# MULTI-AGENCY REVIEW

# EXECUTIVE SUMMARY

## Conducted within the statutory framework for a Domestic Homicide Review

Gwynedd and Anglesey Community Safety Partnership

## Report into the death of 'Dawn'

## April 2022

Confidential until authorised for publication.

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**January 2024**

## Contents:



## Preface

This review concerns Dawn[1] who sadly took her own life in April 2022. Dawn was a daughter, sister, aunt, mother and grandmother within a large, close-knit family and is missed a great deal by those who knew and loved her. The review panel extend their sincere condolences to the family and friends of Dawn for their loss. The review panel is grateful for the contributions that Dawn's family have made to the review process – this has been critical to aide our understanding of who Dawn was as a person and to ensure that Dawn's voice is present in the review.

The panel recognised that this report may provoke difficult feelings for the reader and so has provided a list of organisations providing support in relation to some of the issues raised in Appendix B.

*"Dawn, it was your children and grandchildren that kept you going in life. We will endeavour to keep your memory alive through them and keep you in our hearts forever...xx"*[2]

[1] Not her real name.
[2] Extract from family tribute provided in the Overview Report.

## Abbreviations used

AAFDA: Advocacy After Fatal Domestic Abuse

BCUHB: Betsi Cadwaladr University Health Board

CMHT: Community Mental Health Team

CPS: Crown Prosecution Service

CSP: Community Safety Partnership

DARA: Domestic Abuse Risk Assessment

DASH: Domestic Abuse, Stalking and Harassment

DHR: Domestic Homicide Review

DVDS: Domestic Violence Disclosure Scheme

DWP: Department for Work and Pensions

GP: General Practitioner

IDVA: Independent Domestic Abuse Advisor

IMR: Individual Management Review

MARAC: Multi-agency risk assessment conference

NWP: North Wales Police

SMS: Substance Misuse Service

SPOAA: Single Point of Assessment and Allocation

VAWDASV: Violence Against Women, Domestic Abuse and Sexual Violence

WAST: Welsh Ambulance Services NHS Trust

WRAG: Work-Related Activity Group

## 1. The review process

1.1 This summary outlines the process undertaken by the Gwynedd and Anglesey Community Safety Partnership Domestic Homicide Review (DHR) Panel (hereafter 'the panel') in reviewing the murder of a resident in the city.

1.2 The following pseudonyms have been used in this review to protect the identities of the persons involved in this DHR. The pseudonym for the deceased was chosen by her family. Others were chosen by the panel and checked with the family to ensure there was no conflict.

| Pseudonym | Sex | Age at the time of the death | Relationship | Ethnicity |
|---|---|---|---|---|
| Dawn | Female | 45 | Deceased subject of the review | White British |
| Sean | Male | 34 | Dawn's partner | White British |
| Angharad | Female | 33 | Ex-partner of Sean | White British |

1.3 Dawn was the youngest of six siblings and had lived in Gwynedd all of her life. Dawn is survived by three adult children, a son and two daughters, and two grandchildren.

1.4 During April 2022 the police attended the home address of Dawn, at which her partner, Sean, was present. Her partner stated there had been a verbal argument during the night and they had both gone to separate bedrooms. Sean claimed that, because Dawn had gone quiet, he went to check on her and found her hanging from the staircase. Dawn was taken to hospital and died five days later.

1.5 A police investigation began and concluded that there was no third party involvement in her death and that Dawn had taken her own life.

1.6 Bruising was observed on Dawn's body, although this was impossible to date, and statements of evidence were recorded from numerous witnesses which disclose several assaults that were previously unreported to the police. Sean was arrested and interviewed in relation to these matters. The police instigated an investigation into several crimes including posthumous domestic abuse.

1.7 Following advice from the Crown Prosecution Service (CPS), Sean was charged with controlling and coercive behaviour towards Dawn between 2016 and 2022. These matters never progressed to trial because in March 2023, Sean was found deceased at his home address.

1.8 The Gwynedd and Anglesey Community Safety Partnership (CSP) agreed that this case met the criteria for a DHR on 12th July 2022 and the Home Office was informed. Initial scoping requests were sent to 10 statutory and voluntary sector agencies that may have had contact with the subjects of the review. Agencies were asked to secure and preserve any written records they had pertaining to the case.

## 2. Contributors to the review

2.1 The following agencies were identified as having had relevant contact with the subjects of the review and so were asked to provide an Individual Management Report (IMR) or a short report, depending on the level of contact they had.

| Agency | Nature of report provided |
|---|---|
| Betsi Cadwaladr University Health Board (BCUHB) | Chronology of contact and IMR |
| Gwynedd Citizens Advice | Chronology of contact and IMR |
| Welsh Ambulance Services NHS Trust (WAST) | Chronology of contact and IMR |
| North Wales Police (NWP) | Chronology of contact and IMR |
| Department for Work and Pensions (DWP) | Chronology of contact and IMR |
| Adra Housing | Chronology of contact and short report |
| Children's Social Care | Chronology of contact and short report |
| Substance Misuse Services (SMS) | Chronology of contact and short report |
| Gwynedd Council One Stop Shop | Chronology of contact and short report |

2.2 Report authors were independent of any direct contact with the subjects of this DHR and were not the immediate line managers of anyone who had had direct contact.

2.3 The review also benefited from contributions from, engagement with, and attendance at one panel meeting of Dawn's sister, on behalf of her family.

## 3. The review panel members

3.1. The following were members of the review panel undertaking this review. All panel members were independent of any direct contact with the subjects of this DHR and were not the immediate line managers of anyone who had had direct contact.

| Name | Job title | Agency |
|---|---|---|
| Nicki Noman | Independent Chair | N/A |
| [redacted] / [3] | Senior Operational Officer | Gwynedd and Anglesey Community Safety Partnership |
| [redacted] | Services Manager | Gorwel Domestic Abuse Service |
| [redacted] | Head of Services | Welsh Women's Aid |
| [redacted] | Senior Operations Manager | Children's Services |
| [redacted] | Senior Manager, Safeguarding, Quality Assurance and Mental Health. | Adult Social Services |
| [redacted] | Quality Manager | Gwynedd Citizens Advice |
| [redacted] | Head of Adult Safeguarding | BCHUB |
| [redacted] | Detective Inspector | North Wales Police |
| [redacted] | Senior Safeguarding Specialist | Welsh Ambulance Services NHS Trust |
| [redacted] | Clinical Operations Manager | Substance Misuse Services |
| [redacted] | Neighbourhood Services Manager | Adra Housing Association |

[3] [redacted] represented the CSP whilst [redacted] was on maternity leave.

| | | |
|---|---|---|
| [redacted] | Job Centre Plus Advanced Customer Support Senior Leader | Department for Work and Pensions |

3.2. The North Wales Suicide and Self Harm Prevention lead was invited to the final panel meeting. This role had been vacant for some time prior to this. There is a recommendation that this role engages with future suicide related DHR panels in North Wales.

