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GWYNEDD AND ANGLESEY COMMUNITY SAFETY COMMUNITY SAFETY PARTNERSHIP DOMESTIC ABUSE-RELATED DEATH REVIEW EXECUTIVE SUMMARY

Report into the death of Joan

February 2021

Independent Chair and Author of Report: James Rowlands

Associate, Standing Together Against Domestic Abuse

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Joan was a wonderful, kind, caring, loving daughter, sister, granddaughter, mother and friend.

Joan always put others first and although she lacked confidence, she always managed to overcome her difficulties rising to the challenge.

Joan will be dearly missed by everyone. Losing her has left a huge void in our lives and her presence will be dearly missed.

We would all like to remember Joan as the adventurous child that she was, the cheeky teenager, and a fabulous mother.

Pen Portrait by Joan's parents

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1. Preface

1.1 The Review Process

1.1.1 This Executive Summary outlines the process by Gwynedd and Anglesey Community Safety Partnership (CSP) to review the death of Joan,[1] who was a resident in their area and died by suicide in February 2021.

1.1.2 Early one morning on a day in February, Matthew,[2] who had previously been in a relationship with Joan, returned to her home after a night out. He found Joan dead from self-inflicted injuries. At the time of Joan's death, the children were in the property.

1.1.3 Joan and Matthew met when Joan was a teenager (around 14 or 15), with Matthew being over the age of 18 at the time, reflecting an age gap of a few years. Matthew and Joan's first child, Child A, was born in 2011. Joan and Matthew reportedly separated at some point during 2014 and 2015, although later the relationship resumed. Child B was born in 2015.

1.1.4 Joan and Matthew separated in 2019, during which time Joan made the first disclosures to agencies about domestic abuse by Matthew. After that, the nature of their relationship is unclear, but their relationship appears to have resumed at some point in 2020 (although Joan and Matthew told some agencies that this was not the case). However, Matthew had come to stay with Joan in December 2020 and was still living at the property at the point of her death.

1.1.5 The following pseudonyms have been used in this review to protect the identities of the victim, family members, other parties, and the perpetrator:

Name	Relationship to Joan
Joan	n/a
Matthew	Ex-Partner
Child A	Child
Child B	Child
Carwyn	Father of Joan
Ffion	Mother of Joan
Hazel	Maternal Grandmother

[1] Not her real name.

[2] Not his real name.

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Mari and Tomos	Paternal Grandparents
Claire	Friend

1.1.6 Joan's parents requested that she be known as 'Joan' and asked the Chair to select pseudonyms for the other people referred to in this review. The family had the opportunity to approve these pseudonyms when they reviewed the draft report.

1.1.7 The Review Panel has recommended that only the Executive Summary is published, in part because it has not been possible to engage Matthew in this review, but also because of concerns about specific case circumstances and the potential impact of publication on Child A and Child B.

1.1.8 In addition, because of concerns about the identifiability of the professionals involved, the Review Panel has also recommended that the names of the Review Panel should not be published.

1.1.9 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and should be conducted in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the statutory guidance'). The statutory guidance states that: "*Where the victim took their own life (suicide) and the circumstances give rise for concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken…Reviews are not about who is culpable*" (Para 18). Given the circumstances of Joan's death by suicide, a DHR has been commissioned but it is described as a 'Domestic Abuse-Related Death Review'.

1.1.10 This review was commissioned by the Gwynedd and Anglesey Community CSP. Having received notification from North Wales Police in March 2021, a decision was made to conduct a review following a scoping exercise with local partners. Subsequently, the Home Office was notified of the decision in writing in the same month.

1.1.11 Standing Together Against Domestic Abuse (hereafter 'Standing Together') was commissioned to provide an Independent Chair (hereafter 'the Chair') for this review in April 2021. The completed report was handed to the Gwynedd and Anglesey CSP in February 2023. In April 2023, the completed report was tabled at a meeting of CSP and signed off, before being submitted to the Home Office Quality Assurance Panel in May 2023. In November 2023, the completed report was considered by the Home Office Quality Assurance Panel. In December 2023, the Gwynedd and Anglesey Community Safety Partnership CSP received a letter from the Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the Executive Summary.

1.1.12 The review considered agencies' contact/involvement with Joan from 2009 to the end of 2018, with a focus on the period from January 2019 until the date of Joan's death.

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In addition to agency involvement, the review also examined Joan's past experiences to identify any relevant background or trail of abuse before her death, including whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.1.13 The Review Panel has considered what Matthew's status should be in the review given he has never been found guilty of any offences related to domestic abuse and Joan died by suicide. The Review Panel concluded that, based on the evidence available, it was reasonable to assume on the balance of probability that Matthew was responsible for domestic abuse towards Joan. Matthew will therefore be referred to as the (alleged) perpetrator of domestic abuse.

1.2 Contributors to the Review

1.2.1 In undertaking this review, the Review Panel struggled with the limited guidance available about how to conduct a review into a death by suicide, particularly regarding what this means for information sharing about, or engaging with, the (alleged) perpetrator of domestic abuse. The Review Panel considered making a recommendation on this issue, but has not done so, given the Home Office is currently working to reform the DHR system, including providing further guidance on suicide DHRs. However, the Review Panel has made a recommendation for the Home Office to identity emerging learning and make recommendations to develop policy, practice, and systems with respect to learning from reviews commissioned into domestic abuse-related deaths completed since 2016.

1.2.2 A total of 40 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, 5 had only limited contact and submitted a Short Report. However, 9 had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared.

