abuse outlines controlling, or coercive behaviour as follows:

- "Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

- Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

- Controlling or coercive behaviour does not only happen in the home; the victim can be monitored by phone or social media from a distance and can be made to fear violence on at least two occasions or adapt their everyday behaviour as a result of serious alarm or distress."[36]

There are some indicators in the information we have from IMRs that coercive and controlling behaviour could have been a feature in the relationship between Elizabeth and David. This may have prevented Elizabeth's ability to work with agencies.

10.2.1 DASH Risk Assessments: (see IMR NWP 9.1) On the two occasions where NWP were called out to the family home because of David's behaviour, both incidents resulted in NWP officers stating *'DASH declined'* by Elizabeth and George. The IMR author for NWP helpfully notes that the DASH should still be completed on professional judgement by officers. The review author would note further that refusal to complete a DASH could be a strong indicator of fear of the consequences of *'telling on'* perpetrators. This is particularly relevant when the perpetrator is the victim's child, which will be discussed in more detail in section 10.3. There is also evidence of Elizabeth initially consenting to support from AS after the second incident that was reported to NWP, then refusing support on contact with AS (see 9.4.17). The trend of 'engaging' and 'dis-engaging' in services is a common one for victims of CCB, and professionals need to be alert and mindful that these responses form a part of how victims 'manage' the fear around agencies becoming aware of what they are being subjected to.

It is important for professionals to understand when CCB is a feature in domestic abuse relationships, victims may present as *'non-engaging'*, or they may minimise the

[35] https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf

[36] Controlling or Coercive behaviour in an intimate or family relationship – Statutory Guidance Framework – Home Office December 2015 p. 3-4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

abuse. Given that we know on the second incident both Elizabeth and David presented as *"very frightened"*, with Elizabeth so fearful she was *"shaking like a leaf"* and had an angina attack, the subsequent 'refusal' to complete a DASH form could be surmised as a trauma response. Victims will do anything to keep themselves safe, and that includes not telling professionals everything that is happening, and/or shutting down conversations entirely. Part of the assessment of risk should consider this type of presentation. Professionals must be alert to the fact that victims tell us so much when they are not telling us anything at all, particularly when the reasons for the reported incident of violence and abuse do not match up with what the victim is formally recording with professionals.

The QA panel noted the missed opportunities by the police to undertake DASH risk assessments on the call outs of DA incidents, this is especially important when dealing with victims with compounding factors like age and relationship to perpetrator. The use of the DASH can open up an opportunity for professionals to understand more about the subtle ways perpetrators may be exerting power and control, even if the victim does not necessarily view the relationship as abusive.

Helpfully NWP have commissioned Safelives to undertake DA Matters with the force. The DA Matters training is endorsed by the College of Policing[37], and includes a focus on CCB, this can also be an element that features heavily in cases of adult dependents towards their parents.

The undertaking of NWP in the rollout of DA Matters was to ensure 75% of staff are trained by Safelives. At the point of submission for this review, NWP have reached that target. In addition, all new recruits receive the input via internal DA Matters Safelives accredited staff, and NWP have further secured training with Mother Mountain[38] for 300 frontline officers to have CCB virtual reality training.

10.3 Filial Abuse

Filial abuse is a relatively under-researched phenomenon internationally, and even more so when the issue relates to adult dependents on elderly parents who go on to commit parricide[39]. The reality for parents who are being subjected to abuse from one of their children, no matter the age, is this will present with a unique set of challenges when accessing support.

Research[40] on filial abuse and parricide evidence that victims are usually female, and perpetrators are overwhelmingly white and male, there are also a higher proportion of perpetrators who have severe mental health issues and personality disorders.

The shame associated with DA is well understood and victims will often minimise what they are experiencing to professionals. When the abuse is being perpetrated by their

[37] https://www.college.police.uk/career-learning/licensed-products/domestic-abuse-da-matters-change-programme
[38] https://www.mmpvr.com/
[39] https://www.tandfonline.com/doi/abs/10.1080/13229400.2021.2018349
[40] https://www.sciencedirect.com/science/article/pii/S1359178997000566

child, victims report[41] experiencing a further sense of shame and feel they are to blame for their children's behaviour.

The numbers of women killed by their adult sons in the UK has been on a steady increase since 2016[42]. Our responses as agencies to filial abuse are still not adequate, and although recent efforts have been made to redress this, the vast majority of interventions focus on adolescent to parent abuse, rather than adult dependents and their parents.

As a society we are geared towards the idea that we should never give up on our children, no matter the issue, this expectation is especially true for mothers. Professionals need to understand that for victims of filial abuse, even telling outside agencies would go against the beliefs of most parents, they often feel that they should keep the abuse to themselves and any outside interference from agencies will either exacerbate the abuse and/or make their children's lives worse.

The IMR author for AS noted the issue of filial abuse was particularly pertinent to Elizabeth, George, and David. The panel agreed with her assertions, especially in regard to:

- The relationship Elizabeth and George had with their son, and that the sense of maternal/paternal responsibility may have made it much harder for them to act against him. David had never left home and was dependent on them during his whole adult life.
- Elizabeth and George both expressed fear of the consequences of disclosure on David. They expressed a strong desire to get David help but as a family they were very reticent in any involvement from outside agencies.
- When police reports were made in relation to David's behaviour, both George and Elizabeth did not want to press charges. This includes George not wanting to support any criminal justice investigations after Elizabeth's death.
- David disclosed a level of resentment towards George in his conversations with the police and he adopted a blaming attitude for what he perceived as a difficult childhood.
- David also had an issue with alcohol, and some self-reported mental health issues. We also know he was unemployed and appeared isolated from the community.

Given the above analysis it is understandable that Elizabeth and George, like most parents, had an overwhelming sense of love and duty to protect their son. The desire to keep abuse hidden when a dependent is the perpetrator (no matter that dependent's age), means that even disclosure to outside agencies is a huge step for victims of filial abuse. As professionals we must adapt our approaches to understand more about the compounding factors for victims of filial abuse. The panel have made

[41] https://www.theguardian.com/society/2023/jan/15/women-killed-by-sons-violence-children-parents-britain-abuse

[42] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf

recommendations regarding this issue, which links closely with the same unique features of older people as victims of domestic abuse.

10.4 Older people as victims of domestic abuse

The abuse of older people (also known as elder abuse) is an intentional act, or failure to act, by a caregiver or other person in a relationship of trust, that causes harm to an adult aged 60 or over[43]. Data from the World Health Organisation (WHO) estimates that the prevalence of abuse in community/home settings may be as high as 1 in 6 people aged over 60 each year, with early indications that this has increased as a result of the COVID19 pandemic[44].

Despite this, older people who are maltreated and abused by their carers are unlikely to disclose abuse, for reasons including:

- fear of retaliation, of abandonment or of being removed from the home or family setting.
- the belief that the abuse was deserved.
- the sense that there is nowhere else to go or that nothing can be done to help.
- shame in admitting such treatment from one's own family.[45]

Victims aged over 60 years of age are much more likely to experience abuse from an adult family member than younger victims[46]. In their "spotlight" on Elder Abuse, national charity Safelives noted that 44% of the perpetrators in cases of elder abuse are adult family members, with older victims experiencing abuse for twice as long as those under 61 and being far less likely to access services[47].