## 4. Chair and author of the report

The Chair of this review and author of this report, Nicki Norman, has never worked in North Wales, is independent of all agencies involved and has had no prior involvement with any subjects of the review. This is the first review that Nicki has undertaken in Wales. Nicki is an Independent DHR Chair and has undertaken the Home Office online training on DHRs, including the additional modules on chairing reviews and producing overview reports, and the three-day accredited training for DHR Chairs delivered by AAFDA[4]. Nicki is nationally recognised as an expert in domestic abuse, having been active in this area of work for over 30 years.

## 5. Terms of Reference

5.1 The purpose of a DHR is to:

- 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.
- 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.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

5.2. The review considered the involvement of agencies with Dawn and her partner Sean from January 2017 until the date of Dawn's death as this is when they were known to be in a relationship. The review also considered any other relevant information prior to this period.

5.3. The specific lines of enquiry agreed as pertinent to this review were:

i. Were there any indications of domestic abuse, including coercive control, within the relationship between Dawn and Sean? If so, what action was taken in response to this and how effective was this?

ii. Were there opportunities for Dawn or Sean to disclose concerns about domestic abuse? What barriers may have existed to prevent a disclosure?

iii. What training, policies and procedures are in place to identify, respond to and escalate concerns regarding domestic abuse, and were these effective in this case?

iv. What opportunities were there to identify and manage any risks presented by Sean?

[4] Advocacy After Fatal Domestic Abuse.

v. What is known about the substance use and mental health concerns presented by Dawn – the possible reasons for this, impact of it, and responses to it?

vi. What information sharing protocols exist between agencies? Were they needed, appropriate and effective in this case?

vii. Were services accessible to Dawn and Sean? Are there any barriers that may have prevented them seeking help regarding domestic abuse?

viii. Are there any specific considerations in relation to Dawn or Sean's age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may have had a bearing on access to services or agency responses?

ix. Were agencies sufficiently resourced and individuals effectively supervised to respond to the needs of Dawn and Sean?

x. What did Dawn's family or community members know about Dawn and Sean, their relationship, their needs, and whether they sought or received help?

xi. Did the Covid-19 pandemic impact on any aspect of the case and service responses?

xii. What lessons can be learnt during the review process and where might practice, policy and resource allocation be improved?

xiii. Have any changes already been implemented as a result?

xiv. Are there any particular examples of good practice to highlight?

## 6. Summary Chronology

This section summarises the key relevant contact that the subjects of the review were known to have had with agencies in chronological order.

### Significant events prior to the review timeframe

6.1. Dawn was known to the Substance Misuse Service (SMS) from February 2012 and was prescribed an opiate substitute and allocated a key worker for ongoing support, achieving abstinence from all illicit substances by July 2012. Dawn was last seen by a SMS keyworker in July 2014, who noted that she appeared well. Dawn did not attend appointments offered in October and December 2014. The case was closed to SMS in February 2015. There were no concerns raised regarding Dawn's wellbeing at this time. On receipt of a referral from Dawn's GP in September 2015, the SMS offered Dawn an assessment, but Dawn did not respond.

### Events within the review timeframe (January 2017 – April 2022)

### 2017

6.2. 9th January 2017 - Dawn sought advice from Gwynedd Citizens Advice regarding rent arrears and possible eviction. She disclosed that she had left her violent partner several years ago and mentioned that Women's Aid were involved[5]. Dawn did not disclose any current or ongoing domestic abuse during the meeting.

6.3. 20th February 2017 - NWP received a report from Angharad (Sean's ex-partner) of a verbal argument between Sean and Angharad regarding the parking in the street outside their house. The purpose of her call was to inform the police that he was in a new relationship with Dawn and that he took their children to her house. Angharad questioned the suitability of this based on Dawn's historic substance use. Information was shared with the Local Authority Children's

[5] The review has been unable to access information about the involvement of Women's Aid at that time. It is likely that this is because the local service was Bangor Womens Aid at the time, who no longer hold the contract to run the service.

Services by NWP and a strategy discussion[6] took place. It was concluded that Dawn had her own children living with her and it was not practicable to prevent other children attending occasionally. This information was logged and closed for information purposes only in relation to Dawn's children.

6.4. The strategy discussion in relation to the above event also referred to a historical (2009) incident of indecent exposure committed by Sean to his ex-partner Angharad. Angharad had described Sean urinating in front of Angharad and two of their children. Angharad believed that it was Sean's intention to urinate on her rather than expose himself to her. This was logged as 'Information Only. 'No Action Required' and deemed insufficient to warrant a disclosure to Sean's new partner Dawn.

6.5. 21st February 2017 - Adra Housing received a call from Angharad reporting an incident involving parking outside Dawn's property (see 6.3) claiming that Sean had verbally abused Angharad. A warning letter was sent to Sean the next day. Sean phoned Adra following receipt of the letter denying any wrongdoing. The case was closed and categorised as low level anti-social behaviour in March 2017 due to no further incidents.

6.6. 2nd June 2017 - A neighbour, wishing to remain anonymous, made a referral to Children's Services, sharing concerns about Dawn's new partner Sean. The report referenced drug use at the address, and that Sean can be abusive and aggressive. A management decision was made on the same day to undertake agency checks in relation to Dawn's children, two of whom were in their late teens at the time, with the third being an adult. The concerns were not substantiated and the case was closed on 26th June 2017.

6.7. 11th July 2017 - Dawn made a report to NWP that a car had driven towards her and close to her legs whilst she was walking on the pavement with her niece. The suspected driver was Angharad, the previous partner of Sean. Both Dawn and Angharad were spoken to by the police. A mediation session was offered to both families, but this was refused, with both agreeing to respect each other's privacy. NWP explored the possibility that the Council could remove one family to another address due to their close residential proximity – this request was made to housing and was acknowledged. Further contact was made by NWP with Angharad a month later and she reported that things had calmed down. A NWP 'Supervisor Review' was documented, which noted that all was in order and finalised.

6.8. 9th August 2017 - Dawn saw her GP sharing that she felt depressed and was having trouble sleeping. Dawn was prescribed a low dose of Amitriptyline[7] to be taken in addition to the Sertraline[8] she was taking.

6.9. 9th August 2017 - Sean saw his GP regarding depression. Sean shared that he had tried to take his own life approximately five weeks ago when his partner found him with a rope tied around his neck (not hanging). Sean said that he fully regretted his actions and confirmed no further suicidal attempts or ideation. A plan was made for Sean to restart Citalopram[9] with a follow up in three weeks prior to further supply. A leaflet and number of Parabl[10] was given to Sean and the importance of seeking advice when his mood deteriorates, or suicidal ideation occurs, reiterated.