1.2.3 The scoping that was conducted identified 40 agencies who had contact. The following agencies had contact with either Joan and/or Matthew. Their contributions to this review are:

Agency	Contribution
Adra (Tai) Cyfyngedig[3]	Short Report and Chronology
Isle of Anglesey County Council Children and Families Service	IMR and Chronology
School 1	IMR and Chronology
Isle of Anglesey County Council Housing	Short Report and Chronology

[3] A registered social landlord. For more information, go to: https://www.adra.co.uk/en/.

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Betsi Cadwaladr University Health Board (including primary care, community, mental health and acute hospital services) (BCUHB)	IMR and Chronology
Cafcass Cymru	Short Report and Chronology
Gorwel – IDVA service[4]	IMR and Chronology
Gwynedd Council Children's Services	IMR and Chronology
School 2	IMR and Chronology
Gwynedd Council Housing	Short Report and Chronology
Live Fear Free Helpline	IMR and Chronology
Probation Service	IMR and Chronology
North Wales Police	IMR and Chronology
English County Council Housing	Short Report and Chronology

1.2.4 Information was also sought from Domestic Abuse Safety Unit (DASU), which provides domestic abuse services across Conwy, Denbighshire, Flintshire, and Wrexham. Additionally, the Department for Work and Pensions (DWP) and the Crown Prosecution Service (CPS) provided information to help understand benefit entitlements and charging decisions respectively.

1.2.5 *Independence and Quality of IMRs*: All IMRs/Short Reports were written by authors independent of case management or delivery of the service concerned.

1.2.6 There was a delay in the early part of the review process because several agencies were unable to submit IMRs within the agreed timeframe. Nonetheless, the IMRs and Short Reports received were of good quality and enabled the Review Panel to analyse the contact with Joan and to produce the learning for this review. Where necessary, further questions were sent to agencies and appropriate responses were received.

1.2.7 In some cases, IMRs/Short Reports reported changes in practice and policies over time and made single agency recommendations of their own. The potential impact of Covid-19 on agency contacts with Joan and others has also been considered.

1.2.8 *Involvement of the Victim's Family, Friends, Work Colleagues, Neighbours and Wider Community*: Following the decision to conduct the DHR in March 2021, the Gwynedd

[4] Provides domestic abuse services in Gwynedd & Anglesey. For more information, go to: http://www.gorwel.org/eng/domestic-abuse-services-gwynedd-and-anglesey.html.

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and Anglesey CSP notified Carwyn and Ffion (the parents of Joan) in writing, in April 2021. This notification letter was sent along with the Home Office leaflet, which outlines the DHR process.[5] Thereafter, the Chair wrote to Carwyn and Ffion. It was also confirmed that the family were being supported by Advocacy After Fatal Domestic Abuse (AAFDA)[6] and contact was also established with that service. Carwyn and Ffion have been actively involved in the review, including participating in the development of the Terms of Reference, sharing a range of information, and reviewing and commenting on the report. Other family members were also involved (including Hazel, Joan's maternal grandmother, as well as Mari and Tomos, Joan's paternal grandparents). One friend, Claire, was also involved.

1.2.9 The Review Panel considered Matthew's status in the review. This included considering whether – as the (alleged) perpetrator – information should be sought and used relating to Matthew. Given the decision not to invite Matthew to participate (see 1.11 below), the Review Panel agreed that it would take a proportionate approach to information sharing. As a result, while information was collated from agencies about Matthew during the review, it has only been used where it is directly relevant to Joan's experiences (or those of the children). This necessarily means that some aspects of Matthew's experiences have not been examined.

1.3 The Review Panel Members

1.3.1 As noted in 1.4, the Review Panel members have not been named but their roles and agencies were as follows:

Agency	Job Title
Adra (Tai) Cyfyngedig	Assistant Director of Customers & Communities
BCUHB	Head of Safeguarding Children/ Deputy Named Nurse
BCUHB	Senior Manager for Safeguarding Quality and Assurance and Mental Health Services
BCUHB	Head of Nursing Central Locality Mental Health & Learning Disability Division
Cafcass Cymru	Head of Operations – North Wales
Gorwel IDVA service	Domestic Abuse Services Manager
Gorwel IDVA service	Independent Consultant

[5] This leaflet does not address reviews conducted into suicides directly.

[6] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: https://aafda.org.uk.

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Gwynedd and Anglesey Community Safety Partnership	Senior Operational Officer
Gwynedd and Anglesey Community Safety Partnership	Senior Operational Officer
Gwynedd Council Children's Services	Senior Manager for Safeguarding and Quality
Gwynedd Council Education Department	Head of Education
Gwynedd County Council Children's Services	Head of Children and Supporting Families Service
Gwynedd County Council Housing	Senior Officer – Property and Housing
Gwynedd County Council Housing	Housing Supply Manager
Isle of Anglesey County Council Children and Families Service	Service Manager (Safeguarding and Quality)
Isle of Anglesey County Council Education Department	Senior Wellbeing Manager
Isle of Anglesey County Council Housing	Neighbourhood Team Manager
Isle of Anglesey County Council Housing	Service Manager Community Housing
Live Free Helpline	Helpline Manager
North Wales Police	Senior Investigating Officer
Probation Service (North Wales)	MAPPA Co-ordinator
School 1	Head Teacher
School 2	Head Teacher

1.3.2 The Review Panel did not include a representative from an agency supporting Deaf victims and survivors.[7] Although the Terms of Reference identified Joan's hearing impairment as an issue to consider, it would have been appropriate to additionally include a specialist service representative. This is recorded here as a reminder to ensure that specialist service representation is tailored to the case being reviewed.

1.3.3 The Review Panel did not include a representative from Public Health and/or with a role in suicide prevention.[8] At the point the review commenced, the post of Regional Coordinator for Suicide and Self Harm Prevention was vacant. As a result, it was agreed that links to this agenda would be facilitated via existing Review Panel members, including from BCUHB. Later, when a postholder was available,

[7] This was noted as an issue in the feedback from the Home Office Quality Assurance Panel.

