MULTI-AGENCY REVIEW

Conducted within the statutory framework for a Domestic Homicide Review

Gwynedd and Anglesey Community Safety Partnership

Report into the death of 'Dawn'

in April 2022

Confidential until authorised for publication.

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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 D.

[1] Not her real name.

Family tribute

Dawn was the last of 6 siblings but this is probably why she had such a strong character. She never took any nonsense from the others. Although a twin, Dawn and Tony[2] were very different. Tony was always clean and tidy in his half of the room but no, not Dawn....He would happily cover for his sister regardless of her misdemeanours.

Dawn was always a mischievous child but with a lovely cheeky smile and kept the family on their toes. Dawn would watch cartoons while Tony would run around after her making sure she didn't get into trouble.

As she grew older, Dawn was known locally as someone that was jolly, easy going and so considerate that she would give someone her last loaf of bread if they needed it. Having said that, if someone was taking liberties with her or a family member, her pint size frame would not hold her back and she would not hesitate to stand her corner or defend those being picked on...Everyone knew not to mess with Dawn .....

She wasn't really keen on school but did have a passion for art and achieved an A grade GCSE in Art which she and the whole family were very proud of. She became the mother of 3 children, all of which she adored. She did her best to be a good mum but after splitting with the children's father, she became embroiled with a very toxic partner, that led her into darker times and addiction. But the tenacity she had always showed previously, came to the fore again.

She joined a support group, climbed Snowdon with them, helped others in a similar situation. The love she had for her children drove her to battle the addictions and eventually beat them. This was a monumental achievement. She regained her children's love and they became a family once more, her life was back on track, seeing the kids on a daily basis. Her cheeky smile had returned, she had down a couple of part time jobs and life was good.

Things remained ok until she entered a relationship with Sean[3]. All things appeared rosy at first but as we all know this changed over the course of their relationship. A lot of which was kept from immediate family. This strong girl who had already overcome adversity in her life started to avoid contact with family and then suffered mental and physical abuse at the hands of Sean, most of which was kept from us. This led to less contact with her kids too, which was heart-breaking.

The extent of the abuse was kept from the family but one occasion, Dawn left Sean and went to his sister's house for refuge but he frog-marched her straight back home. He took all of the internal doors off in the house so she had nowhere to hide. Towards the end, bruises appeared on her body and some of these were shown to immediate family.

We believe Sean ground Dawn down, telling her that her family didn't love her, he manipulated her, took control of her bank card and made her feel not worthy. The physical and mental abuse that Dawn took, has become more apparent as the family have all spoken about various details and pieced things together.

Only two years ago Dawn was given the news that she would be a 'Nanna'. She was so happy and singing from the rooftops. You could see the glow on her face. This was then repeated one year later with her second grandchild being imminent. With this in mind, never in a million years do we believe Dawn would do what she did...never.

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] Not his real name.
[3] Not his real name

Abbreviations used

AAFDA: Advocacy After Fatal Domestic Abuse

AGRO: Anglesey and Gwynedd Recovery Organisation

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

KPI: Key Performance Indicator

MARAC: Multi-agency risk assessment conference

MHLD: Mental Health and Learning Disability

NICE: National Institute for Health and Care Excellence

NWP: North Wales Police

PVPU: Protecting Vulnerable People Unit

SIO: Senior Investigating Officer

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. Introduction

1.1. Summary of circumstances leading to this review.

1.1.1. 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.

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

1.1.3. Bruising was observed on Dawn's body, although this was impossible to date, and family members shared information on previous domestic abuse towards Dawn by Sean. Sean was arrested and interviewed and made admissions that he had hit Dawn in the past but claimed that she had been violent to him as well. The police instigated an investigation into several crimes including posthumous domestic abuse.

1.1.4. 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. Following advice from the Crown Prosecution Service (CPS), Sean was charged with controlling and coercive behaviour towards Dawn between 2016 and 2022.

1.1.5. These matters never progressed to trial because in March 2023, Sean was found deceased at his home address.

1.2. Reasons for conducting this review.

1.2.1. Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004) and came into force in April 2011. The Act states that there 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 he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.2. The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) states that 'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable'.[4]

1.2.3. This case meets the criteria for a DHR as Dawn took her own life and there was evidence to suggest that she had been a victim of domestic abuse.

1.2.4. This Multi-agency Review has been conducted within the framework of a DHR to examine agency responses and support given to Dawn, a resident of Bangor prior to the point of her death by suicide in April 2022.

[4] DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

1.3. 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]

1.4. Cross government definition of domestic abuse.

The Domestic Abuse Act 2021 created a statutory definition of domestic abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if— (a) A and B are each aged 16 or over and are personally connected to each other, and (b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following -

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse;

(e) psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.[6]

1.5. Local context

1.5.1. North Wales Police recorded 5,141 domestic abuse-related incidents between April 2021 and March 2022[7]. In the same year, North Wales discussed 1,984 case at the MARAC[8], 698 of which were repeat cases. 91.7% of the cases discussed at the MARAC were female victims.[9]

1.5.2. There is a Wales Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2022 to 2026[10], the objectives of which are to:

- Challenge the public attitude to violence against women, domestic abuse and sexual violence across the Welsh population through awareness raising and space for public discussion with the aim to decrease its occurrence.
- Increase awareness in children, young people and adults of the importance of safe, equal and healthy relationships and empowering them to positive personal choices.

[5] Ibid
[6] Domestic Abuse Act 2021 (legislation.gov.uk)
[7] Domestic abuse prevalence and victim characteristics - Office for National Statistics (ons.gov.uk)
[8] Multi Agency Risk Assessment Conference.
[9] Marac data 2021-2022 for publication.xls (live.com)
[10] Violence against women, domestic abuse and sexual violence: strategy 2022 to 2026 [HTML] | GOV.WALES

- Increase the focus on holding those who commit abuse to account and supporting those who may carry out abusive or violent behaviour to change their behaviour and avoid offending.
- Make early intervention and prevention a priority.
- Relevant professionals are trained to provide effective, timely and appropriate responses to victims and survivors.
- Provide all victims with equal access to appropriately resourced, high quality, needs-led, strength-based, inter-sectional and responsive services across Wales.

1.5.3. The Gwynedd and Anglesey Community Safety Partnership Annual Plan 2022-23[11] – cites the following commitments:

- One of the priorities for the new plan will be trying to satisfy ourselves that we are doing enough to get messages out to the public in terms of Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV). Our focus ongoing will be taking stock of our progress in terms of training, awareness raising, and messaging/campaigns. This work will be in line with the revised VAWDASV Strategy.
- Monitoring the progress of Ask & Act training - National Training Framework as required in the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) 2015 Act.
- Domestic abuse remains a priority area of work for the police with dedicated domestic abuse initiatives being run periodically throughout the year including awareness campaigns.
- Domestic abuse matters training is still being rolled out across North Wales Police to all the workforce to increase the understanding of the complex nature of domestic abuse.

1.5.4. The Suicide and Self Harm Prevention Strategy for Wales 2015-2020, 'Talk to me 2' aims to:

- Reduce the suicide and self-harm rates in the general population in Wales; and
- Promote, co-ordinate and support plans and programmes for the prevention of suicidal behaviours and self-harm at national, regional and local levels.

The strategy notes that survivors of abuse or violence are identified as a high-risk group and that there is an association between suicide and area of residence-based deprivation. Suicide rates are higher within the more deprived communities and this gap appears to be widening in Wales. This highlights that suicide prevention should address inequalities that exist in society.[12] The Regional Lead for Suicide and Self-Harm Prevention noted that a renewed strategy was under development and that the North Wales Regional Forum was responsible for overseeing local implementation of the strategy.

1.5.5. Welsh Women's Aid is the national charity in Wales working to end violence against women and girls in all its forms. They are a federation of specialist organisations in Wales that provide lifesaving refuge and community-based services to survivors of violence and abuse. Gorwel is a member of Welsh Women's Aid and provides local domestic abuse services for Gwynedd and Anglesey.

1.5.6. The Live Fear Free Helpline is the national helpline for Wales and provides information, advice and support to individuals who have experienced, or are concerned that someone they know may be experiencing any form of violence or abuse.

1.5.7. BAWSO is the lead organisation in Wales providing practical and emotional support to survivors from ethnic minorities who have experienced domestic abuse, sexual violence, human trafficking, Female Genital Mutilation and forced marriage.

[11] Gwynedd and Anglesey Community Safety Partnership Plan 2022-23.pdf (llyw.cymru)
[12] talk-to-me-2-suicide-and-self-harm-prevention-strategy-for-wales-2015-2020.pdf (gov.wales)

1.5.8. The 2022 population survey registered 74% in Gwynedd and 63% on Anglesey as Welsh speakers.[13]

2. Timescales

2.1. The Gwynedd and Anglesey Community Safety Partnership (CSP) was advised of the death of Dawn by North Wales Police on 16th May 2022 and advised to await further detail. When further information was received at a meeting with the police on 1st July there was some disagreement about whether a DHR was required. The CSP made the case that this case did meet the criteria for a DHR and this was agreed on 12th July 2022.