[6] A strategy discussion takes place between a social worker and other agencies when they are worried a child may be suffering significant harm. Or if they suspect a child is likely to suffer significant harm. The aim of the meeting is to decide whether to start child protection enquiries.
[7] Amitriptyline is a medicine used for treating pain, migraine attacks and depression.
[8] Sertraline is a type of antidepressant.
[9] Citalopram is often used to treat low mood (depression) and also sometimes for panic attacks.
[10] Parabl the Talking Therapies Partnership |

6.10. 14th August 2017 - A Multi-Agency Risk Assessment Conference (MARAC)[11] referral was made by Victim Support due to problems that Sean had been causing for Angharad. Past behaviour included that Sean had followed Angharad and phoned/texted her to the point that she had to block his number. Angharad stated that Sean was jealous as Angharad had a new partner, and that he threatened to kill her and the new baby - "you're lucky you're pregnant or I'd kill you". The situation was DASH[12] risk assessed as medium risk. A Domestic Abuse Officer contacted Angharad, attending her address and issuing target hardening[13]. A non-molestation order was discussed and a supporting letter from MARAC for a move. The MARAC was held in September 2017 and in that meeting it was recognised that Sean had a new partner, Dawn. An action was raised to consider a disclosure to Dawn under the Domestic Violence Disclosure Scheme (DVDS)[14], which was authorised on 7th September 2017 by a Detective Inspector.

6.11. There are a number of attempts to deliver the DVDS to Dawn and details left for her to make contact with the Domestic Abuse Officer. There is no record to confirm the DVDS was delivered, so it appears that it was not completed.

6.12. 17th August 2017 - An Anti-Social Behaviour report was made to NWP by Angharad reporting ongoing issues with her ex-partner Sean. It stated he had been placing posts on social media relating to child access issues which caused her distress and Angharad wanted the matter logged. NWP reviewed the matter and shared details with the Local Authority. The incident was also reviewed by a Domestic Abuse Officer who identified that there had been a recent MARAC referral and was satisfied that no further safeguarding or action is required.

6.13. 5th September 2017 - Adra Housing received an anonymous report that Dawn had attacked three males outside Sean's address. On 14th September 2017 a Housing Coordinator visited both Dawn and Sean at Sean's address. Dawn denied any wrongdoing and stated that a group of males were causing a commotion outside, and that she had gone out to ask them to leave. Dawn said that an argument had ensued and Dawn had been grabbed by the arm and thrown to the floor and her adult son was punched to the face. They were the victims according to Dawn and Sean.

6.14. 12th September 2017 - On the back of the MARAC referral on 14th August, a further crime of Common Assault was recorded against Sean by NWP. This is because Angharad had mentioned that Sean had thrown a bike at her in 2015. The crime was out of time for further action[15] but was recorded as a crime as per Home Office recording rules and not progressed further.

6.15. 18th September 2017 - Dawn was arrested and charged for assaulting a police officer by kicking her once to the leg. Dawn was convicted of assaulting a police Constable and received a community sentence and alcohol treatment requirement with National Probation Service.

6.16. 17th November 2017 - NWP received a further report from Sean's ex-partner, Angharad, regarding parking issues with Sean due to the close proximity of the addresses. A concern for safety referral[16] was submitted to the Local Authority. The DASH risk assessment was reduced to low risk. The Local Authority confirmed that work was ongoing to rehouse Angharad. A NWP

[11] A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.
[12] Domestic Abuse Stalking and Harassment Risk Assessment. An assessment tool used by the police and other agencies.
[13] Target hardening is a term used to describe improving the security of a property to reduce the risk of crime.
[14] The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law" enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.
[15] In 2017 prosecutions of common assault or battery were required to commence within six months of the offence. The Police, Crime, Sentencing and Courts Act 2022 has since increased this time limit to two years.
[16] A concern for safety referral is a non-crime occurrence which is shared with the local authority to highlight identified concerns.

'Supervisory Review' queried the planned disclosure to Sean's new partner Dawn. Again, it was not clear whether this was delivered.

## 2018

6.17. In January 2018 a court warrant was executed by NWP and Dawn was arrested for two offenses of Possession of Controlled Drugs. Dawn was placed before the court where she received a 12 month community discharge and £85 fine.

6.18. 24th April 2018 - Dawn saw a Nurse practitioner at the GP surgery about her Probation conditions that she attend group classes with other people with drug and alcohol problems. Dawn shared that she has avoided being around people who use drugs in order not to relapse and that she was anxious that being in a situation with these people would cause her to relapse. Dawn's Probation Officer had told her that, if she can provide a letter from GP stating group support sessions with other people with dependencies are not in her best interest, then they can find an alternative for her. This letter was provided.

6.19. 28th April 2018 - A referral letter dated 21st April 2018 was received by the Community Mental Health Team (CMHT) from a Specialist Nurse that Sean had seen[17], stating that Sean had been under considerable pressure as he was estranged from his ex-partner and having difficulty in having access to his three young children and this had progressed to court. Sean had disclosed that suicide had crossed his mind and, about a year previously, he had put an electrical cord around his neck but was found by his current partner.

6.20. 29th April 2018 - The above referral was discussed during the daily SPOAA[18] meeting. A Routine Assessment (this should be carried out within 28 days) was arranged for the 1st June 2018 and a letter was sent to Sean, copied to his GP, informing him of this appointment.

6.21. 13th May 2018 - NWP observed Sean driving a vehicle and mounting a kerb almost colliding with a stationary vehicle. Sean was arrested for providing a positive specimen of breath. He was charged with drink driving and later disqualified from driving by the court.

6.22. 4th June 2018 - Sean did not attend the planned appointment on 1st June for a CMHT assessment. Consequently, a discussion was held in SPOAA and the referrer was contacted, who advised that the situation had improved due to Sean now having access to his children. The case was then closed.

6.23. 20th July 2018 - Dawn saw her GP requesting a sick note citing problems with alcohol, drinking at night, and drugs in the past. Dawn was observed as being distressed and restless but with insight of her situation. Coping strategies were discussed and a medication plan was made for 28 days. Red flags were in place[19]. Dawn had an appointment with another GP on 14th August 2018 but she did not attend this.

6.24. 10th September 2018 - Dawn saw a Nurse practitioner and discussed recent problems with Psoriasis. Dawn shared that, for the past six or seven months, she has been drinking a litre of vodka every couple of days, that she was feeling more down and depressed, that there were no thoughts of suicide or self-harm but she was struggling to cope and did not think the Sertraline medication was helping. Dawn was observed as appearing anxious, speaking quickly, and shaking. Dawn denied having alcohol since before the weekend. An appointment with a GP was booked for the same day, which Dawn attended. The GP referred Dawn to Dermatology but did not appear to discuss or respond to concerns about her mental health or alcohol use.

6.25. 4th December 2018 - Dawn attended a work capability assessment with a DWP assessment provider. This noted *'Medication has recently been increased due to an increase in her stress*

[17] Further information was not available from BCUHB.
[18] Single Point of Assessment and Allocation (this is an agreed service process).
[19] Red flags is a term used for safety netting. This is discussing with a patient what they can do or need to do if a problem worsens.