It is also worth noting in the SafeLives research, 73% of elder victims experience coercive and controlling behaviour and there is a *"systematic invisibility"* of older victims of DA due to their differing needs. Whilst the tactics used by perpetrators of coercive control are many and varied, this will often include behaviours designed to isolate the victim, both physically and emotionally, from their social and family networks, professionals, and other sources of support. In contact with professionals, this type of behaviour may present in various ways, including:

- Attempting to lead or dominate meetings or conversations.
- Speaking on behalf of victims.
- Contacting professionals directly to discuss issues pertaining to the victim (that may not be something the victim wants or has asked for).

[43] World Health Organisation, Elder abuse (who.int)
[44] Abuse of older people (who.int)
[45] Risk factor characteristics in carers who physically abuse or neglect their elderly dependants; A. M. CAMPBELL REAY1 & K. D. BROWNE2 (2001)
[46] Safe Later Lives - Older people and domestic abuse.pdf (safelives.org.uk) (p.16)
[47] http://www.safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

- ‘Blocking’ or obstructing professional access to victims by cancelling or rearranging meetings, limiting available contact details, restricting the victim’s access to phone or email, or physically moving the victim away from family, friends or other sources of support.
- Attempting to discredit the victim utilising factors such as their mental health, overall health, disabilities, language barriers, understanding/cognition or similar.

Although we have no evidence to suggest that David was preventing Elizabeth’s access to services directly, the IMR author for AS did raise the pattern of Elizabeth cancelling requests for support that she had previously initiated. Professionals need to be alert to the fact that this may be an indicator of coercive control in older service users.

There were some suggestions during various contacts that David was a carer for Elizabeth and George, although this information was not corroborated officially and could have been taken by professionals at face value. Nonetheless the fact that Elizabeth and George saw David as their carer can also be an indicator of separate compounding power dynamics and stresses that professionals need to be aware of. Stress is not a mitigating factor for domestic abuse, and carer stress is no different. When professionals are adequately trained to understand the dynamics of abusive behaviours it is much easier for them to recognise the difference between systematic use of power and control, as opposed to stress-related relationship breakdown in what is otherwise a non-abusive relationship. Perpetrators will often use the excuse of ‘*being stressed’* to explain away their behaviour, and/or blame a victim for the abuse. It remains essential that professionals are ready and able to offer support and talk about the stress that being a carer can foster. This does not and should not ever excuse any wrongful behaviour, but where it is a straightforward case of carer stress it will become clear that with added support around this issue carers behaviour often changes. It could also highlight if the carer is a perpetrator, because no extra support around caring will change the actions of a controlling perpetrator; in fact they will use it as an excuse for the behaviour and professionals must be very careful not to collude with this.[48] Given we also know that David had his own vulnerabilities, including alcohol dependence and self-reported mental health issues, the disclosures of him being a carer for his parents should have alerted agencies to assessing what support he may have needed as an unpaid carer, alongside his suitability for this role.

From panel analysis of the IMR information, the consensus was that although systems are generally good in dealing with victims of domestic abuse, there is a lack of knowledge on the specific intersections of DA, elderly people, and filial abuse amongst professionals.

The IMR author for Adult Services noted:

[48] https://www.dvrcv.org.au/sites/thelookout.sites.go1.com.au/files/CarerStressOrDomesticViolence.pdf

"The issue of violence and abuse from adult children towards their parents is a neglected area of practice and research[49]. This has led to a lack of guidance for those dealing with this issue". (IMR author, Adult Services, 2023)

This observation is corroborated by leading academic expert of elder abuse, Dr Hannah Bowes[50]:

"At a national level, we have excluded women aged 60 and over from our analysis of domestic violence, sexual violence and stalking until recently, and we continue to exclude those aged 75 and over, and/or those living in care homes, hospitals or other temporary or institutional settings. Our academic research has similarly focused on young women as victims and survivors of male violence. As a result, our policies and practices have been designed to assess and manage risk of violence in young(er) life, and we have built our support services to address the needs of that population. Consequently, we are ill-equipped to recognise and prevent violence against older women; we remain 'shocked' when an older woman is killed by a man, believing this to be an unusual occurrence, when in fact my research has identified at least one in four domestic homicides involves a woman aged 60 or older, despite them constituting only 18% of the population. At least half of these deaths are committed by an adult son or grandson." (Bowes, 2018, Femicide Census 10-year report)

We also know that victims of domestic abuse that are aged 66 years and older are the least likely to leave an abusive relationship and/or seek help[51].

The IMR author for AS astutely noted the links between the compounding factors of elderly parents experiencing abuse and the socio-economic status of adult children:

"Parents who have to face the harsh reality that their adult child is not good for them and need to protect themselves are usually deeply heartbroken, and they tend to feel tremendous shame and guilt for being "not good enough"...Our society instructs us that parents should never give up on their adult children[52]. It is possible for some people to be the victim of abuse from their adult children and staying close to them might be not only painful but dangerous. It is not uncommon for young adults to return to live with their parents or in fact never leave. Some of the known factors are precarious job market, low wage, life challenges, housing market."

We know from the insight of speaking with members of the community on the Isle of Anglesey that there are high levels of deprivation on the island. This has been exacerbated by the COVID19 pandemic and will be discussed further in section 10.7.

[49] https://holesinthewall.co.uk/2020/10/20/abuse-and-violence-from-adult-children/
[50] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf
[51] https://www.theguardian.com/society/2018/apr/25/domestic-violence-abuse-older-couples-increase
[52] https://www.psychologytoday.com/gb/blog/talking-sex-and-relationships/202205/the-unspoken-abuse-when-the-adult-child-abuses-the-parent

The chair of the panel received pertinent feedback from the Gorwel service into the issues they notice with regards to agencies' and the community's understanding of domestic abuse and older people, the feedback from practitioners includes:

- Lack of understanding and awareness about domestic abuse among older people - "something that happens to young people".
- "Marriage is for life, for better and worse" mentality.
- Older people coming from a different generation, where abuse was not discussed.
- Older people often with health problems and dependent on the partner to look after them therefore making it more difficult to leave.
- Older people being abused by children or grandchildren and not wanting to make a statement.
- Older people feeling ashamed and not letting anyone "know their business."
- Mobility problems so unable to go to shelter.
- Older people have often experienced abuse for many years, some in our services state that they have experienced 25-50 years of domestic violence and therefore have normalized the abuse.
- Older people with health issues, including dementia and substance misuse problems. Feeling a duty to stay and support - not wanting to affect the wider family.
- There is no specialist provision responding to domestic abuse among older people in the north region.

Specific feedback from the IDVAs included noticing:

- An increase in cases where children or grandchildren abuse a parent or parents. Parents do not want to refer the matter to the police. Often cases where the children/grandchildren have substance abuse and mental health problems.
- The number of older people who self-refer to Gorwel services is low.
- A high number of older people find it difficult to leave or refer the matter to the police or seek any protection order - older people wanting to "just have a conversation" not take action. The IDVA noticed that older people are not able follow their safety and protection plans.
- The number of referrals into the service does not reflect the number who suffer as a result of stigma, shame, protecting/supporting the perpetrators.
- Lack of awareness of DA among professionals.
- Older people not wanting to be in a shelter with other people or unable to go because of health problems and needing care.
- Difficult to engage with older people who do not want to leave the perpetrators – they are spending 24/7 with the perpetrators as the older person is not in employment and may face isolation due to lack of social life in Anglesey and Gwynedd. Issues that the health of both is deteriorating, fewer opportunities to meet and be able to offer proper support:

"One woman we are supporting can only communicate by email, she doesn't feel able to leave but wants someone to talk to - but she can't answer for a day or two which is worrying in terms of her safety." (Gorwel IDVA, 2023)

Due to the issues noted above, Gorwel and Horizons have worked on some developments to assist with the growing issue of reaching elder victims and domestic abuse; these include:

- Developing a shelter with low maintenance flats and older people fleeing violence can use it.
- Consultation with Dewis-Choice[53] which specializes in providing domestic abuse services for older people. Dewis-Choice will provide special training for Gorwel staff in February 2024.
- Dewis-Choice is currently piloting a "shelter" scheme - a self-sustaining unit for older individuals who experience domestic abuse - Gorwel is interested in developing the same model.
- The IDVA is due to attend the Older Persons Violence and Abuse training delivered by Safelives[54].