2.2. The Home Office were notified of the CSP's intention to undertake a DHR on 20th July 2022.

2.3. An Independent Chair and Report Author was appointed in August 2022.

2.4. The panel met six times and the review concluded in October 2023.

2.5. Progress of the review was delayed by the criminal investigation into post humous domestic abuse and due to the time taken to engage with the victim's family.

2.6. The completed report was handed to the Gwynedd and Anglesey CSP on 14/01/2024. It was signed off, before being submitted to the Home Office Quality Assurance Panel on 05/02/2024.

2.7. In June 2024, the completed report was considered by the Home Office Quality Assurance Panel and in August 2024 the Gwynedd and Anglesey CSP received a letter from the Home Office Quality Assurance Panel authorising the report for publication.

3. Confidentiality

3.1. All information received through the review process and discussed at panel meetings is strictly confidential and not to be disclosed to third parties without discussion and agreement with the CSP/Chair.

3.2. A Confidentiality and Information Sharing Agreement was agreed by all Panel Members participating in the review.

3.3. The findings of this report were confidential to participating officers/professionals and their line managers until it was approved for publication by the Home Office Quality Assurance Panel.

3.4. This review has been suitably anonymised in accordance with the Statutory Guidance.

3.5. 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

[13] Annual Population Survey - Ability to speak Welsh by local authority and year (gov.wales)

4. Terms of Reference

The full Terms of Reference are provided at Appendix B.

4.1. 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.

4.2. 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?

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?

5. Methodology

5.1. At a meeting of CSP representatives on 12th July 2022, the circumstances of this case were considered and the decision was made that the criteria for a DHR had been met and would be commissioned.

5.2. 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.

5.3. The review requested and drew upon chronologies and Individual Management Review provided by five agencies know to have contact with the subjects of the review, as well as short reports provided by four agencies.

5.4. The panel and/or Chair also drew upon the following information to inform the review:

- A recording of the inquest
- Interviews with family members
- The police interview with Sean
- Panel discussions
- Local/regional strategic documents relevant to the review.

6. Involvement of family and friends

In addition to the lines of enquiry set out above, the review set out to find out what Dawn's family, friends or community members knew about Dawn and Sean, their relationship, their needs, whether they sought or received help and, if so, the effectiveness of this help.

6.1. The Chair was initially advised by North Wales Police not to contact the family due to the ongoing criminal investigation into posthumous domestic abuse and their critical roles as witnesses.

6.2. In November 2022, the Chair wrote to the family to introduce herself, explaining the DHR process and inviting their involvement once the criminal investigation was concluded. The Senior Investigating Officer (SIO), who had established an ongoing relationship with the family, delivered the letter to Dawn's mother and talked to her about its contents. Dawn's mother agreed to share the letter with the wider family.

6.3. Information about AAFDA's[14] advocacy services was shared with the letter. The Home Office DHR information leaflet was not shared at this stage as the SIO was concerned that this may give a false impression that the police were investigating a homicide. This was later shared with the family.

6.4. In December 2022, following advice that contact with the family would not now jeopardise the ongoing investigation, the SIO approached the subject again with Dawn's mother, who at that time felt unable to engage with the review.

6.5. In March 2023 the Chair was advised by North Wales Police to make direct contact with Dawn's mother. Two telephone calls were held between Dawn's mother and the Chair in March and April 2023. The Chair shared information about the DHR process and Dawn's mother shared some initial reflections about Dawn. Dawn's mother did not, however, wish to have any further involvement in the review.

6.6. The Chair spoke with Dawn's sister on the phone, who expressed a willingness to be involved in the DHR and wanted to represent the family during the review. In early May 2023 the Chair and CSP lead met with Dawn's sister at her home.

6.7. The Terms of Reference for the review were shared with the family and they were invited to comment on them. Dawn's sister attended a panel meeting in June 2023, raising specific questions and concerns that the family had identified.

6.8. The Chair made periodical contact with the sister during the review. With their permission, a direct referral was made to AAFDA on the family's behalf.

6.9. Via the SIO, Sean's ex-partner, Angharad, was offered the opportunity to speak with the Chair. This was declined.

[14] Advocacy After Fatal Domestic Abuse.

6.10. The Chair did not approach Sean due to the ongoing investigation about posthumous domestic abuse. Sean then died in March 2023.

6.11. On behalf of the review panel, the Chair extends her thanks to Dawn's family for their contributions to the review. In addition to the family tribute above, where relevant, their comments are weaved throughout the report.

7. Contributors to the review

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

7.2 IMRs were provided by:

- Betsi Cadwaladr University Health Board
- Gwynedd Citizens Advice
- Welsh Ambulance Services NHS Trust
- North Wales Police
- Department for Work and Pensions.

7.3 Short reports were provided by:

- Adra Housing
- Children's Social Care
- Substance Misuse Services
- Gwynedd Council One Stop Shop.

7.4 A briefing session was held for IMR authors to prepare them for and support them with their report writing. Follow up meetings were held to discuss the agency IMRs where necessary.

7.5 Each report was quality assured by the producing organisation and signed off by a senior manager before being shared with the DHR Panel.

7.6 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.

8. The review panel

8.1. 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][15]	Senior Operational Officer	Community Safety Partnership
[redacted]	Services Manager	Gorwel Domestic Abuse Service
[redacted]	Head of Services	Welsh Women's Aid

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

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

8.2. 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.

9. Chair and author of the report

9.1. 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. Nicki is nationally recognised as an expert in domestic abuse, having been active in this area of work for over 30 years. Further details are provided in Appendix C.

10. Parallel reviews

10.1. An inquest was held following Dawn's death. The Coroner concluded that:

"*[Dawn] died as a result of her own actions of hanging from the banister at her home address using a jumper as a ligature. It is possible, but not probable, that [Dawn] intended death to be the consequence of her actions"*

10.2. The police instigated an investigation into posthumous domestic abuse following Dawn's death, which resulted in charges being brought against Sean. These matters never progressed to trial because in March 2023, Sean was found deceased at his home address.

10.3. Following the death of Sean and due to the charges against him, the case was referred to the Independent Office for Police Conduct (IOPC) in March 2023. The IOPC confirmed that they were satisfied that the Police could not have foreseen or prevented the death of Sean based on the information available to them.

11. Equality and diversity

11.1. The review sought to be mindful of the nine protected characteristics[16], in line with the Equality Act 2010 (age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation). The review identified the following protected characteristics as being relevant to this case.

11.2. Sex: Dawn was female and data reflects that women are disproportionately the victims of domestic abuse, and men more often the perpetrators[17].

11.3. Disability - The Equality Act 2010 says that a person has a disability if they have a physical or mental impairment that has a substantial, adverse, and long-term effect on their ability to carry out normal day-to-day activities. Whilst not registered disabled, Dawn cited mental health difficulties as one of the reasons she was unable to work. Sean was engaged with mental health support services.

11.4. These protected characteristics, and how they might have shaped the experiences of Dawn and Sean, and the agency responses to them, are explored in the Analysis section.

12. Dissemination

12.1. The following individuals/organisations will receive copies of this report:

- Dawn's family
- Member agencies of the Gwynedd and Anglesey CSP
- Agencies contributing to the review
- The Domestic Abuse Commissioner's Office
- North Wales Police and Crime Commissioner's Office
- North Wales Regional Lead for Suicide and Self-Harm Prevention
- Public Health Wales.

13. Background information

13.1. 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.

13.2. When Dawn's children were young, she went through a difficult time with substance use and, for a time, they were required to live with their maternal grandmother. The family pay testament to the efforts Dawn made to seek support and to deal with her addictions, enabling her to re-establish care for her children again.

13.3. Dawn was known to be in a relationship with Sean since 2017.

13.4. Dawn was a social housing tenant and was in receipt of benefits. She was unable to work at the time of her death due to mental health issues and alcohol use.

13.5. Dawn was found hanging at her home in April 2022 and died five days later in hospital. Following concerns being raised by family members and a subsequent investigation, Sean was charged posthumously with controlling and coercive behaviour between 2016 and 2022 towards Dawn. This did not progress to trial because Sean was found deceased at his home address in March 2023.

[16] Protected characteristics | Equality and Human Rights Commission (equalityhumanrights.com)
[17] Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk)

14. Chronology

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

Relevant events prior to the review timeframe

14.1. Dawn was known to the Substance Misuse Service (SMS) from February 2012, where she was supported via her General Practitioner (GP) under the shared care GP/SMS service. At this time, she was prescribed an opiate substitute and allocated a key worker for ongoing support, achieving abstinence from all illicit substances by July 2012. Dawn expressed concerns in July 2012 that her ex-partner had been bailed to her address, due to his ongoing use of illicit substances. During 2013, Dawn remained abstinent from illicit substances and was engaging in community activities and support. Dawn began a reduction in her opiate substitute medication and remained engaged with the SMS service. In mid 2013, Dawn reported that she was not having any contact with her ex-partner, who had recently been released from prison.

14.2. Dawn was last seen by a SMS keyworker in July 2014, who noted that she appeared well and would prefer a home detox from her opiate substitute medication, rather than inpatient. It was agreed that this would be looked at later in the summer.

14.3. Dawn did not attend appointments offered in October and December 2014. The case was closed to SMS and communication sent to her GP in February 2015. There were no concerns raised regarding Dawn's wellbeing at this time.