*levels. She drinks alcohol most nights and, although she has been clean from drugs for seven years, she has recently been tempted to start up again due to stress. She has refrained as she talks to her GP about it'.*

## 2019

6.26. 11th December 2019 - A concern for safety referral was generated by NWP due to Sean contacting them to report that an unknown person/persons have gained access to his property via the attic. Officers attended and found Sean in the attic searching, and he stated there were people under the insulation. Officers searched and found no one to be there. Support was offered for Sean's mental health but declined. Sean showed signs of anxiety and admitted not sleeping for days. He would not attend his GP's surgery and did not provide consent to share a referral with adult social services but, recognising that he had three children, NWP shared the information with the Local Authority under child protection arrangements. This information was logged and closed by the Local Authority.

6.27. On the same date Welsh Ambulance Services NHS Trust (WAST) received a 999 call from NWP due to a concern that Sean was hearing voices. The WAST call taker contacted the female on scene with Sean (this was not Dawn). The female shared that Sean thinks there are people in his house; that no one understands and refuses to leave; that he can be violent but hasn't been towards her today; that he has no weapons currently but has access to the kitchen where there are knives; that he has not mentioned suicide. The outcome was that a more detailed assessment was required, an ambulance would not be dispatched at this point, and worsening recall advice[20] was provided. The call was forwarded to NHS Wales 111 for a clinician assessment over the phone in line with WAST Clinical Response Model. The outcome was to refer to primary care service within 12 hours.

6.28. Between 12th - 31st December 2019 Adra Housing became aware of and responded to concerns about Sean's mental health, having received information from a concerned maintenance team member, and NWP. This resulted in a welfare check by a Housing Coordinator, then subsequent referrals to the CMHT and Children's Services, and a warning marker on the property to visit in pairs. As a result of one of Sean's children being in receipt of specialist services the referral was forwarded to that team for information and action. The information was logged and closed in relation to the two other children.

6.29. 18th December 2019 - Sean's GP received a referral from Adra Housing raising concerns about Sean's paranoia that someone was entering his property via the attic, lack of sleep and the effect this could be having on his children who regularly stayed with him. This was discussed at a SPOAA meeting the following day with the agreement to offer a routine appointment with the CMHT. This was arranged for the 30th December 2019 and a letter was sent to Sean, copied to his GP, informing him of this appointment.

6.30. 30th December 2019 - Sean did not attend the appointment with the CMHT as planned. CMHT contacted the SMS to ascertain if Sean was open to them, and SMS confirmed he was not. The CMHT contacted the Housing Support Worker to discuss Sean's non-attendance. A voicemail message was left due to no response.

6.31. 31st December 2019 - A further discussion was held in SPOAA Meeting where it was agreed to offer Sean another appointment on the 13th January 2020 with the CMHT and a letter was sent to Sean, copied to his GP, informing him of this appointment.

6.32. During 2019 Sean attended two appointments (in January and July) at the Jobcentre citing stress that prevented him from being able to consider any work.

[20] Meaning advice about when the caller should call 999 back.

6.33. During 2019 Dawn attended three appointments (in January, June and December) at the Jobcentre where she shared feeling low, her struggles with alcohol and difficulties in accessing the support that she needed.

## 2020

6.34. 13th January 2020 - Sean attended the appointment with the CMHT and an assessment was completed. It was agreed with Sean that no service was required and he would be discharged following the assessment. However, the assessment documentation was not fully completed as should be expected and in line with legislation. A letter was sent to Sean by the CMHT, copied to the GP, informing him that the case would not be allocated.

6.35. 18th February 2020 - Dawn attended a DWP work capability assessment and the assessment provider noted *'Significant disability appears unlikely with all mental health tasks'* and recommended that Dawn was found capable for work. The decision maker[21] contacted Dawn on the 5th March 2020 to discuss this further. The decision maker placed Dawn in the Work-Related Activity Group (WRAG), stating that Dawn had advised that she was struggling at present in relation to family and drinking problems. Dawn's daughter had moved out of their house a week before Christmas, as she and her friends witnessed Dawn drunk and arguing with a friend in the street. Her daughter was now living with her grandmother and, although seeing Dawn every other day, was not ready to return home. It is recorded that Dawn was drinking a variable amount of strong cider every day, dependant on how much money she had. Dawn was slowly trying to reduce the amount she consumed, and had spoken to Arch support group, with a view to engaging with them when she is ready, expressing determination to reducing her alcohol intake over the longer term.

6.36. 9th October/early hours of 10th October 2020 - WAST received a 999 call regarding a head injury to Sean. The clinical desk attempted to complete a clinical triage assessment, documenting that the patient and his girlfriend were intoxicated. Although both stated that hospital was not necessary, the patient would not co-operate long enough for completion of capacity assessment. NWP were informed and the situation was assessed as not suitable for a taxi, so an ambulance was despatched. NWP called to cancel the ambulance as Sean was in his own home and told them he did not want an ambulance. Shortly after the call to cancel, an ambulance did arrive on scene. There is no evidence of patient contact, and no patient clinical record available for this incident.

6.37. NWP also have a record of this incident; they received a report of a domestic at the home address of Dawn from WAST. Sean reported that he has smashed a bottle over his own head causing an injury to his head and a substantial cut to his hand. On police arrival Sean and Dawn were found together. They were separated and spoken to individually. They both gave an account that Sean, due to intoxication, had smashed a glass bottle on his own head, causing a cut. He had then cut his hand on glass and had quite a substantial cut to the palm of his right hand. Sean could not explain why he had done this to himself, but wanted to go home to take care of his dogs. Dawn did not have any visible injuries and both stated that there had not been any form of disagreement between them. Medical assistance was discussed with Sean and he stated that he did not require an ambulance or want to attend the hospital. He said that he would treat his wounds himself. The decision was made to separate the parties for the evening. As they lived at separate addresses, this was achievable. Engagement with the DASH risk assessment was refused by both parties. When a Supervisor reviewed the case, they asked for further checks to be made to establish if the account of what was provided by Sean to the police was true and accurate. House to house enquiries were conducted and no further evidence to the contrary of his account was discovered. NWP concluded that there was no evidence to seek

[21] A DWP member of staff who makes entitlement decisions on benefit claims.

a prosecution in this case. A concern for safety form was completed which was reviewed by a Detective Sergeant and shared with Gwynedd Local Authority.

6.38. 13th October 2020 - Dawn made an online claim for Universal Credit and then on 15th October Dawn had a telephone appointment with Universal Credit to discuss her claim. The claim was verified by telephone due to Covid-19 restrictions. Money advice was discussed and declined. An advance payment was discussed and agreed - to be repaid over 12 months and to credit on the same day as Dawn had said she was desperate for money. A Managed Payment to Landlord[22] was agreed due to budgeting issues.