[8] This was noted as an issue in the feedback from the Home Office Quality Assurance Panel.

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appropriate connections were made, leading to a Review Panel Recommendation (see Recommendation 5).

1.3.4 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.3.5 The Review Panel met a total of five times, with the first meeting of the Review Panel on the 7th June 2021. There were subsequent meetings on the 19th November 2021, the 13th January 2022 (arranged to discuss delayed IMRs, as noted in Section 1.3 above), the 13th April 2022 and the 16th June 2022. Thereafter, the report was circulated twice electronically, with final sign off in January and February 2023.

1.3.6 The Chair wishes to thank everyone who contributed their time, patience, and cooperation to this review.

1.4 Chair of the Review and Author of the Overview Report

1.4.1 The Chair and author of this review is James Rowlands, an Associate of Standing Together. James is a qualified Social Worker and Independent Domestic Violence Advisor (IDVA) and has worked in a variety of frontline and strategic roles in the domestic abuse sector since 2004. James has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 17 previous DHRs.

1.4.2 *Independence:* James has no connection with Gwynedd and Anglesey, the CSP or any of the agencies involved in this case.

1.5 Terms of Reference for the Review

1.5.1 This review aims to identify the learning from this case, and for action to be taken in response to that learning with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2 The Review Panel was comprised of agencies from Gwynedd and Anglesey, as the victim and perpetrator had lived in both counties. Agencies were contacted as soon as possible after the review was established to inform them of the review, invite their participation and request them to secure their records.

1.5.3 Additionally, it was established that Joan had contact with agencies in an English county and therefore agencies in that area were contacted for information and involved remotely in the review.

1.5.4 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time to be reviewed would be from 2009 to the end of 2018, with a focus on the period from January 2019 until the date of Joan's death. This timeframe was chosen because it included the most significant periods of agency contact with Joan and Matthew.

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1.5.5 *Key Lines of Inquiry*: The Review Panel considered both the generic issues as set out in the statutory guidance and identified the following as key lines of enquiry:

- The communication, procedures and discussions, which took place within and between agencies;
- The co-operation between different agencies involved with victim and/or perp [and wider family];
- The opportunity for agencies to identify and assess domestic abuse risk;
- Agency responses to any identification of domestic abuse issues;
- Organisations' access to specialist domestic abuse agencies;
- The policies, procedures and training available to the agencies involved in domestic abuse issues;
- Any evidence of help-seeking, as well as considering what might have helped or hindered access to help and support; and
- The impact of the COVID-19 pandemic.

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2. Summary of Chronology

2.1.1 The focus of this review has been on Joan's experiences and her contact with services, in part because of the decision not to involve Matthew. This review has determined that, aside from more routine matters, including relating to pregnancy, Joan had significant contact with services in two periods. The first period, in 2019, came about following disclosures of domestic abuse. The second, in the latter part of 2020 and in early 2021, was largely related to Matthew.

2.1.2 The period of contact in 2019 related to disclosures of domestic abuse made by Joan for the first time, during which she separated from Matthew. Joan initially contacted the Live Fear Free Helpline, which provided timely and effective advice and support, and this then led to her contact with North Wales Police. Ultimately, this contact led to an investigation into allegations against Matthew, but the case against him did not proceed after Joan withdrew her support. [In a report completed by the CPS to review the decision-making in this case, it was confirmed that prosecutorial decision making appropriately applied CPS policy in respect of this decision, including advice with respect to further lines of enquiry during the investigation and after Joan had withdrawn her statement].

2.1.3 North Wales Police also had some contact in 2020 which is discussed below. A feature of some of these contacts was that domestic CID16s were not always completed.

2.1.4 Gorwel's IDVA service also became involved in this period, with an initially good relationship being established with Joan. However, while the IDVA service appears to have provided a wide range of support, it has been identified that there were several issues in their response, ranging from inconsistent case recording, risk assessments, and Individual Safety and Support Plans, as well as case closure. Arrangements for staff supervision were also inconsistent. One consequence of these issues was that Gorwel's support for Joan ended abruptly, and this was then not reviewed until 2020, with this discussed below.

2.1.5 This period of contact also led to the involvement of the Isle of Anglesey County Council Children and Families Service, as well as – as part of Private Law proceedings – Cafcass Cymru.

2.1.6 The Isle of Anglesey County Council Children and Families Service undertook an assessment following Joan's disclosures. The assessment itself was appropriately conducted, with Joan and two children being spoken with separately, as well as Matthew. However, in the assessment undue weight was placed on Joan's separation from Matthew. As a result, there was therefore limited consideration about the impact on Joan's ability to protect herself (including sustaining her decision to separate from Matthew) and/or the safety and wellbeing of the children in the context of the risk of post-separation abuse.

2.1.7 This period of contact also triggered a single MARAC meeting. There has been learning about the extent to which the MARAC itself adequately captures a record of

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risks and needs, but the review also identified that the Isle of Anglesey County Council Children and Families Service relied on the MARAC meeting alone as a means of risk management and no inter-agency support plan was developed to help coordinate or provide support to the family.

2.1.8 Cafcass Cymru became involved following a private law application made by Matthew and – following direct contact with Joan, Matthew, and the children – made reports to the court, with a focus on risk, safeguarding, contact arrangements, the wishes and feelings of the children and the impact of their situation. In these reports, Cafcass Cymru considered previous behaviour by Matthew, including allegations of domestic abuse, as well as family functioning. Matthew and Joan were separated during Cafcass Cymru's involvement. At the time the report was filed, safe contact arrangements were in place and agreed by both parents and reported to be working well by parents and the children. Both parties subsequently agreed to the final order that the court made. This was a consent order. While there is the possibility that Joan felt coerced it is not possible to know this. The learning in this case for Cafcass Cymru relates to a suggestion in the Child Impact Analysis where there was a reference to a referral to the (WT4C) course. WT4C is not intended for parents where domestic abuse is a feature of the case, it is questionable that a referral for this course was made.