14.4. On receipt of a referral from Dawn's GP in September 2015, the SMS offered Dawn an assessment, but Dawn did not respond. The GP reported that there was some violence from her ex-partner and that she denied using any illicit substances at this time. As her GP's request, a re-referral to the SMS was offered to Dawn in December 2015. Dawn did not engage with this. This was the last contact the SMS had with Dawn.

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

2017

14.5. 9th January 2017 - Dawn sought advice from Gwynedd Citizens Advice regarding rent arrears and possible eviction. During the meeting Dawn disclosed that she had left her violent partner several years ago. She mentioned that Women's Aid were involved[18]. Dawn disclosed that she had a support worker with the AGRO project (Anglesey and Gwynedd Recovery Organisation)[19] who she trusted and could talk to if she needed support. Dawn did not disclose any current or ongoing domestic abuse during the meeting.

14.6. 20th February 2017 - North Wales Police (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. Angharad requested that Sean was not spoken to directly about this report. 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

[18] 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.

[19] AGRO is a volunteer-based organisation, run by people in recovery for people in recovery. The purpose of AGRO is to promote recovery from alcohol and other drug problems through activity, supporting families, raising awareness, breaking down stigma, and providing information in Anglesey and Gwynedd.

the Local Authority Children's Services by NWP and a strategy discussion[20] 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.

14.7. 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.

14.8. 21st February 2017 - Adra Housing received a call from Angharad reporting an incident involving parking outside Dawn's property (see 14.6) 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.

14.9. 15th March 2017 - NWP logged an intelligence report submitted that Sean had purchased a new car but did not have a full licence to drive and concerns were raised about the manner of his driving around Bangor. The vehicle details were checked, and it transpired that Sean did have a full driving licence and insurance. Local officers were made aware of the information concerning Sean's manner of driving.

14.10. 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. The report also refers to Sean's own children no longer visiting him at Dawn's home. 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 school nurse, the school, CCG Housing Association[21] and the SMS were contacted during the enquiries and the concerns were not substantiated. It was determined that universal agencies involved would monitor and contact Children's Services should they have any concerns. The case was closed on 26th June 2017.

14.11. 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. Dawn reported that, although the car was not moving quickly, it did shake her up. 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. Both families were asked to ignore each other from now on and to respect each other's privacy, which they agreed to. 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.

[20] 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.

[21] Now Adra Housing.

14.12. 9th August 2017 - Dawn saw her GP sharing that she felt depressed, that the Sertraline[22] medication was helping but she was having trouble sleeping. Dawn was prescribed a low dose of Amitriptyline[23] to be taken in addition to the Sertraline.

14.13. 9th August 2017 - Sean saw his GP regarding depression. It is noted that he had ran out of his Citalopram[24] medication a few weeks ago but did see the benefit in taking this. 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 now appreciates that he wants to live for his children and partner. He confirmed no further suicidal attempts or ideation. A plan was made for Sean to restart the Citalopram with a follow up in three weeks prior to further supply. A leaflet and number of Parabl[25] was given to Sean and the importance of seeking advice when his mood deteriorates, or suicidal ideation occurs, reiterated.

14.14. 14th August 2017 - A Multi-Agency Risk Assessment Conference (MARAC)[26] referral was made by Victim Support due to problems that Sean had been causing for Angharad stating that Sean resided next door to Angharad and listened to her conversations if she was passing or outside. Other information shared was that Angharad had made her gates higher in order for Sean not to see them, that in the past Sean has followed Angharad and phoned/texted her to the point that she has had to block his number, that Sean is jealous as Angharad has a new partner, and that he has threatened to kill her and the new baby and told her "you're lucky you're pregnant or I'd kill you". The situation was DASH[27] risk assessed as medium risk. A Domestic Abuse Officer contacted Angharad, attending her address and issuing target hardening[28]. 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)[29], which was authorised on 7th September 2017 by a Detective Inspector. The following form of words was agreed for the DVDS:

[Sean] has a history of violence over a 9 year period from 2008-2017. In 2008 he has hit a male with a bottle causing male head injuries. In 2009 [Sean] has assaulted a male who sustained cut to bridge of nose swollen has left jaw and painful knee – guilty. In 2012 [Sean] has assaulted a male by hitting him twice in the face – guilty. Also that year his ex-partner reports that she has been assaulted by [Sean] in front of her children following a verbal altercation [Sean] has grabbed hold of the her and punched her to the face several times. In 2015 [Sean] was reported as harassing his ex-partner by placing posts on FB, following her and continually phoning her. He was reported that he was jealous that the ip [injured party] has a new partner. [Sean] has threatened to kill her and the baby and has also told her "you're lucky you're pregnant or I'd kill you". In 2016 police received a report of an ongoing domestic in the street between partners with child present. In 2017 there have been 3 further reports from [Sean]'s ex-partner that he is still harassing her.

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[22] Sertraline is often used to treat depression.
[23] Amitriptyline is a medicine used for treating pain, migraine attacks and depression.
[24] Citalopram is often used to treat low mood (depression) and also sometimes for panic attacks.
[25] Parabl the Talking Therapies Partnership |
[26] 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.
[27] Domestic Abuse Stalking and Harassment Risk Assessment. An assessment tool used by the police and other agencies.
[28] Target hardening is a term used to describe improving the security of a property to reduce the risk of crime.
[29] 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.

14.15. 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.

14.16. 17th August 2017 - An Anti-Social Behaviour report was made to NWP by Angharad reporting ongoing issues with her ex-partner Sean stating he had been placing posts on social media which caused her distress and that the posts identified Angharad, claimed that she was a bad mother and suggested there are ongoing issues in relation to child access. Angharad confirmed that she was in contact with solicitors and the Local Authority in relation to access and managing these matters. 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.

14.17. 5th September 2017 - Adra Housing received an anonymous report that the police had been called and attended to an incident at Sean's address. It was alleged that Dawn had attacked three males outside who were walking home from a night out. 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. Her adult son was punched to the face and sustained injuries. They were the victims according to Dawn and Sean.

14.18. 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[30] but was recorded as a crime as per Home Office recording rules and not progressed further.

14.19. 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.

14.20. 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[31] 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 'Supervisory Review' queried the planned disclosure to Sean's new partner Dawn. Again, it was not clear whether this was delivered.

14.21. 7th December 2017 - Sean approached Gwynedd Citizens Advice for help with a court hearing in relation to child contact. A conflict of interest was identified, in that Gwynedd Citizens Advice were advising his ex-partner (not Dawn) on the same issue, and so a referral was made to Ynys Mon Citizens Advice to support him.

[30] 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.
[31] A concern for safety referral is a non-crime occurrence which is shared with the local authority to highlight identified concerns.

2018

14.22. 17th January 2018 - Dawn attended a work capability assessment with a Department for Work and Pensions (DWP) assessment provider. The health conditions reported were mental health problems, Asthma and Psoriasis. Dawn was placed in the Work-Related Activity Group (WRAG)[32].

14.23. During 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.

14.24. 19th April 2018 - Dawn attended a DWP compliance interview. Dawn wrote a statement *'I have had the allegation put to me that I have Sean living with me. I deny this allegation, he is my boyfriend but he does not live with me.'* No further action was taken and Dawn's Employment and Support Allowance remained in place.

14.25. 24th April 2018 - Dawn saw a Nurse practitioner at the GP surgery. This related to her being charged with being intoxicated in a public place and Probation conditions that she attend group classes with other people with drug and alcohol problems. Dawn stated she does not have problems with alcohol but has a history of drug dependency. Dawn shared that she has avoided being around people who use drugs in order not to relapse and that she was anxious that being a situation with these people would cause her to relapse, that this is worsening her anxiety and depression, and that she feels that she cannot work in a group due to social anxiety. 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.

14.26. 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[33], 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.

14.27. 29th April 2018 - The above referral was discussed during the daily SPOAA[34] meeting, where all new referrals are discussed. 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.

14.28. 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.

14.29. 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 it was agreed that the referrer needed to advise as to whether Sean still needed the appointment. The referrer was contacted and advised that the situation had improved due to Sean now having access to his children. The case was then closed.

14.30. 5th June 2018 - Sean attended an appointment in the Jobcentre and it was noted that his mental health was still up and down at times, that he had been referred to Hergest[35] for

[32] When someone claims Employment and Support Allowance their ability to work is assessed. Following this assessment, they are placed into one of two groups; either the Support Group or Work Related Activity Group. If someone is assessed as being able to return to work in the future, they are placed in the WRAG.
[33] Further information was not available.
[34] Single Point of Assessment and Allocation (this is an agreed service process).
[35] The Hergest Unit provides acute in-patient psychiatric services for the North West Wales NHS Trust.

additional support. Sean spoke about seeing his children more regularly and going through the courts to formalise contact arrangements.

14.31. 12th June 2018 - The Specialist Nurse and CMHT discussed Sean and agreed that the Specialist Nurse will re-refer if needed following their planned appointment with Sean in August 2018.

14.32. 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[36]. Dawn had an appointment with another GP on 14th August 2018 but she did not attend this.

14.33. 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.

14.34. 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 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'.* Dawn remained in the WRAG.