6.39. 7th December 2020 - The GP tried, unsuccessfully, to call Dawn regarding a medication request that she had made. There is no record of what medication Dawn was requesting, however she had not had any medication since 2018, therefore nothing would have been issued without further consultation. The practice subsequently sent Dawn a letter and left her a voicemail asking that she make contact to arrange an appointment to review her medication but she did not respond. This was the last contact that Dawn had with the practice.

6.40. Throughout 2020, there were several contacts made with Dawn and Sean by Adra Housing regarding their rent accounts and arrears. In December 2020, Dawn received a warning letter regarding the poor condition of her garden. This was quickly remedied by Dawn.

## 2021

6.41. 11th January/early hours of 12th January 2021 - A male caller rang 999 reporting to WAST that he had heard an argument down the road two hours ago and, as he later walked past, had seen a woman huddled on the doorstep, in pyjamas and a dressing gown, with no shoes, looking like she was freezing. The caller was not sure whether to approach her due to Covid-19. The caller noted that she appeared drunk but alert and that he had heard her shouting and banging on the door requesting to be let into the property. The call was categorised as requiring ambulance attendance. The caller later rang back to cancel the ambulance stating that he had been to see her again, put a blanket on her and had a chat with her, and that she said that she didn't want an ambulance. The caller confirmed that the woman was a neighbour of his called Dawn. When walking back home the caller came across Dawn's partner and told him that Dawn was outside the property and to go back home to let her inside. The caller advised that he would walk past again in a while to make sure Dawn had gone indoors. Recall advice was provided by the call taker.

6.42. 4th March 2021 - Dawn attended a telephone work capability assessment, supported by her son. It was noted in report that her overriding conditions were her anxiety and depression, and drug and alcohol misuse. Dawn shared that she had spoken to her GP surgery in December 2020 about her worsening mental health and had been advised she will be given a telephone appointment with the GP, but as yet she hadn't received this. Her son had apparently been emailing the surgery regarding this but received responses saying that there are delays due to Covid-19. The Health Care Provider completed a UE1 (Unexpected findings following Assessment)[23] for the GP, which noted: *'Deteriorated mental health in last 4-5 months, self-medication with drugs and alcohol. Drinks daily on waking whatever she can afford. Uses amphetamine daily'*.

[22] This is a service for landlords to request direct payments of rent or rent arrears to be paid directly from a tenant's Universal Credit, if a tenant is having difficulty paying their rent.

[23] A Health Care Professional fills this out with any additional information and sends a copy to the GP and a copy to the Claimant.

6.43. During 2020 Dawn continued to communicate with DWP about her Universal Credit claim, including requesting an advance payment to buy a new cooker and fridge/freezer in December 2020.

6.44. 15th June 2021 - NWP received a third party report of a domestic incident on the golf course at Bangor. The informant stated to the call handler that the male and female were fighting and the female was on the floor. Officers attended the location and found Dawn and Sean. Dawn was described as extremely intoxicated and evasive with police. Sean was spoken to separately and stated that he had been drinking with Dawn all day on the golf course. Sean said that Dawn had become intoxicated and she wouldn't walk home and kept lying down and falling asleep. Sean had decided to take the dogs home and returned to try and get Dawn home again and found her lying in a hedge on a dark pathway and said he was concerned for her safety. Sean said that Dawn was refusing to leave and go home so this resulted in the pair arguing and that Dawn was attempting to get up but would fall over and Sean was struggling to hold her up. Officers spoke to the original informant who clarified that he had seen no assault taking place but had witnessed and heard the pair arguing. Dawn and Sean were both taken home to separate addresses. Dawn declined engagement with the DASH risk assessment. No offences were disclosed by either party so no further action was taken. When reviewed by a Detective Sergeant, they took the view that, as it was a verbal argument with no children present, there was no need to share this with Childrens Services.

6.45. 2nd July 2021 - NWP received a report about a vehicle possibly being driven under the influence and that this had driven into another vehicle. Officers attended, and when they located the vehicle, Sean approached them in an aggressive manner and resisted arrest. In custody, Sean was breath tested and his specimen indicated he was over the drink drive limit. Dawn was also present and became involved. She resisted arrest and eventually was charged for resisting a constable in the execution of their duty. She received a fine and costs. Sean was arrested for resisting arrest and being unfit to drive. He was initially released but both matters were 'no further actioned' at a later date. There is no clear rationale recorded for the decision not to progress the charges against Sean.

6.46. 23rd August 2021 - Sean's ex-partner Angharad reported further harassment from Sean to NWP, stating that Sean had posted numerous things on social media about her and Angharad's daughter (also his daughter). He had posted that Angharad wouldn't let the children visit for various reasons, which Angharad said was untrue. Angharad said that the reason that the daughter refused to visit was because she had previously witnessed Sean hitting his current partner after sex. A Domestic Abuse Officer made contact with Angharad and made a referral to Gorwel, the local domestic abuse service. The DASH risk assessment was reviewed and categorised medium risk. A decision was made to record the historical event as a crime. Information was shared with Childrens Services and a referral made to the floating support team at the Local Authority. The information was received by the Local Authority who made a decision that the event was historical, contact with Sean was not taking place so there were no immediate safeguarding concerns and no request for support, so the information was logged and closed.

6.47. 24th August 2021 - NWP recorded a common assault by Sean on Dawn following the above report. The matter was reviewed by a Sergeant and a decision made to take no further action in relation to this matter due to lack of further detail and a mistaken belief that it related to the incident reported on 12th September 2017. Dawn was, therefore, not linked as a victim in relation to this matter.

6.48. Throughout 2021, there were several contacts made with Dawn and Sean by Adra Housing regarding their rent accounts and maintenance issues. During one call in April 2022, Dawn shared that she was finding things difficult at the moment. It was noted that she had support from her daughter and neighbours and she was advised to call if she had any issues or worries.

## 2022

6.49. 5th January 2022 - NWP received a report from Angharad that Sean had made threats towards her during a telephone conversation with their son. The police spoke to Angharad who raised concerns about the amounts of alcohol that Sean was drinking and her reluctance to allow their children to visit him. Angharad stated that she would not engage with a complaint and was happy for the Local Authority to be made aware of her concerns. The information was shared with the Local Authority and the matter closed.

6.50. 7th January 2022 - NWP received a report from the new partner of Angharad saying that he had received threats of violence from Sean and he had also been threatened with having his previous convictions placed on social media. The suspect was spoken to by the police and given words of advice. The details of the incident were shared with Children's Services. Due to ongoing issues between Sean and Angharad, a MARAC referral was submitted and it was listed on 18th January 2022. IDVA[24] support was provided to Angharad and the Local Authority made aware of ongoing issues.