2.1.9 While Joan had a range of contact with services in 2019, ultimately, by the end of the year she was no longer being directly supported by any agency. Joan and Matthew separated in 2019, during which time Joan made the first disclosures to agencies about domestic abuse by Matthew. After that, the nature of their relationship is unclear, but their relationship appears to have resumed at some point in 2020 (although Joan and Matthew told some agencies that this was not the case).

2.1.10 In early 2020, there was brief contact with Joan. The first was the Isle of Anglesey County Council Children and Families Service. This contact was triggered by a police referral where police shared information after a non-actionable report. In this contact, the emphasis was on reinforcing the message to Joan that she should not reconcile with Matthew, rather than examining the context of the incident that had been reported or her disclosures, including about coercive control. Additionally, in April 2020, Gorwel – to which she had remained open, although she had not been contacted since autumn 2019 – attempted to contact Joan. After three unsuccessful calls were made, Joan's case was closed and no alternative ways to reach out to Joan were attempted, nor were other services informed.

2.1.11 In late 2020 and early 2021, there was significant contact with Joan. However, this was primarily related to Matthew. This is discussed below. Significantly, however, this means that possible concerns about Joan's experiences of domestic abuse were not identified.

2.1.12 Beyond historical contact with Joan concerning Child A and Child B through maternity and then health visiting services, BCUHB's involvement was primarily triggered at the

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start of January 2021. This was following mental health concerns about Matthew after he presented at an Emergency Department. A notable weakness in the BCUHB's response was a lack of professional curiosity. In addition to not fully considering Matthew's behaviour, including the possibility of domestic abuse and the relevance to this of other issues (like concerns around alleged substance use), this related also to Child A and Child B (including when and how to share safeguarding concerns) and Joan (with a focus on her ability to support Matthew, rather than consideration of historical and the potential for current domestic abuse). As a result, there has been significant learning for BCUHB.

2.1.13 The Probation Service were also involved in this period, with their contact with Matthew related to a driving offence. Initially there was a good awareness of the history of domestic abuse that Matthew was alleged to have perpetrated. However, despite this awareness, and assessing Joan as being at medium risk from Matthew, no specific actions were taken with regards to Joan's safety. While the Probation Service's remit is Matthew, and the time from the sentence to Joan's death was only two months – meaning assessment and the gathering of information was in its infancy – the Probation Service could have taken steps to assure itself that other agencies were aware of Joan. Like BCUHB, the Probation Service did not fully share the information known to the service, including about Matthew's alleged substance use.

2.1.14 Gwynedd Council Children's Services involvement came about at the end of 2020 and into 2021. This was triggered by a referral from Isle of Anglesey County Council Children and Families Service, which itself had been the result of concerns identified by the Probation Service. This led to an assessment, including home visits and contact with Joan, Matthew, and the children. These visits were well conducted and thoughtful, although they were constrained by the absence of information sharing by BCUHB and the Probation Service as noted above. Nonetheless, the assessment identified that the relationship had resumed and, although Joan and Matthew said otherwise, Matthew was spending most of his time at the property. Importantly, in this assessment, although Joan did not make any disclosures, the difference between what had been disclosed historically and the possibility of disguised compliance if Matthew was controlling and coercive was identified. Ultimately, the assessment recommended a care and assessment plan. While this had not been put in place by the time Joan died, by supporting Joan, this plan might have enabled disclosures, including about domestic abuse if this was happening.

2.1.15 More broadly housing providers and schools had contact in this case:

- In terms of housing, a range of different services were involved at different times, including Gwynedd County Council Housing, Isle of Anglesey County Council Housing, an English County Council Housing Options Team, as well as Adra (Tai) Cyfyngedig. Consistent with agency contact more broadly, this contact was primarily triggered in 2019 when Joan separated from Matthew and because of her concerns about her safety in the home she shared with Child A and B. There were

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examples of good practice in this contact, with for example, consideration of emergency accommodation, but also enquiries about domestic abuse. However, cumulatively, Joan's experiences of these contacts with services may have been overwhelming and confusing, and she may have felt hopeless if it seemed that it was not possible to secure the outcome she most wanted, such as to move away. As a result, in addition to learning for individual housing providers, a key finding is that the learning from this review may invite an opportunity to look at how to ensure responses to domestic abuse are as robust as possible. One model that is recommended is Domestic Abuse Housing Alliance (DAHA) accreditation.

- Finally, the children's schools – School 1 and School 2 – were involved in this period. School 1's involvement was relatively short – spanning July 2019 to September 2020 – and, from March 2020, this was challenging because of Covid-19 restrictions. Later in 2020, the children transferred to School 2. While the transfer arrangements between the schools were appropriate, there has been learning for school 1 about the process for targeted enquiries in cases where domestic violence could still be a threat, including with respect of bail conditions. For School 2, attempts to secure support from Gwynedd Council Education Department were not successful, meaning there has been learning about ensuring Welfare Officers can be more flexible in terms of visits to family if a school has a concern.

2.1.16 Taken together, the review identified issues including, the challenge of responding to domestic abuse over time, particularly given reports of domestic abuse in 2019, but this not being disclosed (and in some cases, considered) in 2020.