These interventions and observations by Gorwel above are notable and welcome. Research released by Dr Hannah Bowes, et al[55], in October 2023, noted:

"Through interviews with 66 professionals across the core statutory public services, this paper has shown how older victims embody many of the 'ideal' victim attributes—they are old and perceived as inherently vulnerable—yet in the context of domestic abuse they are ***not ideal enough****, for they fail to meet several of the criteria required for the 'ideal' victim of domestic abuse or the ideal offender. In fact, whilst the older domestic abuse victim may have what van Wijk (2013: 174) described as the 'right attributes' for an 'ideal victim' (being old, female, and perceived as inherently vulnerable), the attributes that make her ideal may also serve to undermine her credibility. In the data presented here professionals described instances where the perceived credibility of the victim because of dementia or other health conditions became the focus of the case, and domestic abuse was either missed or dismissed. Similarly, perpetrators may weaponize ageist stereotypes that older people lack capacity, and their accounts cannot be relied upon, to downplay domestic abuse or hide it altogether. Ageist stereotypes underpinning assessments of vulnerability thus act as counter-powers to older victim's legitimate claims to victim status. (Bowes, et al, 2023).*

The panel will recommend that the North Wales Vulnerability and Exploitation Partnership Board include older victims into their VAWDASV priorities. The board can use the newly released data from the Wales Violence Prevention Unit (WVPU), on

[53] https://dewischoice.org.uk/
[54] https://safelives.org.uk/training/responding_to_older_people_training
[55] https://academic.oup.com/bjc/advance-article/doi/10.1093/bjc/azad057/7289076

abuse against older people[56], combined with the research recently published by Bowes, et al, 2023[57]. This evidences an increase in reported violence against older people across Wales, including domestic abuse and sexual offences. The recommendations can provide a focus for the partnership board on the intersecting needs of older victims and the training required to ensure interventions for older victims are appropriately responded to.

10.5 Rural Communities and Domestic Abuse

As previously described in section 10.1, Anglesey is a rural community with a small population, a large proportion of whom are elderly. We also know that the community in Anglesey is tight knit, and the community member interviewed explained that it is one of those areas where *"everyone can know your business"*. This may be one of the reasons that Elizabeth, George, and David purposefully chose not to integrate in community life; it may also have been one of the reasons that Elizabeth and George felt cautious about engaging with services on the island.

The Rural Crime Network published a report in 2019[58] and evidenced:

> *"Strong community spirit is one of the joys of rural life, but it can be equally powerful in keeping domestic abuse hidden and in facilitating abuse – not knowingly, not willingly, but by virtue of the way communities are in rural Britain. It is almost impossible for a victim to seek help without it being known to others, call the police without further community questioning or even share their fears with others in confidence. Without knowing it, the community is facilitating the abuse, allowing the abuser to act almost with impunity. There is also evidence that abusers deliberately 'recruit' the community to their cause, which unwittingly becomes a mechanism for controlling and isolating the victim yet further. This can have a direct impact on the effectiveness of the response provided to victims" (Rural Crime Network, 2019).*

There is growing research into the level of availability of support for victims of domestic abuse who live in rural areas. A recent in-depth study of 67 victims of domestic abuse in rural areas in England revealed[59]:

- Rural victims are half as likely to report their abuse to others.
- Rural victims' abuse goes on significantly longer.
- Rural victims cannot readily access support services.
- Rural victims live in a society that sometimes protects the perpetrators.

[56] https://mcusercontent.com/af96e5bc7dd21d56d7a30afc0/files/0fbcecea-5119-4888-b7f1-ce515d88c540/OFFICIAL_Violence_Against_Older_People_in_Wales_Report.pdf
[57] https://academic.oup.com/bjc/advance-article/doi/10.1093/bjc/azad057/7289076
[58] https://www.northyorkshire-pfcc.gov.uk/content/uploads/2019/07/Domestic-Abuse-in-Rural-Areas-National-Rural-Crime-Network.pdf
[59] https://www.ruralactionderbyshire.org.uk/what-is-different-about-rural-domestic-abuse

- Rural victims are isolated, unsupported, and unprotected in a rural hell, which is purposefully 'normalised'.

Even when victims do want to access support, public transport links can be sporadic and access to broadband can be patchy. The community member interviewed commented on this:

> *"Transport remains a huge problem for many living in rural areas and away from the main A55 corridor, for which there is only limited access to public transport. This will impact significantly on those who have no access to their own transport or have limited or no social network and require access to key services such as medical appointments, welfare benefits or other similar services. Such is the rurality of Anglesey, many can feel isolated, detached from having easy access to services and therefore become hard to reach, thus increasing their vulnerability" (Community Member, Isle of Anglesey, June 2023).*

Resources and strategies proposed and provided by the Welsh Government must consider the compounding factors of rural areas like Anglesey for victims of domestic abuse. On the release of the 2019 report[60] into the issues of domestic abuse in rural communities, Julia Mulligan, Chair of the Rural Crime Network stated:

> *"Too often, rural communities and people play second fiddle to the clamour of urban demands. We see this in all sort of ways, from access to broadband and public transport, to the per person funding by government, and not least, the gulf in policing satisfaction and confidence between rural and urban communities set out by the most recent National Rural Crime Survey. But these are arguably the obvious and tangible differences, and certainly issues rural dwellers experience every day. This research examines a different problem. We have uncovered a deeply hidden and disturbing side to rural life. Far from the peaceful idyll most people have in their mind when conjuring up the countryside, this report bears the souls and scars* of *domestic abuse victims, who all too often are lost to support, policing, and criminal justice services. Hidden under our noses. Hidden by abusers who like to keep it that way. A scale of abuse hitherto unseen."*

The responses afforded to victims of domestic abuse in rural communities need to be different, unique, and bespoke to the culture and makeup of rural life. During the analysis of IMR data, it became apparent that both Elizabeth and George were reluctant to disclose their experiences of domestic abuse with agencies. Their reluctance would be in line with the research undertaken into the experience of being a victim of DA in a rural community. The panel make a series of multi-agency and national recommendations in response to this.

[60] https://www.northyorkshire-pfcc.gov.uk/content/uploads/2019/07/Domestic-Abuse-in-Rural-Areas-National-Rural-Crime-Network.pdf

10.6 Health Routine Screening

Health based routine enquiry or 'Asking the Question' of a patient whether they have experienced domestic abuse has been researched in detail for over a decade[61]. There are many benefits to ensuring health professionals are trained to ask patients whether they are experiencing domestic abuse, and this is of particular importance for GP practices because 41% of victims attend general practices for support[62].

Research shows us that the routine opportunities to ask victims whether they are experiencing domestic abuse in health-based settings yields better results. In addition, this should not be a one-off as routinely 'asking' gives the message to victims and survivors that disclosing domestic abuse is acceptable and that everyone is asked, therefore nobody is particularly targeted[63].