6.51. 12th January 2022 - A report was made to NWP by Angharad that Sean had sent a message to their son intimating self-harm and blaming her for his behaviour. This was recorded by police as an incident of harassment. Sean was visited to do a welfare check due to the belief that he was intoxicated and may self-harm. Sean was seen at his home address and was noted to be argumentative. He apologised for his behaviour. Angharad declined to make a complaint. An evidence based prosecution was considered by the Sergeant but disregarded based on the circumstances.

6.52. 14th January 2022 - Dawn called Adra Housing to report a broken window. This was responded to within a couple of days with the maintenance worker noting that the sash had fallen off completely. On 19th January Adra received an anonymous report of a disturbance between Dawn and Sean, alleging damage had been done to the property and that a window had been broken off its hinges and fallen into the garden. Following this, the Housing Coordinator was unable to make contact with Dawn and Sean, was unable to verify this with the police, and upon confirmation that the maintenance worker believed the window had fallen off due to corroded and rusty rivets and not by force, no further action was taken. Between January and April 2022 there were also several contacts made with Dawn and Sean regarding their rent accounts and maintenance issues.

6.53. 9th March 2022 – A Sexual Health Consultant called Sean's GP citing that Sean had been repeatedly presenting to them with itchy skin, mood issues and had disclosed drinking a bottle of vodka a day. He had been signposted to SMS for alcohol support but the GP was also asked to review him. A GP appointment was offered for the following day.

6.54. 10th March 2022 – Sean saw his GP regarding the above referral. The consultation concentrated, however, on treatment for skin and bowel complaints. It is not recorded why the issues of alcohol misuse was not raised during the consultation. This is the last time prior to the fatal incident that Sean was in contact with the practice.

6.55. On a date in April 2022 NWP received a 999 call from the sister of Sean reporting that her brother's girlfriend, Dawn, had hung herself on the stairs. Police spoke to Sean who stated that both him and Dawn had been drinking upstairs in the front bedroom, that they had been arguing and he went off into another bedroom and Dawn remained in the front bedroom. Sean stated that it went quiet for a period of approximately 10 minutes at which point he went to go and check on Dawn and found her hanging over the banister. Dawn was taken to hospital and died five days later.

[24] Independent Domestic Abuse Advisor

### Events following the death of Dawn

6.56. Family members subsequently shared information about historical domestic abuse which led to a police investigation. Statements of evidence were recorded from numerous witnesses which disclose a number of assaults that were previously unreported to the police. Sean was arrested and interviewed in relation to these matters. Following CPS advice, Sean was charged with controlling and coercive behaviour between January 2016 and April 2022 towards Dawn. These matters never progressed to trial because in March 2023, Sean was found dead at his home address.

## 7. Key issues arising from the review

### 7.1 Opportunities to disclose or identify domestic abuse

7.1.1. The statements made by family members following the death of Dawn disclose several assaults that were previously unreported to the police. Following Dawn's death, neighbours also reported to the police that altercations between the couple were almost daily. Family members reported signs of coercive control in the relationship. For example, Sean had taken all doors off of their hinges in the house meaning that Dawn could not hide anything from him or have any space for herself at all. This was discovered by the family following Dawn's death.

7.1.2. Dawn's family reported that Sean took control of her bank card and controlled her spending, indicating that economic abuse may have been a factor. On two occasions Dawn requested an advance payment from DWP (the most recent for a cooker and fridge freezer). Direct payments were set up to her landlord due to budgeting issues. There is no further information on file to indicate whether the financial difficulties Dawn was experiencing were a result of economic abuse, but it is a possibility.

7.1.3. GPs are recommended to practice Clinical Enquiry which sets the threshold to facilitate the possible disclosure of domestic abuse and uses the information from the interaction with the patient to complete an assessment. Dawn and Sean had disclosed depression, heavy alcohol and drug use, and an attempted suicide was made - these are indicators to suggest that the possibility of domestic abuse should have been discussed.

7.1.4. BCUHB's Violence Against Women, Domestic Abuse and Sexual Violence Service User Procedure states that *'All staff members and managers of BCUHB should be conversant with routine, selective enquiry and the requirements of Ask and Act (Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) (Wales) Act 2015) where there are concerns or suspicions regarding domestic abuse'*. Opportunities to enquire about domestic abuse were not, however, undertaken in response to indicators presented. Furthermore, on one occasion, the GP did not address the mental health and alcohol concerns that had prompted the nurse to get Dawn a same day appointment, focusing only on her skin complaint.

7.1.5. Disclosure of domestic abuse is not limited to agencies and there is an increasing understanding of the important role that friends, families and communities can play in responding to domestic abuse[25]. Dawn's mother reported that, prior to her death, Dawn had visited her mother and showed her bruises that she said were caused by Sean. Dawn had also shown injuries to other family members. They feared saying anything to Sean about these as they thought there would be further repercussions for Dawn.

7.1.6. Initiatives such as the 'Ask Me' scheme[26] and the 'Findaway' project[27] are proactively taking steps to inform and support communities to provide a positive and safe response when they

[25] See for example, About Us | Findaway (wefindaway.org.uk)
[26] Ask Me project : Welsh Women's Aid (welshwomensaid.org.uk)
[27] Home | Findaway (wefindaway.org.uk)

know someone that is being abused. Schemes such as these may have provided a non-statutory agency line of support and information for Dawn's family.

7.1.7. Dawn did not make any disclosures about domestic abuse to NWP. Family members shared that there is a reluctance by the family and the local community to involve the police in matters and that people tend to try and sort things out themselves. This was also reiterated in Sean's interview with the police following Dawn's death within which he said *'we don't usually phone the police'*.

7.1.8. The Police did attend incidents where the DASH risk assessment was attempted and Sean was known to be a perpetrator through the MARAC process instigated in relation to his ex-partner. However, due to the fact that neither party disclosed domestic abuse to agencies and declined to engage in the DASH risk assessment, no further action was taken.

7.1.9. NWP have moved to a position recently where officers are asked to complete a DASH using professional judgement if those involved refuse to participate. These jobs will also be forwarded to NWP Domestic Abuse Officers to review and offer appropriate support if necessary to the victims.

7.1.10. The College of Policing have reviewed the use of the DASH due to its inconsistent use by frontline officers.[28] A new Domestic Abuse Risk Assessment (DARA) tool has been developed which has evidenced assessments from officers that are more in line with those of domestic abuse specialists. This will be the preferred risk tool for first responders moving forward. A date for implementation in North Wales is still to be agreed.

7.1.11. In August 2021, the report by Angharad that one of her children witnessed Sean assaulting Dawn resulted in no further action being taken by NWP. This was based on a lack of detail in the report and apparent confusion that it related to a historical crime. On receiving the report, a decision to speak to Dawn about this matter would have allowed a further opportunity to explore the nature of the relationship. There is no rationale for why the child who witnessed the assault was not spoken to and further details gathered. Bearing in mind the wealth of knowledge that the family have disclosed about the relationship between Dawn and Sean after her untimely death, this was a missed opportunity.