2.1.17 A further issue was the extent to which Joan's hearing impairment may have affected her experiences, including of contact with agencies. There is limited evidence that Joan's hearing impairment was explicitly considered or identified by agencies. This may have been exacerbated by Covid-19 because of mandates around the wearing of face masks. However, there was also evidence of good practice demonstrated by agencies during the pandemic (including, for example, Gwynedd Council Children's Services prioritising home visits and attempts by School 2 to secure a visit from the Welfare officer).

2.1.18 Finally, in relation to Welsh being Joan's first language, in accessing local services (for example, Gorwel and the local authority), Joan appears to have been able to access services provided in Welsh. In a predominately Welsh-speaking area the availability and accessibility of services in a person's first language should not be underestimated.

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3. Conclusions and Lessons to be Learnt

3.1 Domestic Violence and Abuse

3.1.1 Considering information from agencies, as well as family, on the balance of probabilities, it appears more likely than not that Joan had historically experienced sustained and extensive domestic abuse from the (alleged) perpetrator, Matthew.

3.1.2 Tragically, it will never be possible to know the full extent of Joan's experiences. In part, this was because it was probably difficult for Joan to disclose what was happening to her. Accounts from her family and friends suggest that Matthew had been abusive throughout their relationship. While her family and friends had concerns, the impact of Matthew's behaviour might have meant that Joan did not feel able to talk, for the most part, about what was happening to her. As a result, much of what can be said about the first 10 years or so of their relationship is speculative.

3.1.3 However, Joan did make several significant disclosures in 2019, not just to family and friends, but also to agencies. Linked to these disclosures, Joan was also briefly able to separate from Matthew. Based on these disclosures, it is possible to say with more confidence, the types of behaviour used by Matthew.

3.1.4 After October 2019, Joan had very little contact with agencies. Her contact with her family and friends was also limited. It appears likely that this was potentially due to the ongoing presence of Matthew in her life. At some point, although Joan and Matthew said it had not, the relationship appears to have begun again or, at the very least, Matthew was routinely at the family home.

3.1.5 The Review Panel is reluctant to describe this as Joan and Matthew having 'reconciled' considering what has been disclosed about Matthew's alleged behaviour. However, at the same time, over several meetings with the social worker from Gwynedd Council Children's Services, Joan indicated that she was "*seeing how things go*" and said that Matthew had changed, albeit she was cautious about this. Linked to this, neither Matthew nor Joan disclosed Matthew's ongoing cocaine use, with Joan saying that this was in the past and, in part, attributing his previous behaviour to this. While Matthew clearly had a motive for not disclosing his use of cocaine, Joan's decision not to disclose was likely more conflicted and may have, for example, included feeling she could not (safely) disclose this information.

3.1.6 Yet, it is possible that Joan did not feel she had a choice but to resume the relationship with Matthew. This possibility is suggested by the ambivalence and concerns Joan expressed about Matthew to Isle of Anglesey County Council Children and Families Service in February 2020. The difficulty of being clear about the relationship between Joan and Matthew could be an example of the challenges that victims of domestic abuse may face in their own lives, as well as the issues that this raises for professionals in trying to understand someone's circumstances and lived experience.

3.1.7 It is also of note that, when asked about domestic abuse in early 2021, Joan denied this. As a result, it is not clear whether Matthew was being abusive at the time of

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Joan's death. However, given the likely history of domestic abuse, it may be that this had continued. If this was the case, as with her previous experiences, Joan may have found it difficult to disclose what was happening to her. Given this, and Matthew's reported criminal history, it is possible that other measures could also have been considered by agencies, including whether a Domestic Violence Disclosure Scheme (DVDS) application would have been appropriate.[9,10] Notably, in discussing this point, Joan's family explained that "*neither [they] nor Joan were aware of the option of Clare's law or what it was*". It was agreed to ensure this was identified explicitly as learning and addressed in Review Panel Recommendation 10.

3.1.8 These issues, including agency responses, are discussed further below. However, in summary, at a minimum it appears Joan experienced the following throughout the relationship with Matthew:

- *Physical abuse:* Including reports by Joan of being hit, having things thrown at her, as well as being strangled. Family have reported seeing Joan with injuries.
- *Coercion, threats, and intimidation:* Family and the friend of Joan have described coercive behaviour, including how difficult it could be to see Joan alone. There were reports by Joan that she could not leave Matthew and was fearful of him and other third parties known to him.

3.1.9 When Joan did separate from Matthew, he was arrested for threats to kill and later there were reports that he breached bail and of stalking. There were reports by Joan that she could not leave Matthew and was fearful of him and other third parties known to him, both familial and through connections from his alleged criminal activity.

3.1.10 When Matthew returned to live with Joan at the end of 2020 and in early 2021, Joan said she was not experiencing domestic abuse, but a social worker identified that, if she was being coerced, she might not feel able to make a disclosure.

- *Emotional abuse and isolation:* Reports by Joan that she felt isolated. Family and friends have reported that their relationship with Joan was affected, either seeing her less often or having to be careful what they said because she was reluctant to talk about her experiences.
- *Children and pregnancy:* Joan was concerned about what might happen to the children, including reporting that she felt pressurised into child contact and that this was being used to threaten her. Joan's family wanted it recorded that they felt Joan's experience of contact would have been a source of considerable anxiety and concern.

[9] For more information, go to: https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet.

[10] This was noted as an issue in the feedback from the Home Office Quality Assurance Panel, which suggested that a DVDS should have been considered. Subsequently, it was agreed to ensure this was identified explicitly as learning and addressed in Review Panel Recommendation 10.

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Reports that the children witnessed assaults on Joan. Reports also of allegations being made by Matthew and his family with respect to the care of the children.

- *Economic abuse:* Reports that Matthew would take money from Joan and reports that Matthew had access to, and used, Joan's bank account. Joan's family wanted it recorded that they felt this constituted financial abuse.