2019

14.35. 17th January 2019 - Sean attended an appointment in the Jobcentre at which he shared that he was now seeing his children but still waiting on medical appointments and further tests. It was noted that he was finding things very stressful at the moment and not able to consider any work.

14.36. 29th January 2019 - Dawn attended an appointment in the Jobcentre. She had just completed the Work Programme but stated that she was feeling low and relying heavily on her mum for support with nobody else supporting her at the moment. Dawn said that she may in the future consider working with Arch and North Wales Recovery[37].

14.37. 16th June 2019 - Dawn attended another appointment in the Jobcentre when, again, she mentioned the possibility of working with Arch and possibly doing voluntary work with Penrhyn House[38]. She shared that she had not been drinking for four weeks but was finding it hard.

14.38. 9th July 2019 - Sean attended an appointment in the Jobcentre. Noted on system is that Sean had issues with his accommodation, that he didn't have a support worker and was very forgetful about appointments. Due to the stress Sean was under, he was not able to consider any work at that time.

[36] 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.
[37] Offering support groups for people in recovery from substance use.
[38] Penrhyn House provide a safe space for participants in early recovery whilst they establish themselves in the local recovery community.

14.39. 3rd December 2019 - Dawn attended an appointment in the Jobcentre and this time stated that her *'situation is a little worse, she has asked for help but its difficult for her to get the support she has asked for and she is still waiting. She's been to all the places she can think of but still needs to wait. She knows she can come back to see us at any time'.*

14.40. 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.

14.41. 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[39] 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.

14.42. 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.

14.43. 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.

14.44. 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.

14.45. 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.

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

2020

14.46. 8th January 2020 - Sean attended an appointment in the Jobcentre. It was noted that Sean had appointment regarding his mental health next week and that he was reliant on his mum and sister to support him.

14.47. 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. A copy of the assessment was sent to the GP and it was noted that Sean "does not feel he has any current mental health difficulties". A letter was sent to Sean by the CMHT, copied to the GP, informing him that the case would not be allocated.

14.48. 18th February 2020 - Dawn attended another 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[40] contacted Dawn on the 5th March 2020 to discuss this further. The decision maker placed Dawn in the 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.

14.49. 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.

14.50. 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.

14.51. 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 the call to the ambulance service, both parties were intoxicated and it sounded like there was a domestic occurring there. 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

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

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 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.

14.52. 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[41] was agreed due to budgeting issues.

14.53. 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.

14.54. Throughout October to December 2020, Dawn continued to communicate with DWP about her Universal Credit claim.

14.55. 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

14.56. 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 caller stated that he was going to put a mask on and check on her. 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.

14.57. 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

[41] 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.

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)[42] 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'*. On 8th March 2021 a Decision Maker awarded 'limited capability for work and work related activity' onto the Universal Credit claim.

14.58. 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.

14.59. 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. She would not speak to Officers and repeatedly told them to leave her alone. 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 Children's Services.

14.60. 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.

14.61. 16th July 2021 - Following an anonymous telephone call, Adra Housing submitted a personal data request to NWP regarding the above event. After receiving a report from NWP Sean and Dawn were visited and the Housing Coordinator shared that Adra were considering a final warning contract. However, since no charges were brought against Sean, Adra did not take any further action.

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

14.62. 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 the mother (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, to provide further assistance to the family. The DASH risk assessment was reviewed and categorised medium risk, but with no current threat that needed a referral to MARAC or further police involvement. A decision was made to record the historical event as a crime. Information was shared with Children's 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.

14.63. 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.

14.64. Throughout 2021, there were several contacts made with Dawn and Sean 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

14.65. 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 declined to provide details about the threats. 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.

14.66. 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. Officers spoke to both males in relation to this matter and an email detailing messages sent from the suspect was obtained. Upon reviewing the messages, it became apparent that a number of persons were involved in exchanging them and this included the victim. It also appeared that the issue related to child contact and it was noted that Sean was subject to a court order which prohibited him from seeing his children[43]. The suspect was spoken to by the police in relation to this matter and was 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[44] support was provided to Angharad and the Local Authority made aware of ongoing issues. As a result of two police reports being received within a short period of time in relation to the two respective fathers and following a discussion with Angharad a decision was made that the Local Authority would undertake a care and support assessment. This was completed

[43] The review was unable to obtain further information about this and whether this was true.
[44] Independent Domestic Abuse Advisor

on the 19th January 2022, the assessment did not identify any care and support needs that required intervention by Children's Services so the case was closed.

14.67. 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.

14.68. 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.

14.69. 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.

14.70. 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.

14.71. 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. Officers arrived on scene to find Dawn lying on the stairs. Officers pulled her onto the hallway floor and began CPR until the arrival of WAST personnel. Police spoke to Sean who stated that both him and Dawn had been drinking upstairs in the front bedroom, that they had been arguing about problems within their relationship and as a result 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.

Events following the death of Dawn

14.72. 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. This matter never progressed to trial because in March 2023, Sean was found dead at his home address.

15. Overview of agency involvement

This section summarises the totality of the information known to the individual agencies and professionals involved with the subjects of the review.

15.1. Betsi Cadwaladr University Health Board (BCUHB) mental health and primary care services

15.1.1. BCUHB is the largest health organisation in Wales, providing a full range of primary, community, mental health and acute hospital services for people across the six counties of North Wales. BCUHB has three main hospitals along with a network of community hospitals, health centres, clinics, mental health units and community team bases. The Health Board also coordinates the work of 109 GP practices and NHS services provided by dentists, opticians and pharmacists in North Wales.

15.1.2. Dawn and Sean were both registered at the same GP surgery in Bangor. Dawn was not engaged with BCUHB Mental Health Services during the agreed timeframe. Sean was known to BCUHB Mental Health Services.

15.1.3. BCUHB report no evidence to suggest that Dawn or Sean were a victim of or perpetrating domestic abuse. This is based on the assumption that Dawn and Sean did not present with any injuries or made any reports to those involved in their care and support within Primary Care services. There were no enquiries or referrals made by the GP practice for either individual during the timeframe specific to concerns around potential domestic abuse.

15.1.4. It is recorded that Dawn did raised concerns in relation to drug and alcohol use and suicidal tendencies, indicating that Dawn may have felt comfortable to disclose sensitive issues with her GP. However, there was no disclosure of domestic abuse and there was also no targeted enquiry about domestic abuse undertaken by the service.

15.1.5. Following an attempted suicide Sean was supported by the GP and deemed to understand the impact this could have on his children. Sean was not in receipt of Mental Health Services at this time.

15.1.6. The referral for Sean received by the CMHT on the 28th April 2018 was discussed at the SPOAA[45] meeting the day after it was received, as would be expected of the service, and the decision made to offer an assessment on a routine basis within 28 days. However, the appointment date offered on the 1st June 2018 was beyond the 28-day timescale for a routine assessment.

15.1.7. There was communication between the CMHT and the Specialist Nurse following the non-attendance off Sean at the appointment, with the agreement for closure and further referral if needed based upon the Specialist Nurse's engagement and involvement with Sean.

15.1.8. Sean was referred again to the CMHT in December 2019. Following a further non-attendance at an appointment offered, there was action taken by CMHT staff to follow this up with the Housing Support Worker and Sean did attend an assessment on the 13th January 2020. The assessment noted that Sean did not feel he needed a service. The documented evidence recorded Sean's presentation (his choices and feelings) and the current risks at the time which led to the decision that he did not need a service. However, the assessment documentation was not fully completed as should be expected and in line with legislation. In detail, the following sections had not been completed, the Capacity,

[45] Single Point of Access and Allocation.

Insight, Plan and Future Orientation, the PHQ9[46], Risk Assessment, HITS Matrix[47], Fair Access to Care, and 'has the patient served in Armed Forces' sections, as well as the Long Term Physical Conditions section. We must assume that, as these sections were not completed within the paperwork, the assessor did not complete them verbally.

15.1.9. Sean had a GP consultation in March 2022 following concerns being raised by the Sexual Health Consultant about Sean's skin complaint and his excessive drinking. There is, however, no evidence that the latter was discussed.

15.1.10. Dawn and Sean both had parental responsibility for separate children. The practice did not identify any current or future risk to the children due to the issues being discussed with Dawn and Sean or their engagement with other agencies, although there is no documented assessment and decision making regarding this.

15.2. Department for Work and Pensions (DWP)

15.2.1. The DWP is responsible for welfare, pensions, and child maintenance policy. As the UK's biggest public service department, it administers the State Pension and a range of working age, disability and ill health benefits to around 20 million claimants and customers.

15.2.2. Dawn's contact with DWP related to her Employment Support Allowance claim and latterly her Universal Credit claim.

15.2.3. Dawn did not indicate to DWP that there was domestic abuse, including coercive control, with her relationship with Sean. DWP became aware that they were in a relationship when there was an allegation that Sean was living at Dawn's address and Dawn made a statement in April 2018 denying this.

15.2.4. When, in December 2019, Dawn shared that 'the situation had got a little worse', no details are recorded on of why her situation had got worse and there are no notes of signposting or details of organisations that Dawn have contacted.