7.1.12. There may have been opportunities to talk to Dawn arising from Children's Services referrals made. The anonymous referral made to Children's Services in June 2017 related to Sean's behaviour towards Dawn. As it was a Safeguarding referral there was no requirement for consent to be obtained prior to referring and therefore there was no consent to offer child in need support either and no evidence to suggest that the family required statutory intervention. The absence of Dawn in this risk assessment is notable, however, and may have provided information of interest to Children's Services. Furthermore, this represents a missed opportunities to talk directly to the two daughters living at home at this time as teenagers, and to potentially facilitate protection from the harm they were subject to.

7.1.13. From the information provided by agencies and family for this review, it is evident that Dawn's children were living within a household where domestic abuse was being perpetrated. The presence of domestic abuse is also known to be a risk factor for child physical abuse, with children who were exposed to domestic violence being more likely to be physically abused and neglected. Additionally, research has highlighted that witnessing domestic abuse can negatively impact on the children's physical, mental, behavioural and relational development.

### 7.2 The identification and management of risk

7.2.1. Sean was known to NWP to have a history of violence and to be a perpetrator of domestic abuse. When NWP became aware of Sean's relationship with Dawn, they did attempt to warn her of his history through the use of the DVDS. Unfortunately, despite a number of attempts,

[28] See Domestic Abuse Risk Assessment (DARA): Frequently asked questions (college.police.uk)

they did not deliver this disclosure to Dawn. Whilst the chronology infers a difficult relationship between Dawn and NWP, this was a missed opportunity to understand what Dawn knew about Sean's history and explore whether she felt she needed any support. NWP are now undertaking a review of how DVDS applications are processed, including how difficulties in delivering a disclosure are managed, with a view to improving this.

7.2.2. Sean was known to have mental health concerns and substance abuse issues. Whilst mental health issues and substance use do not cause domestic abuse, research suggests that they do heighten the risk of domestic abuse[29] and that opportunities to be professionally curious about Sean's wider circumstances may have been missed. The CMHT assessment was incomplete and did not assess risk in line with their procedural expectations, which may have elicited information indicative of domestic abuse in his relationships. It may be that Sean declined to engage with elements of this, but, if this was the case, this should have still been documented.

7.2.3. The GP practice did not identify the possible risk to children Sean was having contact with and the need to share information with Children's Services. Sean wasn't living with his own children and wasn't living with Dawn's children, so the link to Sean's suicidal ideation wouldn't have necessarily prompted a referral. Some consideration should, however, have been given to the fact that Sean was having contact with both his own and Dawn's children. The practice did not document their assessment and decision making regarding this which would have provided acknowledgement of the consideration of the Child at Risk process.

7.2.4. When the GP saw Sean following a referral from the Sexual Health Consultant regarding Sean's skin complaint and excessive drinking, the latter was not discussed so an opportunity was missed to address this. The action may, at least, have been to reiterate the signposting to SMS that had already been undertaken and recorded by the Sexual Health Consultant.

7.2.5. The absence of Dawn's perspective in the information gathering by Children's Social Care may have been a missed opportunity to identify risks posed by Sean.

**7.3 Dawn's support needs**

7.3.1. Research suggests that women experiencing domestic abuse are more likely to experience mental health problems and that women with mental health problems are more likely to be domestically abused.[30] Women who have experienced gender-based violence are also 5.5 times more likely to be diagnosed with a substance use problem over their lifetime.[31] Dawn was known to have historically had issues with addiction but had overcome these and it is her family's view that her relationship with Sean was a significant factor in her reverting back to substance use.

7.3.2. Despite presenting to health services with these issues, Dawn was not asked about domestic abuse, nor was a holistic assessment of her circumstances and needs undertaken.

7.3.3. In addition to increasing the risk of abuse towards her, Dawn's sex may also have increased her risk of domestic abuse related suicide. A review of 18 months of VKPP project data comprising 294 domestic homicides and suspected victim suicides highlighted that, for suspected victim suicides, white victims were more likely to be female (93%) than male[32].

7.3.4. Despite the evidence, women's experiences of abuse often lack recognition as drivers of mental ill-health, addiction or other difficulties. As in Dawn's case, this link is rarely reflected in the

[29] Seena Fazel et al; *Mental disorders and intimate partner violence perpetrated by men towards women: A Swedish population-based longitudinal study*; 2019.
[30] Howard, L.M., Trevillion, K., Khalifeh, H., Woodall, A., AgnewDavies, R., & Feder, G. (2009). Domestic violence and severe psychiatric disorders: Prevalence and interventions. Psychological Medicine, 40(6), 881–893.
[31] Rees, S. et al (2011) 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function', Journal of American Medical Association, 306/5: 513–521.
[32] Ethnicity Spotlight Briefing_FINAL.pdf(Shared) - Adobe cloud storage

support available to women with mental health problems – service design and delivery frequently fails to take gender into account and trauma informed services are rare[33].

### 7.4 Multi-agency working

7.4.1. Sexual Health services were proactive in sharing their concerns about Sean's skin complaint and excessive drinking with his GP and the GP was responsive in offering a next day consultation. Sean's alcohol use was not however, discussed during this consultation, meaning that the information sharing, in this instance, failed to produce any meaningful assessment or action.

7.4.2. The MARAC provides a proactive forum for connecting what agencies know and information sharing. Adra Housing were not however, aware of the MARACs held in relation to Angharad and Sean, nor referrals being made to the Housing Options team regarding possible management move for Angharad due to her close proximity to Sean and Dawn. The MARAC did, however, alert agencies that Dawn was Sean's new partner which then prompted consideration of a disclosure to Dawn under the DVDS, although this was unfortunately not able to be delivered.

### 7.5 The impact of the Covid-19 pandemic

7.5.1. The first national lockdown in response to the Covid-19 pandemic began on 23rd March 2020 and a period of varying levels of restrictions ensued until restrictions were gradually lifted and were mostly ended by August 2021.

7.5.2. The review has highlighted the following instances where the Covid-19 pandemic may have impacted on service responses, positively or negatively.

7.5.3. Dawn attended a DWP telephone assessment on 4th March 2021, supported by her son. The health provider noted that Dawn's mental health had got a lot worse in the last four to five months. Dawn shared that she had spoken to her GP (in December 2020) about her worsening mental health and had been advised that she would be given a telephone appointment with the GP but hadn't yet received this. Dawn's son had been emailing the surgery regarding this but was told that there are delays due to Covid. Dawn felt that the lock down due to Covid was exacerbating her mental health as her support networks were not there.

7.5.4. BCUHB noted that, during and following the Covid-19 pandemic, there has been a positive impact of the adoption of a 'total triage' system where all requests for appointments by a patient are triaged by senior clinicians so there is no risk that a patient has requested an appointment and has been turned away due to lack of capacity, or not subsequently been seen or spoken to or signposted to another appropriate agency.