Through the IMR data we can see that health agencies had the most interaction with Elizabeth. There were opportunities to ask her whether domestic abuse was something she was being subjected too. Equally through the targeted questioning approach undertaken by WAST and BCUHB, we know there were chances to approach Elizabeth, and the QA panel noted the lack of professional curiosity from health staff at these appointments.

There was a recognised pattern in Elizabeth cancelling support services she had previously initiated. This also occurred with Elizabeth's interaction with the pain clinic (see 9.3.3), where Elizabeth discharged herself from their care, but no exploration was undertaken as to why she had done this. Although there may be nothing to suggest that this isn't anything other than a patient's wishes, we cannot know whether perpetrators are controlling victims' access to health care and exerting power and control without curious professional exploration.

When Elizabeth accessed the pain clinic in February 2019 (see 9.3.2), she and George disclosed they were experiencing:

"Lots of stress at home with the son"

The IMR author for BCHUB notes this as a missed opportunity to explore these disclosures further. The review author and chair discussed this further with the panel. All panel members felt that the notes did not reflect what would have happened had the healthcare professionals at the pain clinic explored these comments further and suspected domestic abuse. The review author notes that although clearly empathetic to the feelings of stress, if a victim like Elizabeth was trying to tell a professional that her son was being abusive, the response of teaching Elizabeth breathing techniques could prevent further disclosures later down the line. We cannot know if Elizabeth and George were trying to inform professionals that David was being abusive, and although the professional in question was responding to the presenting problem of pain relief techniques, the response was to teach breathing exercises. For victims of

[61] http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf
[62] http://irisi.org/
[63] http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf p.8

abuse any message that they are able to manage the abuse they are subjected to misses the point of the dynamics of domestic abuse entirely. We have to take every opportunity to explore comments like these from potential victim/survivors - our responses, actions, body language, and words all matter when it comes to how victims perceive what will happen next after disclosing abuse. In addition, it is also imperative to be clear in all record-keeping the reasons why we have taken certain actions. For example if the record from the pain clinic had clearly stated that the breathing techniques were taught to manage the pain, there would be no question mark over their intention.

As previously stated, the panel recognised through analysis that one of the main areas of development for the workforce in Gwynedd and Anglesey was with regards to elder abuse. Alongside a need for focused multi-agency training on elder abuse the panel felt it important that specialist domestic abuse organisations also re-focus their response to elder victims.

There is an embedded health-focused Independent Domestic Violence Advocacy (IDVA) service based in the three hospitals in Anglesey, which is a welcome initiative. The investment from the North Wales Police and Crime Commissioner into a health-based IDVA service is a much-needed intervention.

Research[64] proves that hospital-based IDVAs provide earlier intervention than community-based services and enable health services to meet their domestic abuse obligations. In addition, health-based IDVA teams are in a unique position to engage victims who face additional barriers to getting help, with 10% of victims aged 55+ seeking support through health-based IDVA services, compared to 7% in the community.

Although a relatively new intervention, the partnership working between health staff and the IDVA service is strong. The statistical data for victims over the age of 55+ using the local domestic abuse service, Gorwel[65], was as follows:

Hospital IDVA referrals August 2022-August 2023

Total referrals 66

14 of those referrals for aged 55+ = Total 21%

- 10 for ages 55-65
- 3 for ages 65-75
- 1 over 80 years old

The panel welcome and commend the developments undertaken by Gorwel to ensure the team will receive specialist training on elder people and domestic abuse in February 2024.

The panel were also very supportive of the current IRISi model[66], which is a specialist Domestic Violence and Abuse training model for General Practitioners (GPs), so they

[64] https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf
[65] http://www.gorwel.org/eng/domestic-abuse-services-gwynedd-and-anglesey.html
[66] https://irisi.org/what-is-iris/

can identify victims of DVA and refer them to specialist support services. It is incredibly positive that an IRISi pilot is being delivered across the Denbighshire area, but unfortunately funding is not secure, and the current service is due to close without a further financial commitment at the end of March 2024.

The IRISi model is an important investment in local areas, particularly where access to services can be challenging, GPs surgeries can be instrumental in ensuring victims of abuse, including that older victims receive the support and safeguarding they need.

The panel will make recommendations to sustain and secure IRISi in the long term, across a wider area. IRISi is not a short-term fix as a model and requires sustained investment to ensure positive outcomes for communities. In addition, the panel will make further multi-agency recommendations on training and awareness-raising for professionals to understand the dynamics of elder abuse more holistically in their approaches to victims of domestic abuse.

10.7 Substance misuse and mental health

Mental health issues and/or substance misuse are not causes, consequences, or excuses for perpetrating domestic abuse[67] against a loved one. It is important to analyse the impact of the issues present in David's life to assess where policy responses can facilitate support for men like David, and in turn reduce the harm for victims.

Research[68] indicates[69] that the combination of substance misuse and mental health conditions can both exacerbate and increase the severity of the abuse they perpetrate. In their Spotlight on Mental Health and Domestic Abuse[70], SafeLives found that most people who perpetrate domestic abuse are not receiving support for their mental health issues. We also know from the information previously stated in section 10.1, that Anglesey has high levels of deprivation and unemployment, and research[71] indicates that economic recessions have a direct impact on the increase of substance misuse and negative mental health amongst populations.

On a number of occasions David disclosed he experienced mental health issues; on one occasion he informed NWP that he had a diagnosis of schizophrenia, and on another occasion, he alluded in notes sent to AS from the police that he had previously been sectioned under the Mental Health Act. Panel agencies did rigorous research to corroborate these disclosures but there was no evidence to suggest that these disclosures were factually accurate. It appears that David self-diagnosed his own mental health issues, and this is not uncommon for some perpetrators of domestic

[67] https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-and-domestic-abuse
[68] https://journals.sagepub.com/doi/abs/10.1177/0886260514527172
[69] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3532855/
[70] https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf
[71] https://www.sciencedirect.com/science/article/pii/S0955395917300877?ref=pdf_download&fr=RR-2&rr=7e4051a24ccc892a

abuse. Undiagnosed mental health issues can be a tactic to divert attention away from behaviour and or garner sympathy by way of making excuses for violent or abusive incidents. However, any disclosures like these should be explored further with potential perpetrators as they can lead professionals to understand more about the motivation of behaviour, and/or they could be seen as a means of engagement with perpetrators who might indicate they want to change their behaviour and get support for any compounding factors that may indeed be present.

Elizabeth and George expressed a desire to get David help. They spoke to NWP about his drinking issues and David himself talked to NWP and health services about his struggles with his mental health. There were attempts after Elizabeth's death to engage David in the ADAPT model[72] of support. There is no criticism from the panel on the inability to engage David in this intervention, and evidence suggests that George was also reticent for David to engage in this support.

However, given the needs of the population in Anglesey it is important for mental health and substance misuse agencies to be enabled to respond in a more targeted way to people who are using their services and potentially perpetrating violence and abuse towards loved ones. The panel will make appropriate recommendations for these services, so that interventions for men like David can be initiated earlier in their behaviour.

10.8 COVID19 pandemic and Domestic Abuse

We can learn from the emerging findings of research[73] on the impact the pandemic had on victims and survivors of domestic abuse. We also know from national research[74] undertaken that there were exacerbating pressures on professionals working with victims and perpetrators.