15.2.5. Dawn stated her barriers to work as mental health and alcohol abuse. However, there is no information on whether Dawn was signposted to any organisations for help regarding this. The DWP has a district provision tool which is used to signpost customers to charities and organisations in their area for support where required. The IMR author clarified that Dawn had shared information about the different services that she was engaged with, leading DWP professionals to conclude that further signposting would not be helpful to her.

15.2.6. Sean had a Personal Independence Payment claim and Employment Support Allowance claim. On both claims, his address was recorded at a different address to Dawn.

15.3. Citizens Advice Gwynedd

15.3.1. Citizens Advice Gwynedd is the primary advice provider offering face to face, telephone advice and online advice through their website for anyone living or working in the county.

15.3.2. The interactions with Dawn were regarding debt due to rent arrears. Dawn did mention she left her violent partner several years ago, but reassured the worker that Women's Aid were involved and that she had a support worker with the AGRO project. As the

[46] Patient Health Questionnaire-9 which is used to screen for depression in primary health care.
[47] HITS is a screening tool and scale that stands for Hurt, Insult, Threaten and Scream. A series of questions are asked about how often the individual's partner hurts, insults, threatens or screams at them. In response to feedback, BCUHB will be moving to an alternative acronym (possibly THIS) which uses the same words, but in a better order – **T**hreaten **H**urt **I**nsult **S**hout/**S**afe, or a variation of this, to be launched during the 2023 Safeguarding Week.

information regarding the domestic abuse occurred several years prior to the meeting and Dawn had a support worker, there was no further intervention from Citizens Advice.

15.3.3. The service/adviser followed operational guidelines and procedures in the decision making process, which were appropriate to the issues presented.

15.3.4. If either Dawn or Sean had disclosed any issues of domestic abuse the staff are directed to provide basic support and to refer the client to relevant organisations better able to provide further support.

15.4. North Wales Police (NWP)

15.4.1. NWP staff had several contacts with Dawn and Sean across the period under review. The first recorded acknowledgement of the relationship was in February 2017 when police were informed by the ex-partner of Sean that he was in a new relationship with Dawn. This information was shared with the Local Authority as both individuals had children.

15.4.2. There were ongoing issues between Sean and his ex-partner Angharad. As a result of this, a MARAC was held in September 2017. It was agreed in that meeting that, due to his behaviour towards Angharad, a disclosure of Sean's violent history should be considered for Dawn through the DVDS. The action was reviewed by the Detective Inspector who agreed that a disclosure was proportionate and necessary. There were difficulties in making contact with Dawn and, after a number of unsuccessful visits, a message was left for her to make contact with the police. There is nothing on record to indicate that she did make that contact or that the disclosure was made.

15.4.3. In September 2017, Dawn was found intoxicated in a public place by the police. She assaulted a police officer and was charged. She was given a community sentence and an alcohol treatment requirement that was overseen by Probation. There were further contacts with NWP where substance misuse was an issue for Dawn and other members of her family, but no concerns raised throughout the whole of 2018 or 2019 regarding domestic abuse between Dawn and Sean.

15.4.4. At the end of 2019, NWP attended to an incident with Sean where there were concerns for his mental health as he thought there were people hiding in his attic. He refused to seek assistance from his GP and would not consent to a referral being made to adult services for support. Despite not receiving his approval, NWP still shared the information with the Local Authority as he was having contact with his children.

15.4.5. On 9th October 2020, NWP attended the home address of Dawn responding to a report of a domestic disturbance. The initial call had been made to WAST and in the log to the police it stated *'female has smashed bottle over male's head'*. It also describes Dawn as in an 'aggressive mood' with the clinician and Sean. Both parties were intoxicated and Sean had an injury to his head. The parties were separated and spoken to and provided consistent accounts that the injury was self-inflicted. They both refused to provide any answers to the DASH checklist. Sean refused to go to hospital and was taken to his own address to prevent any further issues. The incident was reviewed by a supervisor and they asked for house to house enquiries to be conducted to seek independent evidence. No concerns were raised as a result of these enquiries and so the incident was closed.

15.4.6. The next recorded domestic incident was on 15th June 2021. Again, alcohol was a factor with both parties being intoxicated. A third party report from a member of the public suggested that the couple were fighting on the golf course, although when the witness was spoken to they confirmed that they had not seen them fighting and had just heard raised voices. Neither party appeared to have any injuries. Both parties were separated and taken home to their own addresses. A response to the DASH risk assessment was refused again.

15.4.7. In August 2021, there was a further report from Sean's ex-partner Angharad about ongoing harassment by Sean. Angharad made a report that one of their children had witnessed Sean assaulting Dawn after they have had sex. In line with Home Office recording rules a crime was created. The crime was reviewed by a Sergeant and a decision was made to take no further action in relation to this matter. The decision was based on the lack of detail in the report and there also seemed to be some confusion that this was a duplicate crime of an incident in 2017 where Sean had thrown a bike at Angharad.

15.4.8. In January 2022, there were further incidents reported by the ex-partner of Sean about his behaviour towards her new partner. No complaints were forthcoming but the incident was taken back to MARAC on 18th January 2022. IDVA support was provided to Angharad and the Local Authority were made aware of the ongoing issues.

15.4.9. In January 2022 NWP spoke to Sean at his home address after he sent a message to his son asking him not to wear black at his funeral. A welfare check was conducted and Sean was described as intoxicated and argumentative. A referral was shared with the Local Authority as a child was involved.

15.4.10. There were no further reported incidents between Dawn and Sean to NWP until the date of Dawn's death.

15.4.11. It was at this point that members of Dawn's family came forward raising concerns about Sean's behaviour towards Dawn. An investigation was commenced and Sean was arrested and interviewed. A decision was made to charge him with controlling and coercive behaviour between 2016 and 2022 towards Dawn. This matter never progressed to trial because in March 2023, Sean was found dead at his home address.

15.5. Welsh Ambulance Services NHS Trust (WAST)

15.5.1. WAST delivers emergency clinical care and non-emergency hospital transport across Wales. The 999 call handlers respond to calls 24 hours a day and 365 days of the year. WAST hosts the NHS 111 Wales Service, which is a 24-hour health advice service and information for the public and the front-end call handling and clinical triage elements of the GP out-of-hours services.

15.5.2. Within the review timeline 999 was contacted requesting WAST assistance twice for Dawn and twice for Sean.

15.5.3. The first call regarding Sean in December 2019 was in response to a mental health episode. There was no reference to Dawn, or any information shared which would have caused concerns regarding domestic abuse.

15.5.4. The second call regarding Sean was in response to the head injury he incurred after smashing a bottle on his head. Dawn was present and the police were involved. There was no patient clinical record available for this incident. WAST policy states that a patient clinical record should be completed for every patient interaction. Approximately the same time as the ambulance crew arrived on scene, a call was received from the police to cancel the ambulance. Based on this information, it appears that there was no patient interaction, and so a patient clinical record would not be required.

15.5.5. In January 2021 a third party called an ambulance concerned about Dawn unable to get into a house while it was freezing outside. The ambulance was cancelled once the caller confirmed Dawn had gained access into the house.

15.5.6. The second 999 call in relation to Dawn was the fatal incident.

15.5.7. Where practitioners identify signs of domestic abuse or where there is an overt disclosure, WAST work in collaboration with the Live Fear Free helpline. This enables colleagues to signpost or support victims/survivors of domestic abuse/domestic violence in accessing specialist help. In November 2021 WAST digitalised the referral pathway with the Live Fear Free helpline for all colleagues with iPads. Since the introduction of this digital referral pathway WAST 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.

15.6. Adra Housing

15.6.1. Adra is a Registered Social Landlord providing homes in north Wales.

15.6.2. Dawn and Sean's contact with Adra largely related to rent arrears and maintenance issues.

15.6.3. There was one occasion when Dawn shared with her Housing Officer that she was 'finding things difficult'. Dawn refused the Officers assistance in completing a claim form but stated that her daughter and neighbour were helping her to complete this. The Officer understood that the reference to "finding things difficult" was in the context of financially and with regards to her rent arrears.

15.6.4. Adra were not informed of any cases being held at the MARAC in relation to this DHR, which are normally made known through the MARAC meeting that they attend on a monthly basis[48].

15.6.5. There was some confusion regarding an apparent request for a management move by Angharad, which NWP supported, and a lack of knowledge of this within Adra. Adra is a stock transfer Company, derived from the old Gwynedd Council Housing Stock in 2010. Housing Options is run by Gwynedd Council who administers the Housing Register for all Social Landlords in Gwynedd.

15.6.6. An application for a Transfer can be submitted to Housing Options but Adra would not necessarily be aware of this unless the Transfer materialised. Alternatively, Adra has the right outside of the Housing Allocation Policy to grant a Management transfer within its own stock. Adra have no record of a Managed Transfer request direct to Adra.

15.6.7. The Chair made contact with the Housing Options team who confirmed that the only information they held about the subjects of the review was that Angharad had applied for a move in October 2019 and was rehoused in April 2021, and that Sean had an ongoing active housing application with them.