## 8. Conclusions and lessons learned

8.1. The reluctance of Dawn and Sean to engage with the DASH acted as a barrier to risk assessment and the potential for a multi-agency response. The use of professional judgement is important to enable exploration of risk and to facilitate appropriate responses and NWP are now expecting Officers to use this when subjects do not engage with the DASH. A date for the implementation of the new DARA developed by the College of Policing is still to be agreed in North Wales.

8.2. There were times when Dawn was not consulted about allegations made about Sean's behaviour towards her to NWP, or engaged with risk assessments regarding herself or her

[33] DHSC (2018) The Women's Mental Health Taskforce final report. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf

children by Children's Services. Victims are the experts in their circumstances and should always be consulted and involved, wherever possible and safe to do so.

8.3. BCUHB's policy on routine and selective enquiry was not implemented and this was contrary to the Ask and Act approach advocated in Wales. It is incumbent on all professionals to maximise opportunities to identify domestic abuse and demonstrate professional curiosity in response to possible indicators of domestic abuse. The effective implementation and monitoring of clinical enquiry schemes is critical to supporting disclosure.

8.4. Compliance with organisational assessment procedures was lacking at times. The CMHT assessment undertaken with Sean was incomplete and did not assess risk in line with their procedural expectations, which may have elicited information indicative of domestic abuse in his relationships.

8.5. An assessment of the potential risks Sean may have posed towards children that he was connected with was not made by the GP practice. It would be good practice for GP practices to record information, particularly when supporting patients with mental health issues, substance misuse issues or domestic abuse indicators, relating to children they may have contact with or parenting responsibilities for, particularly given the victim status of children now applied by the Domestic Abuse Act 2021[34].

8.6. The review highlighted the importance of documentation and record keeping regarding the detail of contact had and decision making by professionals, whether this results in action or not.

8.7. Suicide needs to be recognised and considered as a possible outcome of domestic abuse. This reflects learning from a previous local DHR in 2021 which identified the need to raise awareness of the links between domestic abuse and its impact on mental health, including suicidality.

8.8. The collective substance use and mental health issues presented by Dawn should have been a red flag for agencies, requiring further exploration and a holistic assessment of need. It is incumbent on all professionals to demonstrate professional curiosity in response to possible indicators of domestic abuse and associated distress.

8.9. Many domestic abuse victims do not recognise the link between their own experiences of trauma and the difficulties that they have with mental health and substance misuse. Services responsive to their need can help them to understand what is happening to them. A 'one size fits all' approach is least effective. Gender and trauma informed services can increase the accessibility and impact of services for vulnerable women.

8.10. Family members were aware of domestic abuse towards Dawn but feared repercussions if they acted on this knowledge and did not consider reporting to the police because the family culture was to sort things out themselves. Communities need access to information about domestic abuse, and support to know how to respond, that goes beyond reporting to the police.

8.11. MARACs are most effective when all relevant agencies know about and are engaged with them, and when there is effective information sharing and monitoring of subsequent action.

8.12. The learning arising from Dawn's experiences sadly will not bring her back but may contribute to preventing another similar tragedy. It is reassuring that the agencies represented in this review are taking steps to strengthen their practices and multi-agency approach, and the resulting recommendations illustrate commitment locally to ensuring this review facilitates positive improvements for victims locally.

# 9. Recommendations

## 9.1. Multi-agency recommendations

[34] Section 3 of the Domestic Abuse Act 2021 came into force on 31st January 2022 and specifically provides that a child (under 18 years old) who sees, hears, or experiences the effects of domestic abuse and is related to the victim or the suspect is also to be regarded as a victim.

9.1.1. Relevant agencies to engage with the work of the regional MARAC Steering Group to review the membership and effectiveness of the MARAC and ensure it is meeting its intended purpose.

9.1.2. Ensure that suicide as a domestic abuse related risk is reflected in local guidance and training. Take forward the recommendation from a previous DHR to work with the Regional Coordinator for Suicide and Self Harm Prevention to develop a work plan relating to the better understanding and response to domestic abuse and its impact on mental health and suicidality.

9.1.3. Increase public awareness locally of the options available for families who are concerned about a family member being abused.

9.1.4. Connect with and promote implementation of the 'Ask Me' scheme locally.

9.1.5. Increase local knowledge amongst agencies regarding the benefits of gender and trauma informed responses and provide learning opportunities about this approach.

9.1.6. Include representation for the North Wales Suicide and Self Harm Prevention Team on suicide related DHRs in the future.

### 9.2. Single Agency Recommendations

The following single agency recommendations were made by the agencies in their IMRs or arose from panel discussions.

**BCUHB**

9.2.1. The Supporting Children, Supporting Parents with Severe Mental Health Problems and or Substance Misuse Issues Practice Guide to be redistributed within MHLD Services and Primary Care GP Services to support the assessment of patients who are known to have children.

9.2.2. The Mental Health and Learning Disability (MHLD) service to ascertain the compliance data in relation to domestic abuse routine enquiry across the Community Mental Health Team service and ensure regular quarterly audits of the clinical records are registered and embedded into practice as this includes compliance with key Domestic Abuse targets.

9.2.3. BCUHB commissioned and managed GP services to review VAWDASV training compliance and provide organisational assurance of compliance to the Health Board.

**North Wales Police**

9.2.4. Introduction of DARA for frontline officers – to improve recognition of coercive and controlling behaviour – owner Strategic Protecting Vulnerable People Unit (PVPU).

9.2.5. Update the CSP on the implementation of the new DARA risk assessment tool.

9.2.6. Need to know/PVPU bitesize/7minute briefing – DASH considerations/professional judgement reminder to all staff through our learning media tools to support informed decision making.

**WAST**

9.2.7. 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.

9.2.8. During 2023/2024 complete work to digitalise the pathway for WAST colleagues who work within the 999 and NHS111 Wales call centres to enable direct digital referral to the Live Fear Free helpline.

**Children's Social Care**

9.2.9. Share the findings of the review with the intake team and discuss their implications for practice.

# APPENDIX A: LIST OF SUPPORT ORGANISATIONS

Reading about suicide can be distressing, If you have been affected by this report and need support, or to talk to someone, the following Helplines are available:

- For 24/7 mental health support, call 111 Option 2
- C.A.L.L. Community Advice and Listening Line for Wales - 0800 132 737
- Samaritans 116123 / jo@samaritans.org
- Papyrus Hopeline (for young people up to 35 years) 0800 068 41 41

If you, a family member a friend, or someone you are concerned about has experienced domestic abuse or sexual violence, you can contact the Live Fear Free Helpline 24 hours a day 7 days a week, for free advice and support or to talk through your options.

- Call: 0808 80 10 800
- Text: 07860077333
- Email: info@livefearfreehelpline.wales
- A live chat service is also available on the website: Contact Live Fear Free | GOV.WALES