Whilst the panel recognise and commend the hard work and stretched resources of all professionals during the pandemic, the NWP, BCHUB and AS IMRs all noted that the responses available to Elizabeth could have been influenced by the pandemic due to the impact on resources.

ONS data[75] shows us that there was both an increase in the use of domestic violence services during the pandemic and the Metropolitan Police recorded more reports to the force during the first lockdown period. This is thought to be from third party calls, as a result of more people being at home and thus exposure to hearing domestic abuse from neighbours. The first incident of domestic abuse regarding Elizabeth,

[72] https://www.leaderlive.co.uk/news/20205738.police-work-perpetrators-tackle-domestic-abuse/
[73] https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf
[74] https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/61826677bdb3b572a7350941/1635935884071/Shadow_Pandemic_Report+FINAL+%282%29.pdf
[75] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020

George and David was reported to NWP via a third party during a period of lockdown in Wales[76]; this could be an indication that their neighbours were becoming more aware or were more willing to report DA to police. Interestingly there was a higher level of domestic awareness campaigns and media reports across England and Wales during the pandemic, these types of targeted campaigns can lead to more reports of domestic abuse. This should be seen as a positive development and can enable us to learn about how the public and communities respond to domestic abuse as they become more aware about it.

We are still learning about public policy responses to the pandemic and the review author urges the Domestic Abuse Commissioner for England and Wales to lobby for the UK COVID19 Public Inquiry[77] to incorporate the responses afforded to domestic abuse victims so that we can learn the lessons for any future pandemics. In addition, we know that many communities, including Anglesey, are still dealing with the knock-on effects of the pandemic, as referenced by the community member interviewed. The long-lasting impact on resources as a result of COVID19 will not be fixed swiftly and we must therefore ensure that these issues are taken into consideration in both policy and fiscal responses by central and local governments.

10.9 Impact on Professionals

During panel discussions a number of panel members reflected on the impact on professionals of reviewing the interventions in the case. This could also be true for professionals who worked directly with Elizabeth. Sometimes the clinical process of a DHR does less to illuminate the impact of the loss of a victim on staff than it does to illuminate the changes that can be made. To make changes in organisational culture or practices, professionals need to feel heard and understood. Challenges to professional practice and systems are essential to bring about change, however, before professionals can reflect on what changes are needed, they need to be supported to move past the impact of the death of someone they worked with.

Given the cultural features in the area of Anglesey, it is likely the death of Elizabeth was felt by professionals and community members in a wider way than the panel is aware of. The panel support the review author in making a further national recommendation to ensure professionals are able to come forward for emotional support after the death of a victim of domestic abuse they have worked with.

11 Equality Act 2010

11.1 The Equality Act 2010 defines the following as protected characteristics:

[76] https://en.wikipedia.org/wiki/Timeline_of_the_COVID-19_pandemic_in_Wales_(2020)
[77] https://covid19.public-inquiry.uk/

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

All protected characteristics have been considered throughout this process. Services must adhere to the Public Sector Equality Duty (PSED)[78] and have due regard to the protected characteristics of individuals in order to harmonise equalities and foster good relations.

There are generally three aims[79] under the PSED and these involve:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

11.2. The sex of the victim is relevant. Females are disproportionately the victims of homicide in domestic abuse cases. According to new data released by the United Nations Office on Drugs and Crime (UNODC), research shows that an average of 137 women across the world are killed by a partner or family member every day, the research further evidences that 58% of women are killed by a partner or family member[80]. In addition, through the work of Karen Ingala Smith[81], we know that in the UK 1,425 women have been killed by men over the ten-year period between 2009 and 2018[82]. That equates to one woman being murdered every three days by a man, and one woman every four days by a man she knows. Elizabeth shares many of the same experiences and characteristics as the other women killed, however, the overriding factor they all have in common is their sex.

11.3 With respect to this DHR, the conclusion is that the protected characteristic of sex should be known and understood much better by service providers and

[78] https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty
[79] https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty
[80] https://www.bbc.co.uk/news/world-46292919
[81] https://kareningalasmith.com/counting-dead-women/
[82] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf

commissioners in relation to domestic abuse. The analysis and recommendations set out in the Femicide Census[83], ten-year report provide more detail.

Protected characteristics and the discrimination people face because of them often intersect. This was true for Elizabeth as it is for many women who experience domestic abuse. Elizabeth's age was also a feature in the barriers she had to reporting and seeking help.

11.4 In terms of filial abuse, we are aware from research that this is a sex-based crime. The overwhelming majority of victims of murder are females and the perpetrators are their adult sons[84]. However, the lack of research in this area is a cause for concern. Without academic research into the crime of filial abuse, especially from adult dependents towards their parents, frontline professionals are at a significant disadvantage in knowing how to provide appropriate interventions for victims.

This factor, combined with older victims of abuse, means victims with the protected characteristic of age are not adequately supported and their needs are not well understood.

Although there was nothing within the IMR or chronology data to suggest that any professionals directly discriminated against Elizabeth, there were indications that her presenting needs, and those of David, could have resulted in unconscious bias, therefore clouding the judgement of some professionals as to what was going on in the family home. Unconscious bias is when professionals make quick judgements and assumptions about people and situations without really thinking about it. Through the detailed analysis and conversations at meetings, the panel were able to ascertain that there was a lack of knowledge across agencies about the needs of victims of filial abuse, and for victims who hold the protected characteristic of age, which is in line with current national research[85]. These issues will be a focus of the recommendations for the review, to ensure that moving forward professionals are alert to the equality needs of victims who share the same identifying features as Elizabeth, both locally and nationally.

12 Good practice

The panel noted the high calibre of the IMRs from all agencies. The work of the Domestic Abuse Police champion was exemplary and her willingness to pursue the concerns she had regarding George and Elizabeth are to be commended.

It is clear that each agency had care and regard in their dealings with Elizabeth. Although hindsight offers us a unique perspective and an opportunity to recommend changes for the future, the chair and author of this report roundly commends the professionals who dealt with Elizabeth. Given the need to develop the workforce on

[83] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf
[84] https://www.femicidecensus.org/wp-content/uploads/2022/02/010998-2020-Femicide-Report_V2.pdf
[85] https://academic.oup.com/bjc/advance-article/doi/10.1093/bjc/azad057/7289076

the intersecting needs of elder victims, the chair of the review feels that this will enhance the practice for professionals in Anglesey and Gwynedd, who are already providing good services in a tough and challenging climate.

13 Key findings and Conclusions

13.1 Coercive and Controlling Behaviour

Signs of Coercive and Controlling behaviour are 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 depending on the compounding factors and diverse nature of a victim's culture and protected characteristics, for example 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 homogenous 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 CCB, 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.

13.2 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 conversations about filial abuse, and the focus of research must also incorporate adult dependents who reside in households with elderly parents.

13.3 Older people as victims of abuse

Although older people as victims of domestic abuse is better researched than filial abuse as a phenomenon, 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 (WVPU) published their data on abuse against older people[86]. The data evidences an increase in domestic abuse and sexual offences against older people across the country. This increase in offences recorded can be seen as a positive development as more victims are coming forward, however, professionals need the infrastructure and support to respond adequately to victims who are older.

Skilling 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)[87] incorporates the Ask and Act training previously mentioned in the IMR for BCUHB (9.3.9). This training framework is already well established in Wales and includes the following features:

- One of the key mechanisms for delivering the VAWDASV (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.