15.6.8. In recognition that safeguarding concerns are often noticed by Repairs and Maintenance Operatives when responding to maintenance issues in the home, this group of professionals are given a 20 minute toolbox talk yearly or when starting employment with Adra. This teaches them that, if a concern is observed, the staff member will phone it through to the Call centre, where a referral form is completed and sent through to the Safeguarding Mailbox, monitored by eight Designated Safeguarding Coordinators. If domestic abuse is identified, a Domestic Abuse Welfare Case is opened and contact initiated with the victim, where it is safe to do so. Support is offered with practical housing related issues such as change of locks, target hardening, advice on removing a joint tenant/perpetrator, or advice on rehousing. There was one occasion when a report about a broken window being as a result of an altercation between Sean and Dawn, may have

[48] This may be because the case was discussed at the Mini MARAC which is held weekly by PVPU and which Adra do not attend.

led to this process being initiated. However, because the maintenance operative reported the breakage was due to wear and tear, and both Sean and Dawn's account supported this, it did not.

15.7. Children's Services

15.7.1. Gwynedd council's statutory Children's Social Care services carry out the Local Authority's duties relating to safeguarding and promoting the welfare of children. They are the statutory point of referral for any concerns about children at risk of harm.

15.7.2. Contact with Children's Services regarding Dawn and her family within the review timeframe was minimal, and information received did not trigger any active assessments, allocations, or case work. Gwynedd's Children's Service involvement predates the parameters of this review.

15.7.3. Historically there were significant concerns in relation to Dawn's ability to safeguard her children, their names having been included on the child protection register in 2007. They were also cared for a member of the extended family for periods of time as a result of her vulnerabilities. She worked hard to overcome her difficulties and to have her children in her life again.

15.7.4. In total the Children's Services IMR includes information relating to four referrals.

15.7.5. Three of the four referrals included in the chronology are slightly outside of the timeframe but have been included as they make direct reference to Dawn and her new relationship with Sean. Some of the referrals have been made as a result of concern in relation to Sean's behaviour.

15.7.6. Two of these referrals relate to his ex-partner Angharad and were made by her. One relates to a verbal argument between them, the other refers to an incident where Sean acted inappropriately in front of his ex-partner with some of his children present.

15.7.7. These referrals were appropriately shared with Children's Services by NWP as a result of Dawn and Sean's relationship and because Dawn had her own children. None of these behaviours were in relation to Dawn's care of her children and so did not lead to any direct contact with Dawn and her children.

15.7.8. The anonymous referral made to Children's Services in June 2017 also referred to Sean's behaviour; being abusive and aggressive and refers to drug use at the address. This referral did relate to Dawn and her children and a management decision was made to undertake safeguarding checks with partner agencies. These checks did not substantiate that there were safeguarding concerns and again did not lead to any direct contact with Dawn and/or her children.

16. Analysis

Following on from the summary of individual agencies responses, this section explores the thematic, multi-agency and system analysis that arises from the circumstances leading to the death of Dawn. The key lines of enquiry provide a framework for this analysis.

16.1. 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?

16.1.1. 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.

16.1.2. 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.

16.1.3. Welsh Women's Aid define coercive control as '*continuous patterns of behaviour that are intended to exert power or control over a survivor. These behaviours deprive survivors of their independence and can make them feel isolated or scared*'[49]. Controlling or coercive behaviour in an intimate or family relationship became a crime on 29th December 2015.[50]

16.1.4. 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. The charity Surviving Economic Abuse define this as *"exerting control over income, spending, bank accounts, bills and borrowing. It can also include controlling access to and use of things like transport and technology, which allow us to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs".*[51]

16.1.5. Economic abuse is now known to be a common element of domestic abuse[52] which overlaps with and is reinforced by other forms of abuse, with estimates that up to 98% of women seeking services for domestic abuse reported instances of economic abuse in their partnership[53]. The same study found that 20% of women in the general population reported experiencing some form of economic abuse.

16.1.6. 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.

16.1.7. There were several incidents suggesting to agencies the possibility of domestic abuse, including coercive control, within Dawn and Sean's relationship:

- Both were presenting with possible indicators of domestic abuse to health services.
- Police attended incidents where the DASH risk assessment was attempted.
- Sean was known to be a perpetrator through the MARAC process instigated in relation to his ex-partner.

16.1.8. 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.

16.1.9. 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.

16.1.10. The College of Policing have reviewed the use of the DASH due to its inconsistent use by frontline officers.[54] 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.

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[49] What is coercive control? : Welsh Women's Aid (welshwomensaid.org.uk). Accessed August 2023.
[50] Section 76 of the Serious Crime Act 2015.
[51] https://survivingeconomicabuse.org/what-is-economic-abuse/ Accessed August 2023.
[52] Economic abuse is now a legally recognised and defined in the Domestic Abuse Act.
[53] Sharp-Jeffs N. (2015). *A review of research and policy on financial abuse within intimate partner relationships*. London Metropolitan University.
[54] See Domestic Abuse Risk Assessment (DARA): Frequently asked questions (college.police.uk)

16.1.11. When NWP attended at the home address of Dawn to a report of a domestic disturbance in October 2020, the IMR author reflected that, based on the initial information they had that Dawn may have been the aggressor, it would not be unrealistic to have expected the officers to consider the arrest of Dawn but that there may have been some unconscious bias as the aggressor was a female and so they chose not to do so. NWP reflected that an arrest may have provided the opportunity to explore the incident further and gain a better understanding of the current state of the relationship for both parties. This consideration is, however, to be balanced with the evidence that many arrests of women in domestic violence situations likely involved women's use of self-defence and are therefore inappropriate.[55]

16.1.12. 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. The previous interactions with the couple suggest that this may not have yielded a positive result but in identifying a crime and appropriately recording it, the justification for not exploring it further is insufficient. If it was felt that a cold call to Dawn may have caused further problems between the couple, this would need to be documented. 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.

16.1.13. There may have been opportunities to talk to Dawn arising from Children's Services referrals made. Children's Services note that they would not necessarily make contact with the family if there were no concerns being expressed and the referral was not substantiated. 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.

16.1.14. 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.

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

16.2.1. Many victims do not report domestic abuse. One report states that, on average, victims experience 50 incidents of abuse before getting effective help.[56] Womens Aid, England

[55] See Downs WR, Rindels B, Atkinson C; Women's Use of Physical and Nonphysical Self-Defense Strategies During Incidents of Partner Violence; Violence Against Women. 2007;13(1)
[56] Walby, S. and Allen, J. (2004), Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office

highlight a number of reasons why women don't leave abusive relationships, which may all have been factors for Dawn:

- Danger and fear – leaving can be incredibly dangerous and the fear that women feel is very real – there is a huge rise in the likelihood of violence after separation. 41% of women killed by a male partner/former partner in England, Wales and Northern Ireland in 2018 had separated or taken steps to separate from them (Femicide Census, 2020).
- Isolation - domestic abuse often relies on isolating the victim and the perpetrator works to weaken her connections with family and friends, making it extremely difficult to seek support. Isolation leads women to become extremely dependent on their controlling partner.
- Shame, embarrassment or denial - perpetrators may be well respected or liked in their communities because they are charming and manipulative. The perpetrator often minimises, denies or blames the abuse on the victim. Victims may be ashamed or make excuses to themselves and others to cover up the abuse.
- Trauma and low confidence – victims might be told every day that they are worthless and this impacts on their self-esteem. Victims have very limited freedom to make decisions in an abusive relationship, they are often traumatised, regularly told 'you couldn't manage on your own, you need me'.
- Practical reasons - abusers often control every aspect of their victim's life – making it impossible to have a job or financial independence. By controlling access to money women are left unable to support themselves or their children.
- The support isn't there when they need it - asking for help is not easy. Misunderstandings about domestic abuse often prevents professionals from knowing what to do, how to talk about it or where to direct women disclosing abuse.[57]

16.2.2. Welsh Women's Aid also note that structural inequalities and discrimination based on sexuality, class, ethnicity, immigration status and health, can mean that some women and girls will face further barriers when seeking support due to these different intersectionality's.[58]

16.2.3. Furthermore, Stark[59] has argued that the unrelenting nature of coercive control means that women have little space for free will or action between abusive incidents and to exercise autonomy.

16.2.4. 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.

16.2.5. Amongst a range of other symptoms or conditions, NICE[60] cite indicators of possible domestic abuse as:

- symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
- suicidal tendencies or self-harming
- alcohol or other substance misuse.[61]

16.2.6. The NICE Domestic Violence and Abuse Quality Standard requires that *'Health and social care practitioners recognise indicators of possible domestic violence and abuse and respond appropriately. They should make sensitive enquiries of people presenting with*

[57] Why don't women leave? - Women's Aid (womensaid.org.uk)
[58] WWA-Response-The-public-health-approach-to-preventing-gender-based-violence-ENG.pdf
[59] Stark, E; *Coercive control: How men entrap women in personal life;* 2007; Oxford University Press.
[60] National Institute for Health and Care Excellence
[61] Adapted from NICE's guideline on domestic violence and abuse

indicators of domestic violence or abuse about experiences as part of a private discussion and in an environment in which the person feels safe'[62].

16.2.7. 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 (VAWDASV (Wales) Act 2015) where there are concerns or suspicions regarding domestic abuse'*.

16.2.8. 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 (see 14.33).