3.1.11 There were also numerous examples of technology-facilitated abuse identified, with these being both reported by Joan and recounted by her family.[11] Notably, in discussing this point, Joan's family explained that neither they nor Joan were "*signposted to any support services (local and regional) who could assist with technology facilitated abuse"*. Moreover, the family said that they felt that "*professionals involved had limited understanding of the impact of technology facilitated abuse and provided contradicting information on what actions could be taken with evidence provide*". There is an increasing awareness of the potential impact of technology-facilitated domestic abuse.[12] In light of this learning, family feedback, and increased awareness, it is important that agencies identify and consider the potential for, and risks posed by, technology-facilitated domestic abuse. This is included as an area for further training in Review Panel Recommendation 10 below.

3.1.12 The Review Panel felt it useful to highlight several key issues:

3.1.13 First, the early stages of the relationship (beginning when Joan was 14/15 and with Matthew was over age of 18),[13] then the rapid development of the relationship (including Joan becoming pregnant with their first child), and then later its possible resumption: This is significant given the evidence that in domestically abusive relationships, normal romantic expectations and activities can be accelerated. Related to this are issues like possessiveness and an impact on relationships with others like family.[14]

3.1.14 Second, the evidence of extensive coercive and controlling behaviour: The range of coercive control either reported by Joan, or those who knew her, was extensive. Importantly, coercive control can be effective regardless of physical abuse.[15]

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[11] This was noted as an issue in the feedback from the Home Office Quality Assurance Panel, which suggested that technology-facilitated abuse should be considered further. Subsequently, it was agreed to ensure this was identified explicitly as learning and addressed in Review Panel Recommendation 10.

[12] Afrouz, R. (2021) 'The Nature, Patterns and Consequences of Technology-Facilitated Domestic Abuse: A Scoping Review', *Trauma, Violence, & Abuse*, doi: 10.1177/15248380211046752.

[13] This was noted as an issue in the feedback from the Home Office Quality Assurance Panel, which suggested that this should be considered further. The Review Panel did consider this issue, noting the significance of the early and long relationship and its impact on Joan, but did not feel it was proportionate to explore this specifically, choosing to focus instead on the period from 2019 onward.

[14] Monckton Smith, J. (2020) 'Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide', *Violence Against Women*, 26(11), pp. 1267–1285.

[15] Crossman, K. A., Hardesty, J. L. and Raffaelli, M. (2016) "He Could Scare Me Without Laying a Hand on Me": Mothers' Experiences of Nonviolent Coercive Control During Marriage and After Separation', *Violence Against Women*, 22(4), pp. 454–473.

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3.1.15 Third, a lack of focus on Joan as a possible victim, both in the context of parenting Child A and B but also concerning Matthew's mental health needs: As will be discussed in the analysis of agency contact, the substantive contact with Joan and Matthew at the end of 2020 and in early 2021 was focused on either the children and/or Matthew. As a result, and particularly considering the long length of their relationship and the impact of coercive and controlling behaviour, this could have led Joan to feel trapped.

3.1.16 Fourth, the absence of interventions with Matthew as an alleged perpetrator: It is notable that there were few opportunities to intervene with Matthew including, most notably, a disconnect between concerns around his substance use during agency contact with him in early 2021. This too may have meant that Joan felt trapped, with little or no opportunity for agencies to intervene.

3.1.17 A final element of this tragic case is that Joan died by suicide: There is no evidence to indicate that any agency was aware of specific concerns about Joan's well-being in respect of suicidal ideation. In addition, while specific mental health issues had been explored previously (for example, after Joan had given birth to Child B), it was not identified or disclosed as an issue in any of the more recent contact with Joan (in particular, during the assessment by Gwynedd Council Children Services). It is not possible to say with any certainty what the connection between Joan's experience of domestic abuse and her death are. Nonetheless, there is good evidence in research of a connection between domestic abuse and suicide, albeit the pathways between these issues are less clear.[16]

3.2 Conclusions

3.2.1 Joan was a much-loved daughter and mother. Joan's death was a tragedy, and the Review Panel extends its sympathy to her family and those who knew her.

3.2.2 The Review Panel has sought to try and understand Joan's lived experiences and consider the issues she faced to try and understand the circumstances of her death by suicide and identify relevant learning. It is not possible to say how Joan's relationship and experience of abuse affected her death, but nonetheless it is likely that these provided an important background to her decision to die by suicide. In particular, the fact that Matthew appears to have returned to the family home, and the prior reports made by Joan and/or concerns by others about a long history of domestic abuse, may have meant Joan felt isolated and had a sense that she had few options left.

3.2.3 Complicating this review is the fact that Matthew, the (alleged) perpetrator, has never been found guilty of any offences relating to domestic abuse and Joan died by

[16] Bates, L., Hoeger, K., Stoneman, M.-J., & Whitaker, A. (2021). *Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021*. London: Home Office. Available at: https://www.gov.uk/government/publications/domestic-homicides-and-suspected-victim-suicides-during-the-pandemic (Accessed 1 June 2022).

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suicide. With respect to this, the Review Panel has operated on the assumption that it was more likely than not that Matthew was responsible for domestic abuse towards Joan. He has therefore been referred to as the (alleged) perpetrator of domestic abuse.

3.2.4 Nonetheless, there has been significant learning identified during this review in relation to how agencies identified and managed Joan's potential risk and needs, and how they worked together. While it is not possible to say if an improved response could have averted Joan's death, it is vital that the appropriate agencies and partnerships consider this learning to develop and enhance their responses. This is summarised below.

3.3 Key Themes and Learning Identified

3.3.1 The learning in this case has both been particular to individual agencies but also cuts across agencies and the wider local partnership.