13.4 Rural Communities and Domestic abuse

The Domestic Abuse Commissioner provided a detailed survey mapping[88] 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 revealed the difficulties and compounding factors for

[86] https://mcusercontent.com/af96e5bc7dd21d56d7a30afc0/files/0fbcecea-5119-4888-b7f1-ce515d88c540/OFFICIAL_Violence_Against_Older_People_in_Wales_Report.pdf
[87] https://senedd.wales/laid%20documents/sub-ld10514/sub-ld10514-e.pdf
[88] https://domesticabusecommissioner.uk/wp-content/uploads/2022/11/DAC_Mapping-Abuse-Suvivors_Long-Policy-Report_Nov2022_FA.pdf

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.

13.5 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 is a well-established mechanism 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.

13.6 Impact of fatal deaths of victims of DA 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 necessarily 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 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.

14. Recommendations

14.1 Single Agency Recommendations

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

14.2 Multi-Agency Recommendations:

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

14.2.2 Awareness raising on the Isle of Anglesey:

- Promote materials that inform community residents on the importance of reporting DA 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 ADAPT model and the perpetrator programmes across Anglesey and Gwynedd.

14.2.3 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.

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

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

14.3 National recommendations:

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

14.3.2 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.

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

15. Action Plan

Single Agency Action Plan

Organisation	Recommendation	Action	Lead Agency	Target Date	Milestones
North Wales Police	Re-promote force communications on officers questioning style, dying declarations and res gestae evidence.	Force wide communication with operational staff to support learning on admissible evidence. Managed by a 'Need to know' circulation/ linked with training unit.	NWP	February 2024	
	NWP to encourage the use of EOEL 7 (Occurrence Enquiry log within crime recording system) across all areas of the Force to update partners on issues relating to people with vulnerabilities (including offenders) and consent issues.	PRONTO launch - communication and guidance on information sharing.	NWP	March 2024	
	Highlight the importance of "*looking beyond what you are being told"*. Officers to act upon their	To be addressed in AWARE training.	NWP	July 2024	

	professional judgment and report what they observe, not rely upon what they are told, and maximise opportunities to intervene.				
	Highlight the need for robust supervision of DA incidents on the Intergraph Computer Aided Despatch System (ICAD) – consider a Sgt authorising the closure of all DA reports.	Supervisor oversight to identify missed opportunities and when sharing/action is appropriate.	NWP	Force consultation and ongoing training and CPD opportunities – rolling action.	
	DARA implementation to address issues with incomplete DASH referrals – mandatory input from officers on DARA.	DARA training and implementation.	College of Policing and NWP	As per force adoption of DARA model (no confirmed date)	
	Scope whether local policing should be notified when a crime recording has been amended to ‘crime’ from ‘non-crime’ in	Domestic homicide training will provide officers with an insight into hidden offences and offer scope to assist with local	NWP	September 2024	

	Domestic incidents. Officers to consider whether additional work is required in line with crime recording standards.	policing and intelligence in this area.			
	NWP to communicate the CMP to officers in relation to DA – specifically supervisors overseeing and endorsing the ICAD in DASH refused cases. Linking nominals and ensuring adding OEL updates before the end of a tour of duty.	Relaunch of the CMP in 2023 to assist the ongoing improvement of this action.	NWP	January 2024	
Welsh Ambulance NHS Trust (WAST)	To re-affirm with WAST colleagues the importance of including appropriate contextual details on documentation. Information such as the rationale for decisions made or reasons for taking/not-taking actions can provide	Continue to ensure WAST colleagues remember the importance of detailed documentation by circulating a reminder.	WAST	March 2024	

	further explanation regarding a situation.				
	Remind WAST colleagues that when safeguarding concerns are identified they must report via the existing safeguarding reporting mechanisms, even if other agencies are on scene or already aware.	Issue reminder to WAST colleagues	WAST	January 2024	
	Continue to provide training on VAWDASV as part of the induction package to all new WAST employees. During 2023/2024 start arranging standalone VAWDASV training for existing WAST colleagues throughout the organisation.	Ensure this training is provided by the WAST Safeguarding Team.	WAST	March 2024	
	Digitalise the referral pathway to Live Fear Free for WAST colleagues who work within the 999 and	Digitalise the referral pathway and communicate this upgrade to all relevant colleagues by the	WAST	January 2024	

	NHS111 Wales call centres.	WAST Safeguarding Team.			
Betsi Cadwaladr University Health Board (BCUHB)	Conduct an audit of compliance regarding REDA in ED and primary care departments across BCUHB	Audit.	Head of Safeguarding Children and lead for VAWDASV	September 2023 – September 2024	
	Lunch Learn and Inspire Webinars for all ED departments across BCUHB	To further raise awareness of the SCH05b Procedure & revisit the statutory requirements.	Corporate Safeguarding Practice Development Lead Safeguarding Managers	June 2023 (completed)	
Isle of Anglesey County Council Adult Services (AS)	Embed the Wales Safeguarding Procedures 2019 in practice	- Review each section of the procedures. - Map existing practice. - Identify gaps. - Agree solution. - Implement.	Head of Service	April 2024	
	Improve the screening and application of Section 126 criteria	To ensure consistent screening and application of Section 126 criteria by facilitating a workshop for Team Managers and feeding back to Officers following Safeguarding Audits.	Independent Safeguarding & Reviewing Officer	December 2023	

	Systems / workflows show practice with individuals that meet the requirements of Wales Safeguarding Procedures.	Develop and Implement: Managers' decision template Revised enquiry record which enables a clearer recording of decisions following initial screening, as well as the rationale and decision as to whether Section 126 enquiries of the Act are required. Safety Plans/Protection Plans Care and protection - clear and incorporate requirements for monitoring and review and their effectiveness is monitored. Chronologies as an aid to decision making and assessment. These will be supported by practice guidance.	AS		

		Training on record keeping in safeguarding.			
	*Raise awareness of the nature and impact of filial abuse	Better understanding of adult/parent – child violence and how the range of provisions for DA applied in practice.	Local and regional	April 2024	
	*Raise awareness of the nature and barriers to older people reporting domestic abuse. Ensure Health and social care professionals to take opportunities to ask about possible domestic abuse at hospital discharge, care assessments or GP appointments, and direct older people to appropriate support where this is wanted and needed.	Raise awareness among health and social care professionals working with older people and ensure that they feel confident in spotting the signs of domestic abuse in those they work with.			

*The panel have extended to a multi-agency recommendation

Multi-Agency Action Plan

Focus	Recommendation	Action	Lead Agency	Target Date
VAWDASV strategy	North Wales Vulnerability and Exploitation Partnership Board to update VAWDASV priorities to include older victims of domestic abuse.	Utilising the data from the recent publication of violence against older people in Wales, link the ongoing data supplied by WVPU.	North Wales Vulnerability and Exploitation Partnership	July 2024
Awareness Raising	Awareness raising on Isle of Anglesey: Promote materials that inform community residents on the importance of reporting DA 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.	Combining the campaigns already in use via the LA, specialist DA services, and NWP, re-focus materials that represent the intersections of older victims and rural communities into promotional material on how to report DA within communities. (Ensure both digital and hard copies are available to the diverse communities across Anglesey).	Community Safety Partnership	August 2024