16.2.9. 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[63].

16.2.10. 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.

16.2.11. 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'*.

16.2.12. Dawn had been supported by Women's Aid regarding a previous abusive relationship, evidencing that she had some awareness of specialist support services available to her.

16.3. 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?

Training:

16.3.1. One of the key mechanisms for delivering the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 is the National Training Framework on violence against women, domestic abuse and sexual violence.

16.3.2. "Ask and Act" is one of the most significant practice changes facilitated through the National Training Framework and is a process of targeted enquiry to be practiced across the Public Service to identify violence against women, domestic abuse and sexual violence. Ask and Act training is aimed at professionals who are in jobs where violence against women, domestic abuse and sexual violence may be an issue for their client group, who are in a position to 'Ask and Act'. This includes people who assess, support/provide care or are working with someone as a result of violence and abuse.

16.3.3. The Welsh Government emphasises that it is not expected that the same process of 'Ask and Act' will be implemented in each organisation, but that each organisation should consider how best to offer 'Act and Act' within their varying functions and professional roles.

16.3.4. The agencies involved in the review shared the following information regarding relevant training undertaken.

[62] Quality statement 1: Asking about domestic violence and abuse | Domestic violence and abuse | Quality standards | NICE
[63] See for example, About Us | Findaway (wefindaway.org.uk)

BCUHB:

16.3.5. Domestic Abuse Awareness Training has been embedded within mandatory training across BCUHB for more than ten years. The Routine Enquiry Domestic Abuse Minimum Standards was developed and implemented in 2009. Following this, all clinical BCUHB staff have access to training in undertaking routine enquiry using the HITS tool and completing referrals to the MARAC.

16.3.6. GPs have safeguarding training at Level 3 and Group 3[64] of the VAWDASV training based on the VAWDASV National Training Framework (Wales).

16.3.7. Although the current VAWDASV Training compliance remains below the Health Board KPI (key performance indicator) of 85% (70.8% in June 2023), there has been an improvement since March 2022, and work is ongoing to address this throughout BCUHB. The Mental Health and Learning Disabilities Division have a VAWDASV training compliance rate above the Health Board KPI of 85%.

WAST:

16.3.8. WAST is committed to ensuring all colleagues complete appropriate VAWDASV training. VAWDASV Ask and Act Group 2[65] training is provided for all colleagues who respond to 999 calls and clinicians who undertake telephone triage. The training is delivered during induction which is outside the yearly mandatory CPD (continuing professional development) programme.

Adra Housing:

16.3.9. All frontline staff have received safeguarding training at level 1 (identifying signs of abuse) from the National Training Academy. This is mandatory to complete every two years. DAHA[66] training is provided for all Tenancy Services Officers who deal with domestic abuse cases, and Tenancy Support Officers. Neighbourhood staff in front line roles received domestic abuse training delivered by Community Housing Cymru in 2021.

Gwynedd Citizens Advice:

16.3.10. Gwynedd Citizens Advice have been trained to ask about domestic abuse in certain situations (face to face and where client is on their own). However, during the pandemic appointments were not face to face. Citizens Advice are now in the process of arranging refresher training with the intention of returning to this approach.

Gorwel

16.3.11. Gorwel provide staff with a range of domestic abuse and domestic abuse related training. Some staff will also undertake the IDVA,ISVA ,YPVA training and the level 3 QCF Tackling and preventing domestic abuse and sexual violence training.

Gwynedd Council

16.3.12. Gwynedd Council have a mandatory online domestic abuse module that has to be completed by every member of staff. Relevant council employees also complete the Ask and Act training at a level appropriate to their role.

Policies and Procedures:

[64] Group 3 training is aimed at individuals in roles which require them to do more than “Ask and Act” and those who perform a “Champion” role.
[65] Group 2 training is aimed at professionals who are likely to be in jobs where VAWDASV may be an issue for their client group, who are in a position to 'Ask and Act'.
[66] Domestic Abuse Housing Alliance

16.3.13. In the main, agencies had effective policies and procedural guidance in place and these were followed in their provision of services and responses to the subjects of the review, with some exceptions:

- Clinical enquiry was not implemented by the GP practice.
- The CMHT assessment was not fully completed as should be expected and in line with legislation.

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

16.4.1. 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, 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.

16.4.2. Due to a mistaken belief that a report that Sean had assaulted Dawn in August 2021 was a duplicate report of an incident in 2017, which had involved Sean throwing a bike at Angharad, no further action was taken and there was a missed opportunity to gather further information from the child who had witnessed the assault or from Dawn herself.

16.4.3. 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[67] 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.

16.4.4. Engagement with Sean was sometimes poor as demonstrated by missed appointments or telephone calls. The CMHT tried to contact the referrer but did not contact Sean in relation to his non-attendance. Measures are in place to ensure that contact or attempted contact with the patient following any non-attendance is made.

16.4.5. 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.

16.4.6. 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.

[67] Seena Fazel et al; *Mental disorders and intimate partner violence perpetrated by men towards women: A Swedish population-based longitudinal study*; 2019.

16.4.7. 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.

16.5. 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?

16.5.1. 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.[68] 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.[69] 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.

16.5.2. An analysis of reported 'intimate terrorism' cases by Stark revealed that some victims do self-medicate to manage the depression associated with the daily anticipation of violence and that some perpetrators control victims by increasing their dependence on substances and/or restricting their access to them.[70]

16.5.3. 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.

16.5.4. The GP practice has reflected on whether Dawn may have benefitted from being referred to a Social Prescriber[71]. However, this would have required Dawn to have engaged sufficiently with the practice to gain her consent for the referral and also her subsequent engagement with other support organisations.

16.5.5. Domestic abuse is known to be a source of trauma with research indicating that the prevalence of Post Traumatic Stress Disorder (PTSD) in victims of domestic abuse is as high as 64% compared to lifetime estimates of PTSD in general populations, which is 1% -12%.[72]

16.5.6. Women experience trauma in very different ways to men.[73] Due to a growing understanding of this, the last decade has seen a developing advocation for a gender and trauma informed response.

16.5.7. Homeless Link defines gender informed support as seeking to *"adapt and configure elements of support or parts of the service to better support women in the way that works for them, noting that their experiences are different to men".*[74]

16.5.8. Trauma-informed care has been defined as *"a strengths based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and*

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[68] 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.
[69] 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.
[70] Stark, E. (2007), *Coercive Control: How Men Entrap Women in Personal Life*. Oxford University Press.
[71] Social prescribing link workers connect people to community-based support, including activities and services that meet practical, social, and emotional needs that affect their health and wellbeing. This includes connecting people to statutory services for example housing, financial and welfare advice.
[72] Golding JM. Intimate partner violence as a risk factor for mental disorders: A meta-analysis. Journal of Family Violence. 1999;14:99–132.
[73] Why Men and Women May Respond Differently to Psychological Trauma (psychiatrictimes.com)
[74] Womens_research_March_19_1_wBWxUOB.pdf (kxcdn.com)

survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment."[75]

16.5.9. Research suggests that Dawn was at particular risk of suicide. A recent report has highlighted that *"Women who have experienced IPV [intimate partner violence] are three times more likely than women who have not experienced IPV to have made a suicide attempt in the past year"*.[76] Another report states that *"those trapped by domestic abuse can feel so hopeless that they believe the only way out is suicide"* [77].

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

16.6.1. 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.

16.6.2. 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.

16.6.3. NWP were proactive in sharing information with Children's Services when incidents occurred and allegations were made.

16.6.4. Some weaknesses in record keeping have been identified by the review:

- The GP practice did not record what Dawn's medication request was for in December 2020.
- The GP practice did not record their assessment and decision making process regarding potential risk to children arising from Sean's suicidal ideation.
- Information about why the assessment with CMHT was not completed is not recorded.
- DWP recording of concerns mentioned by Dawn are missing detail.

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

See sections 16.2 and 16.8. No additional barriers were identified by the review.

16.8. 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?

16.8.1. As a woman, Dawn was at particular risk of domestic abuse. Domestic abuse is a crime which is deeply rooted in the societal inequality between men and women. It is a form of

[75] Hopper, Bassuk, & Olivet, 2010 Shelter from the Storm TIC in homeless Service setting. The Open Health and Policy Journal , 80-100
[76] Underexamined_and_Underrported_Briefing (1).pdf
[77] Aitken, R & Munro, VE (2018) Domestic abuse and suicide. Exploring the links with Refuge's client base and work force.

gender-based violence, violence "directed against a woman because she is a woman or that affects women disproportionately." (CEDAW, 1992).

16.8.2. The World Health Organisation recognises that intimate partner abuse is a gendered crime that it is generally perpetrated by men against women and describes violence against women as a major public health problem that affects over a quarter of women aged between 15 and 49 who have been in a relationship[78].

16.8.3. As well as statistically being at risk of abuse as a woman, the social acceptance of gender-based violence may also have been present for Dawn who may have felt silenced by seeing responses or representations that were victim blaming or insensitive. Studies have highlighted that domestic abuse is accepted by many people in communities because of religious beliefs, patriarchal beliefs, past exposure to abuse, and media portrayal.[79]

16.8.4. 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[80].