3.3.2 The specific learning for individual agencies has been described in detail and has included issues relating to policy and procedure, as well as the response of staff in specific circumstances, both internally and concerning multi-agency working.

3.3.3 The broad issues identified cut across agencies and relate to several areas:

3.3.4 First, the understanding and response to domestic abuse. Joan was in contact with several services in 2019, and there was a good response to her disclosures, but there has nonetheless been learning in this case. This included the importance of recognising the cumulative impact of domestic abuse over time, including, for example, the early and then rapid development of the relationship and then reports of extensive coercive and controlling behaviour.

3.3.5 An issue remains that Joan had likely experienced a long-term abusive relationship with Matthew, making disclosures about this in 2019. Yet, in 2021, when asked about domestic abuse, Joan denied this, and her focus was on the potential of her future relationship with Matthew as well as what she reported as his changed behaviour. As a result, a key aspect of learning is recognising the challenges that agencies and professionals can face in understanding someone's circumstances and lived experience, as well as balancing any concerns they may have with someone's right to make their own choices.

3.3.6 No agency was aware of specific concerns about Joan's well-being in respect of suicidal ideation at the point she died. It is also not possible to say with any certainty what the connection between Joan's experience of domestic abuse and her death are. Nonetheless, there is good evidence in research of a connection between domestic abuse and suicide, albeit the pathways between these issues are less clear. Thus, the review has considered the links between domestic abuse and suicidality to promote learning opportunities more broadly.

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3.3.7 Second, the robustness of practice and policy in several different agencies. This has included, for example, policy and practice around domestic abuse (most notably for BCUHB). This was also linked to a lack of focus on Joan as a possible victim, both in the context of parenting Child A and B but also concerning Matthew's mental health needs

3.3.8 Third, the effectiveness of multi-agency working, particularly with respect of information sharing. This was most relevant in terms of contact with Joan and Matthew in 2020/2021, when interventions with Matthew did not consider previous allegations of domestic abuse and Joan's safety. Additionally, other issues – including information sharing about his substance misuse – affected the assessment of his potential risk. More broadly, this also links to the recognition of the overlap between the risks and needs of adults and safeguarding children, and the importance of following the local practice guidance, 'Supporting Children, Supporting Parents with severe mental health problems and or substance misuse issues'.

3.3.9 In addition to single agency learning and recommendations, a range of Review Panel recommendations have been made to address issues relating to:

3.3.10 Aspects of the review process, including with respect to the management of this review specifically, but also how information is shared between the family court and reviews conducted under the statutory guidance for DHRs.

- Awareness raising about the links between domestic abuse and its impact on mental health, including suicidality. Additionally, work to improve professional and agency understanding of, and response to, domestic abuse and its impact on mental health and suicidality.
- The developing of housing responses to domestic abuse, as well as improvements to the local MARAC process, and consideration of the needs of service users who are deaf or who have a hearing impairment.

3.3.11 Finally, in Wales, the VAWDASV Training Framework provides a structure through which learning from this review can be taken forward locally.

3.3.12 In addition to this range of learning, good practice has also been identified. For example, in response to specific issues, individual agencies provided timely and appropriate support to Joan. This included the Live Fear Free helpline and North Wales Police, who worked well together to respond to Joan when she first made a disclosure. Furthermore, Gorwel's IDVA support service were useful source of support initially, despite the learning identified for Gorwel overall. Finally, Gwynedd Council Children's Services intervention was thoughtful and timely and, although tragically Joan died before the work it recommended could commence, could have provided an important and supportive intervention.

3.3.13 Following the conclusion of this review, and in response to the learning and recommendations, there is an opportunity for agencies to consider the local response to domestic abuse. This is relevant to agencies both individually and collectively. The Review Panel hopes that this work will be underpinned by a recognition that the

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response to domestic abuse is a shared responsibility as it is everybody's business to make the future safer for others.

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4. Recommendations

4.1 Single Agency Recommendations (Identified by Individual Agencies)

4.1.1 The following single agency recommendations were made by the agencies in their IMRs.

4.1.2 These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to the Gwynedd and Anglesey CSP.

BCUHB

4.1.3 Recommendation 1: To embed safeguarding supervision in the Mental Health Learning Disability Division and provide audit of compliance on a 6 monthly basis.

4.1.4 Recommendation 2: To continue the implementation of Routine Enquiry Domestic Abuse in the Mental Health and Learning Disability Division and to audit the implementation within 6 months.

4.1.5 Recommendation 3: To communicate/share information when a service user is known to be open to other agencies.

4.1.6 Recommendation 4: The Mental Health and Learning Disability Division to conduct an annual audit of clinical files for patients who have children, evidencing compliance with the Supporting Children, Supporting Parents: A North Wales Multi-Agency Protocol. Parents with severe mental health problems and/or substance misuse: A framework for safeguarding children.

Gorwel's IDVA service

4.1.7 Recommendation 1: Grwp Cynefin's Business Development Team to undertake an audit of the management processes in both the IDVA and Children and Young People's Team in Gorwel.

Scope of the audit to include:

- Case Recordings within 24 hours.
- Completion and reviews of risk and needs assessments.
- Completion and reviews of ISSP.
- Supervision in line with policy.
- Case reviews in line with policy.

4.1.8 Recommendation 2: Manager for Domestic Abuse Services to dip sample case reviews quarterly for quality assurance purposes to confirm that risk assessments are being reviewed in line with policy (every 6-8 weeks, after any new incident and prior to case closure) and review is documented in monthly case meeting with team leader.

4.1.9 Recommendation 3: Manager for Domestic Abuse Services to dip sample case reviews quarterly for quality assurance purposes to confirm that Individual Safety and

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Support Plans are being reviewed in line with policy (every 8 weeks) and review is documented in monthly case meetings with team leader.

4.1.10 Recommendation 4: A monitoring system to be implemented that will enable the Manager to monitor the supervision of staff.

Isle of Anglesey County Council Children and Families Service

4.1.11 Recommendation 1: An internal audit of children's files where domestic violence and abuse is a feature to establish if the issues identified within this review are endemic within the practice.

4.1.12 Recommendation 2: An internal audit of children's case files where care & support is provided and whether care & support meetings/plans run in tandem with assessment processes or await the outcome of assessments before interventions are planned.

Isle of Anglesey County Council Housing

4.1.13 Recommendation 1: To review the pathway for existing tenants fleeing domestic abuse and requiring a property transfer, in order that a fleeing victim can become active on the housing register immediately.

4.1.14 Recommendation 2: Utilise the commissioned Social Work Consultant to provide professional mentoring to Housing Officers, including domestic abuse peer groups to allow continuous reflection and ideas on how to further enhance the protection and support available to victims.

4.1.15 Recommendation 3: Work with partner agencies to explore various tools and enhanced target hardening measures available to landlords (including environmental) to support victims who are tenants to remain in their own homes if they wish to do so.

4.1.16 Recommendation 4: Inquisitive approaches to be undertaken by all officers when dealing with the public to ensure avenues such as domestic abuse can be assessed at its earliest opportunity. Where concerns are more apparent, commence the Ask and Act protocol, when it's safe to do so with potential domestic abuse victims.

4.1.17 Recommendation 5: Include information on the 'Live Fear Free' Helpline in the bi-annual Housing Services newsletters to all tenants across Anglesey.

4.1.18 Recommendation 6: Undertake an internal 'lessons learnt' session to support ongoing continuous improvement.

North Wales Police

4.1.19 Recommendation 1: For North Wales Police to review their current processes in high risk Domestic Abuse Investigations, to ensure the timely sharing of risk related information (such as breaches of bail or retraction of complaints) throughout the investigation with relevant partner agencies.

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Probation Service

4.1.20 Recommendation 1: Discussions with Probation Practitioners during supervision of the need to make contact with IDVA and Police Domestic Abuse Officers when supervising an individual where there are domestic abuse concerns, in cases where there is no supervisory element to the order, i.e., Community Payback.

School 1

4.1.21 Recommendation 1: Ensure that key staff at school are familiar with how to make targeted enquiries in known cases where domestic violence could still be a threat.

School 2

4.1.22 Recommendation 1 (discharged by Gwynedd Council Education Department): Gwynedd Council Education Department to ensure flexibility in the Welfare Officers' Intervention Flow Chart to allow Welfare Officers to follow emergency steps in light of the school's concerns about families with a history of Domestic Violence.

4.2 Review Panel Recommendations (Developed by the Review Panel)

4.2.1 The Review Panel has made the following recommendations during this review in response to learning identified.

4.2.2 The Gwynedd and Anglesey CSP is responsible for overseeing the development and monitoring of an action plan.

4.2.3 **Recommendation 1:** The Gwynedd and Anglesey CSP to satisfy itself that the children of Joan (as well as their kinship carers) are offered support in relation to the publication of the DHR.

4.2.4 **Recommendation 2:** After publication of this DHR, the Gwynedd and Anglesey CSP to ensure that this report is attached to the children's social care records. This is so that, if they wish to read the DHR when they are older, it will be available to them.

4.2.5 **Recommendation 3:** The Home Office to work with the Ministry of Justice and the Family Division of the High Court to agree on a process/guidance concerning the sharing of information from the Family Court in DHRs.

4.2.6 **Recommendation 4:** The Gwynedd and Anglesey CSP to use the learning from this DHR to raise awareness of the links between domestic abuse and its impact on mental health, including suicidality.

4.2.7 **Recommendation 5**: The Gwynedd and Anglesey CSP work with the Regional Coordinator for Suicide and Self Harm Prevention to develop a work plan relating to improved professional and agency understanding of, and response to, domestic abuse and its impact on mental health and suicidality.

4.2.8 **Recommendation 6:** The Home Office to commission a study into the findings from reviews into domestic abuse-related deaths completed since 2016 to identity emerging learning and make recommendations to develop policy, practice, and systems.

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4.2.9 **Recommendation 7:** The Gwynedd and Anglesey CSP to facilitate a coordinated approach with the housing providers identified in this DHR – Isle of Anglesey County Council Housing, Gwynedd County Council Housing, the English County Council, and Adra – to develop a business case to secure DAHA accreditation. Each individual housing provider to be responsible for progressing accreditation.

4.2.10 **Recommendation 8:** The Regional MARAC Steering Group to revise the current format of the MARAC action minutes to record the risks and needs identified.

4.2.11 **Recommendation 9:** Local agencies to review accessibility for service users who are deaf or who have a hearing impairment.

4.2.12 **Recommendation 10:** The Gwynedd and Anglesey CSP to work with the Regional VAWDASV Training Sub Group to consider the learning from this review and ensure relevant matters are built into local training as part of the implementation of the National Training Framework and Ask and Act.

Key priorities to include:

- Coercive and controlling behaviour
- Technology-facilitated abuse
- Focus on victim experience, including addressing concerns about adults where these might relate to the safeguarding of children
- Awareness of self the links between domestic abuse and its impact on mental health, including suicidality (linked to Review Panel 5)
- The availability of measures like DVDS or Domestic Violence Protection Notices (DVPNs)/Domestic Violence Protection Order (DVPOs),[17] as well as the understanding of bail conditions and their enforcement.

[17] Bail with conditions and protective measures like DVPOs (or Domestic Violence Protection Notices, DVPNs) can be used simultaneously to build up greater protection for the victim). For more information, go to: https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010.

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