Perpetrators	Sustained financial support for the ADAPT model and the perpetrator programmes across Anglesey and Gwynedd.	From sustained funding via multi-agency partnership, perpetrator interventions to include a focus for professionals understanding and awareness raising of the compounding factors of multiple and complex needs and social disadvantage in the presentation of abusive behaviours.	NWP to lead	September 2024
Training	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.	Utilising already established knowledge, ensure rollout of awareness-raising amongst professionals on how to spot the signs of filial/older abuse. Incorporate the learnings from this review into the National Training Framework and Ask and Act model. Adopt the 7-minute briefing model/ lunch and learn and 'Patient's story' model for a multi-agency promotion using Elizabeth's story as a case study. Hook promotion onto 16 Days of Action/ International Women's Day, Safeguarding Conferences.	CSP	January 2025
Health	Explore funding options to sustain the IRISi	Continued funding and support for the IRISi model and utilise	ICB	April 2024

	project in Denbighshire and the proposed further roll out of the service in the region, including Anglesey.	the 7-minute briefing above in training for GPs via IRIS advocate educator.		
Monitoring progress	Track and monitor increase in referrals of older people to Gorwel DA services, once above actions have commenced.	Gorwel to provide comparable data on referrals from older people from pre actions above to after actions completed.	Gorwel to CSP	January 2025

National Recommendations

Recommendation	**Lead Agency**	**Implementation**
Commission extended research into older victims of domestic abuse and ensure this extends to older people and filial abuse.	Home Office	CSP to follow up request with DA Commissioner 6 months post publication of report
Provide more focused promotion and research into the issues faced by victims/survivors in rural areas across Wales, providing an understanding through research of the culture, demographics and issues that are unique to Wales.	Welsh Government (WG) (CSP to send final report and liaise with WG on outcomes)	CSP to follow up request with WG 6 months post publication of report
Commission research into the impact of domestic homicide/suicide on professionals in emergency services, health/social care, voluntary, and CJS sectors.	DA commissioner's office	CSP to follow up request with DA Commissioner 6 months post publication of report

16. Appendices

Appendix A

Terms of Reference

1. Introduction

1.1 The chair of the Gwynedd & Anglesey Community Safety Partnership (CSP) commissioned this DHR in response to the death of an 83-year-old woman. Her death followed an incident in June 2022 whereby disclosures were made that indicated her son may be in some way culpable for her death. Further information was shared with the CSP to suggest domestic abuse may have been a feature in the family home.

1.2 All other responsibility relating to the review, namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the panel and subsequently the CSP.

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death in June 2022 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family

2.2 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.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
    - the actions of all the involved agencies;
    - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
    - analyses and comments on the appropriateness of actions taken;
    - makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra- and inter-agency working.
- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.
- Recognising that the deceased was an adult with care and support needs: consider whether and how the adult at risk process was used to identify whether she was at risk from domestic abuse: and identify whether there were barriers to identifying domestic abuse because of her age.
- Liase with North Wales Safeguarding Board to facilitate learning for adults at risk and their families in regards to adults at risk processes and linked policies of domestic abuse.

2.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

- Consider the period from January 2018 to June 2022, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours and friends to provide a robust analysis of the events, taking account of the coroners' inquest in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- 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 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 that the 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 organisations 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 from 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.

- Examine 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.

- Examine 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.

4 Role of the Independent Chair

- Convene and chair a review panel meeting at the outset.

- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6)).
- Determine brief of, co-ordinate and request IMRs.
- Review IMRs – ensuring that they incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses.
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel.
- Present report to the CSP (if required).

5 Domestic Homicide Review Panel

5.1 Membership of the panel will comprise:

Agency	**Representative**

This was confirmed at the first Review Panel meeting on January 24th 2023 (see section 3).

5.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website before joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

6 Liaison with Media

6.1 Isle of Anglesey County Council Communications dept.

Appendix B

AWARE Principle

This briefing focuses on the AWARE principle and how this will be used. I will cover how AWARE can be used to support officers reporting information about interactions with children and adults at risk.

AWARE is a guiding principle and framework supporting the development of your professional curiosity and identifying vulnerability. This principle can be used in any context and provides signs to be aware of to identify early safeguarding opportunities and supports both the voice of the child and voice of the adult at risk information gathering within the force.

This concept aims to develop your professional curiosity and provide a method of reporting against those gut feelings and natural observations you'll all have as police officers and investigators to build a picture for risk assessment.

What do we mean by professional curiosity?

Professional curiosity is about being aware of more than what we are told and presented with and listening to that instinct that you will all have as professionals to explore and dig a little deeper to gain a richer picture of what is happening in a person's life. Any intelligence gathered even seemingly small bits of information provide context at potential vulnerability and criminal concerns. So, it's important to remember that every single interaction with a child, young person or vulnerable adult is an opportunity to engage, learn about that person and their experiences. Be aware of their journey and most importantly their context. Enabling you to record and report your observations and views based on key areas that you will be naturally asking and observing will lead to better, quicker safeguarding and greater earlier identification of vulnerability. Therefore, enabling us to prevent harm or neglect from escalating.

The benefits of developing a professional curiosity and widening our thinking with every interaction is that the information you capture and the context in which that information is gathered contributes to bigger picture thinking, seeing beyond what is presented to us.

It also allows us to start developing a deeper understanding over time of common displayed and hidden behaviours which would heighten our understanding about why someone acts the way that they do and allow us to develop those warning markers even earlier.

This AWARE principle is a vital part of us contributing to a person-centred welfare provision, being able to get the right support in place, based on the person's needs which in turn increases the opportunities for and quality of multi-agency information sharing.

Benefits to AWARE

- **Bigger picture thinking** – looking beyond the obvious
- **Deeper understanding of behaviour** – why people behave the way they do
- **Contributes to a person centred approach to welfare provision** -the right support in place for each individual

- **Increases quality of multi-agency information sharing**
- **Supports a consistent approach**
- **Delivered through a clear framework**

So what is the structure of AWARE and how do we think its going to work?

The AWARE principle structure considers 5 key areas for where we should be looking deeper and enhancing that curiosity. These are:

A – Appearance

W – Words

A – Activity

R – Relationships and dynamic

E – Environment

So how does AWARE work?

It's a guiding principle highlighting the potential signs to spot in terms of recognising and proactively managing vulnerability.

It supports the gathering of those details that all add to that bigger picture and gives you a framework to understand a little bit deeper that person's situation. It provides a consistent framework for simpler reporting whether linked to a crime or a non-crime incident.

Importantly it's not a checklist, it's not the creation of the expectation that you will always find vulnerability markers in every case.

It's more an aid to help you develop a more observational mind set and give you a clear structure to report against if you are seeing things that concern you.

AWARE should be used in all interactions with children, young people and vulnerable adults, for victims, witnesses and offenders in any setting. In domestic and non-domestic settings.

So let's run through the 5 elements of AWARE:

First of all

1. APPEARANCE

So this is where we consider, observe and record any outward appearance of those you are engaging with, speaking with, that may indicate neglect, abuse or even a

particular state you would not expect to see. This could include suitability of clothing, bruises or marks in multiple or unexpected locations, as well of any evidence of fatigue as an indicator of vulnerability.

2. WORDS

The WORDS that children typically use is commonly captured under VOICE of the child and though it is often recognised as a vital element of our recording, the choice of language dependent on age, capacity of the child or vulnerable adult means that we must be an advocate for them. Not only recording what the person says to us, but the way in which they say it as well as if they don't say anything at all, as lack of engagement can also provide us with an understanding of their current state. This advocacy through recording in a clear structure and your everyday professional observations will allow us and our partners to better plan and better safeguard our vulnerable children and adults.