16.8.5. Someone is considered disabled under the Equality Act 2010 if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities. Whilst Dawn was not registered as disabled, she did experience struggles with her mental health and these were cited as a barrier to her being able to work.

16.8.6. 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 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[81].

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

16.9.1. There were no concerns raised by agencies regarding their ability to sufficiently resource their responses in this case. However, the review has noted the following circumstance where resourcing may have impacted on the response to Sean.

16.9.2. Following the referral received by the CMHT on the 28th April 2018, Sean was offered an appointment on the 1st June which was beyond the 28-day timescale for a routine assessment. The delay was due to the demand and capacity of the service at that time. The service has reflected on this and is taking steps to reduce any future delays.

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

16.10.1. To support the police investigation and in engaging with this review, the family have shared fairly extensive knowledge of domestic abuse, including coercive and controlling behaviour and economic abuse, perpetrated against Dawn by Sean. A barrier to

[78] Violence against women (who.int)
[79] Sweeney, Kelly. (2016). Factors Contributing to the Social Acceptance of Domestic Violence: A Systematic Review.
[80] Ethnicity Spotlight Briefing_FINAL.pdf(Shared) - Adobe cloud storage
[81] 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

intervening for them appears to be that they were concerned not to make things worse for Dawn by prompting a retaliation by Sean.

16.10.2. The family shared that their approach to things was to sort them out themselves and that it was unlikely that they would report issues to the police.

16.10.3. It is usual that people who are in abusive relationships tell their families and friends before they ask for help from specialist services[82]. Families, friends and community members are, therefore, best placed to offer support and have an important role to play in helping people subjected to abuse.

16.10.4. Initiatives such as the 'Ask Me' scheme[83] and the 'Findaway' project[84] are proactively taking steps to inform and support communities to provide a positive and safe response when they 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.

16.10.5. Following significant impact of the scheme elsewhere in Wales[85], Welsh Women's Aid has received two year funding from September 2022 to roll out Ask Me in North Wales and is working closely with their member services to maximise communities' understanding by providing a two day training course on how to break the silence and raise awareness of violence against women and girls. Community members will also be equipped with the tools and confidence to respond appropriately to survivors should they choose to share their experiences.

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

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

16.11.2. A report on *Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021*[86] has looked at the relationship between domestic abuse and suicide and reported that:

"Covid has acted as an escalator and intensifier of existing abuse in individual cases. Victims have been less able to seek help or advice… vulnerable children and adults have in some cases been made more 'invisible' to services through home-schooling and homeworking. Both victims' and suspects' ability to manage mental ill-health and drug/alcohol dependencies have been reduced by the pandemic." (page 8)

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

16.11.4. Dawn attended a DWP telephone assessment on 4th March 2021, supported by her son. The timing of this appointment followed a year of lockdowns or restrictions due to Covid-19. The health provider noted in the report 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

[82] 62% of survivors told a friend or family member about the abuse before anyone else – WWIN: Who Did You Tell? Survey (2020).
[83] Ask Me project : Welsh Women's Aid (welshwomensaid.org.uk)
[84] Home | Findaway (wefindaway.org.uk)
[85] 1,006 community members spoken to, 233 survivors signposted and 7,437 community members reached via social media through the Ask Me scheme between April 2022 – February 2023.
[86] See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1013128/Domestic_homicides_and_suspected_victim_suicides_during_the_Covid-19_Pandemic_2020-2021.pdf

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.

16.11.5. 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.

16.12. Have any changes already been implemented as a result of learning identified by the review?

Any changes identified as being required by the review are in progress and/or any early learning identified by agencies has already been incorporated.

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

16.13.1. Good practice was noted during consultation with Primary Care health services. Both Dawn and Sean had their physical health routinely assessed with interventions noted.

16.13.2. The police conducting house to house enquiries (October 2020) to seek independent evidence is an example of good practice.

17. Conclusions and lessons learned

17.1. 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.

17.2. 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 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.

17.3. 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.

17.4. 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.

17.5. 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[87].

[87] 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.

17.6. 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.

17.7. 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.

17.8. 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.

17.9. 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.

17.10. 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.

17.11. 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.

17.12. 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.

18. Recommendations

18.1. Multi-agency recommendations

18.1.1. 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.

18.1.2. 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.

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

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

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

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

18.2. Single Agency Recommendations

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

BCUHB

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

18.2.2. The 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.

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

North Wales Police

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

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

18.2.6. 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

18.2.7. 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.

18.2.8. 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

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

APPENDIX A: TERMS OF REFERENCE

Gwynedd and Anglesey Community Safety Partnership

Terms of Reference for the Multi-Agency Review into the death of Dawn[88]

1. Introduction

The Terms of Reference for this Review have been written in accordance with the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[89].

Whilst conducted within the statutory framework for a Domestic Homicide Review (DHR), due to the nature of the death, this review will be referred to as a Multi-Agency Review (MAR)

The relevant Community Safety Partnership (CSP) must always conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:

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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

Whilst Dawn was not the victim of a homicide (the killing of one person by another), paragraph 18 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews states:

'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.'

Consequently, in July 2022 a Gwynedd and Anglesey Community Safety Partnership Core Group met and agreed that the criteria for a DHR had been met.

2. Purpose of a DHR

The Statutory Guidance for the Conduct of Domestic Homicide Reviews outlines the purpose of a DHR as a process to:

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

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

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

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

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

[88] Not her real name
[89] Home Office – last updated December 2016.

f) highlight good practice.

3. Principles of the Review

The Panel members commit that this review will be conducted with:

i. A lack of defensiveness and commitment to seeking the truth.

ii. A commitment to learning lessons to prevent future harm, without blame.

iii. Objectivity and independence.

iv. Transparency, whilst respecting confidential information.

v. Empathy and compassion for the victim, and those impacted by her loss, ensuring their voices are integral to the process.

vi. Consideration of equality and diversity, and intersecting disadvantage.

4. Timeframe for the Review

The Review will consider the involvement of agencies with Dawn and her partner Sean[90] from January 2017 until the date of Dawn's death as this when they were known to be in a relationship. The review will consider any other relevant information prior to this period.

5. Key Lines of Enquiry

In particular the DHR Panel (and by extension, IMR & short report authors) will be seeking answers to the following, case specific key lines of enquiry:

5.1 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?

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

5.3 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?

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

5.5 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?

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

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

5.8 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?

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

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

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

[90] Not his real name.

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

5.13 Have any changes already been implemented as a result?

5.14 Are there any particular examples of good practice to highlight?

6. Panel Membership

Panel members will consist of representatives from the following agencies:

- Community Safety Partnership
- Gorwel Domestic Abuse Service
- Welsh Women's Aid
- Gwynedd Council Children's Services
- Adult Social Services
- Gwynedd Citizens Advice
- BCHUB
- North Wales Police
- Welsh Ambulance Services NHS Trust
- Substance Misuse Service
- Adra Housing Provider
- Department for Work and Pensions

The Panel membership should remain static with consistent representation of named individuals. Any proposed changes of Panel representation should be discussed with the Chair. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

7. Disclosure & Confidentiality

Confidentiality should be maintained by all individuals and organisations involved in the Review. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.

Where a criminal investigation is running in parallel to the Review, any material received by the Panel must be disclosed to the SIO.

The subjects of the Review will be granted anonymity within the Overview Report and Executive Summary and will be referred to by a pseudonym.

Where consent to share information is not available, agencies should refer to and consider Section 10 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews and consider whether the information can be disclosed in the public interest. In this case, any information shared should be proportionate and relevant to the aim of the review to prevent future harm.

8. Family involvement

The review will seek to involve the family of the victim in the review process in ways that they are comfortable with, taking account of their needs and wishes.

Other individuals known to the subjects of the review may be invited to participate where their contribution might add intelligence and depth to the review. This could include neighbours, employers, the alleged perpetrator and their family/friends.

With their agreement, we will seek to establish communication methods that keep the family informed throughout the process.

Contact with the family and any other contributors to the review will be led by the Chair.

APPENDIX B: FURTHER INFORMATION ABOUT THE CHAIR AND AUTHOR, NICKI NORMAN

In 2020 Nicki was awarded an OBE for services to the prevention of violence against women and girls, in recognition of working for over 30 years to end domestic abuse in all its forms – through the provision and management of direct services, training and support to improve the practice of other agencies, and nationally to influence legislation, policy, practice and public attitudes. This includes 14 years' experience as Director and Acting CEO of a national domestic abuse charity, working at a senior level across government and with partner agencies to improve responses to domestic abuse.

Much of Nicki's experience has involved challenging and supporting the improvement of responses to domestic abuse. For example, in her role as expert panel member leading the Ministry of Justice review of family court responses to domestic abuse[91], or Commissioner on Barking and Dagenham Domestic Abuse Commission reviewing the borough's response to domestic abuse.

Nicki has worked as an independent consultant since 2021 and, as part of this, has led the development of the DHR Network aimed at improving the standard of DHRs by supporting professionals involved in DHRS – providing her with extensive knowledge of the DHR framework and process, and all its challenges and opportunities.

[91] Assessing Risk of Harm to Children and Parents in Private Law Children Cases (publishing.service.gov.uk)

APPENDIX C: 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