Of course this covers anecdotal recordings of what the conversation contained and asking open ended questions such as "How do you feel" or starting questions with "Describe for me…" or "Tell me …." can often illicit more conversational disclosures and add context.

Beyond the words themselves reflect upon the type of language used, are they calm? Are they angry? Are they using inappropriate language in any way? Again what could this mean beyond the words themselves? Do their words match their body language? Does their speech seem forced or rehearsed? Do they seem guarded, anxious secretive or are they being really open and honest with you? Now we are not expecting you to be body language experts to do this. This is about listening to your own intuition about what you are experiencing during that interaction. This is also a really key time to note down any phrase that is used that could indicate a vulnerability that CRU can then assess.

And most importantly in this process, think carefully, use your judgement, make use of the AWARE framework to note down your reflections and observations to ensure opportunities for professional curiosity are not lost and everything you feel and experience as a professional is also captured as your notes and reflections are a vital part of the narrative of that child and adult in terms of the protection and the decision makers who can get the right support in place.

3. ACTIVITY & BEHAVIOURS

What kind of activity and importantly behaviours is that person displaying and what us the relation of that activity to where they are? This includes whether you feel the reactions of the person is appropriate based on what has occurred. So its not about drawing conclusions in terms of what these observations mean but simply having a record of initial observations which may have a bearing on further approaches is really useful. For example, if a child has witnessed a violent domestic abuse incident however that child is passive and calm, that behaviour could potentially evidence that this is a natural occurrence in the home and that child has become used to it. Therefore if you

record how passive that child has been following that violent event, it provides an opportunity for an intuitive risk assessment to take place as it would be reasonable to suspect that repeated domestic abuse is occurring in that location and therefore that child maybe at serious risk. You are not necessarily going to be the decision maker in that but the act of recording that the child is calm and not expected allows risk assessors later down the line to look at that as an additional indicator to build in to their protection plans.

You will also use your own judgement on whether the activities observed are considered age appropriate, additionally if activities occur which raise concern, record it and state the observation. Again you do not need to draw conclusions but it could be significant, for example, if a phone is constantly ringing but if the person won't answer the phone in front of you that could be signifying something. And these little considerations and recording of it will allow us to build that bigger picture.

4. RELATIONSHIPS AND DYNAMICS

This is all about recording and understanding the types of relationships that you are observing and how these individuals react with one another. Its really key to establish the relationship that you are observing. Are they parent and child? Foster carers, siblings, relatives, friends etc? Again this is about recording your observations around concerning or inappropriate behaviours and the dynamics between relationships that could include hiding, grabbing, displaying aggression etc. It also includes how a child or a vulnerable adult reacts to you or your colleagues as well as other professionals. In the context of larger groups, do members of the group make eye contact, are there any signs of intimidation, what is the peer group ratio in terms of gender balance or age range?

And also within the home environment, who visits, who comes to the house regularly, who are they in relation to the family? Develop that professional curiosity questioning to build that picture of the household including who lives within the property, who visits, do you feel someone has an unexpected influence or power over other members of the household or in your view there is a total absence of any authority within the household.

5. ENVIRONMENT

Where are you and what are you observing about the physical environment? This is encompassing within a home setting, rooms, also garden areas or bins etc. One example of the importance of recording these observations is an officer who noticed the recycle bin overflowing with alcohol bottles and upon enquiring casually had there been a party at the property, the residents actually disclosed they regularly hosted adult parties and then on further exploration of that it emerged that there wer children in the household who were able to witness these parties and were being exposed to harmful sexual behaviours. And that simple observation, casual curiosity based questioning and subsequent disclosure allowed the officer to progress child protection plans and ultimately safeguard those exploited children.

Also under this you can make note of the surrounding environment, whats the proximity to neighbours, schools, amenities, main roads, any known local criminal hot spots, drug or alcohol paraphernalia or any local transportation links that could be particularly relevant in terms of missing children.

The AWARE principle has been developed to enable clear and effective reporting of vulnerability to identify early needs of children and vulnerable adults. To be part of the dynamic risk assessments for CRU to get the right support in place. We hope that this principle can contribute to dynamic risk assessments, effective problem solving as the more history and context we have, the better and more tailored our problem solving approaches and safeguarding plans for individuals will be.

So please remember:

BE MINDFUL. BE CURIOUS. BE AWARE.

Home Office

Interpersonal Abuse
Unit 2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Gwynedd and Anglesey Community Safety Partnership

Council Offices

Caernarfon

LL55 1SH

23rd April 2024

Dear ,

Thank you for submitting the Domestic Homicide Review (DHR) report (Elizabeth) for Gwynedd Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20th March 2024. I apologise for the delay in responding to you.

The QA Panel felt this was a good review which included effective Individual Management Review (IMR) practice supported by a curious and expert Panel. It brings a light onto an important area regarding abuse of parents by adult children.

Though there has not been any involvement from Elizabeth's family, it feels like there has been real efforts made to understand Elizabeth's experiences (for example, the information on Anglesey is helpful context at 10.1), and that there is good learning as a result.

There was a good use of research within the report and the glossary of terms and genogram included in the overview report is helpful.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The independence of the Chair needs to be made more apparent. The statement needs to say that she was independent of all agencies (para 4.1).

- It is mentioned that Elizabeth's daughter had shared with a FLO that she had expressed interest in taking part in the review (8.1), but it seems that the family were only invited by letters – could (or was) the FLO have been asked to facilitate contact?

- Age UK or Dewis Choice may have been beneficial panel members.

- In Appendix 2, 2.1 includes the date of Elizabeth's death. Only the month and year is required.

- The dissemination statement needs to be developed and should state that the reports will be sent to the Police and Crime Commissioner and the Domestic Abuse Commissioner.

- The timeline and contacts that Elizabeth, her husband and David had would have been easier to follow if there was a combined chronology. Currently, these contacts are presented by agency which makes it harder to follow.

- It is difficult to understand the meaning and purpose of the following paragraph, which could be further clarified. *"Given the privacy of the family, the panel reflected that analysis on this case may never have come to light. There would have unlikely been any review process on the previous incidents reported to the police, and thus the learning for families with similar issues and demographics in the Gwynedd and Anglesey area would not have been forthcoming.",* Section 9.1.9.

- The CSP may wish to double check a reference to the number of women killed in the UK which describes the number of women "*murdered"*, Para 11.2. Some of these killings may have resulted in manslaughter convictions which is not murder.

- The acronyms *"EOEL",* "*ISRO*"*, "WSP"* and *"WG"* in the Action Plan, are not explained.

- There were missed opportunities by police to undertake DASH risk assessments, on call out of domestic abuse incidents.

- There was a lack of professional curiosity and routine enquiry made by health staff with Elizabeth in her attendances at health appointments.

- A little development is required on the Action Plan. There are no milestone updates. Regarding the "*Lead Agency"* column, the entries for Health are populated more fully than are the entries for the other agencies. The national recommendations are not in the Multi-Agency Action Plan. They are listed separately. It would be helpful if the actions to implement these were listed.

- The Executive Summary is missing:
    - Confidentiality statement.
    - Timescales (only the dates of Panel meetings included).
    - Conclusion and lessons learned.
    - There had been previous calls to the police for domestic abuse incidents, involving David towards both his parents. It may be helpful to state the dates and type of abuse reported as this would seem relevant
      `.

- 9.4 Awareness raising on Isle of Anglesey - It would be helpful to clarify what the 'ADAPT model' is.
- The report requires a thorough proofread for typos, missing words and dates.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel