BRIDGEND COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

REPORT INTO THE DEATH OF ANNA IN JUNE 2022

EXECUTIVE SUMMARY

Report produced by Rhian Bowen-Davies
Independent Chair and Author

August 2024

A note to Anna's Family

Anna was a mum, a daughter, a sister and a friend who will be missed by all those who knew and loved her.

The Panel offers its sincere condolences to you all and wishes to acknowledge the contributions that you have made to the Review which have enabled us to really understand Anna as a person and how she lived her life. Your accounts of the months leading up to Anna's death have provided the Panel with a unique insight.

The Panel recognises the indescribable gap that Anna's death has left and how this loss continues to be felt in your day to day lives.

This review aims to offer a detailed and balanced account of events leading to her death and identify opportunities for learning.

The Panel also offer their condolences to you as a family on the death of Anna's mum, who sadly passed away before this review was completed.

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SECTION ONE – CONTEXT FOR THE DOMESTIC HOMICIDE REVIEW

1. Introduction

1.1 This domestic homicide review examines agency responses and support given to Anna, a resident of Bridgend, prior to her death in June 2022. In the absence of the Coroner's verdict, the working hypothesis of the Panel is that Anna took her own life.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse prior to Anna's death, what support was available and whether there were any barriers in her being able to access support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. The Home Office Statutory Guidance[1] allows for reviews to be undertaken where a victim took their own life and the circumstances give rise to concern, even if a suspect is not charged with an offence or they are tried and acquitted.

1.4 In order for lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened and most importantly, what needs to change in order to reduce the risk of such deaths happening again.

1.5 It was agreed with the family to use pseudonyms throughout the report and they were asked whether they had any preference for the names to be used. In the absence of any suggestions the family were happy for the Chair to anonymise the report and decide on the pseudonyms to be used.

1.6 Whilst recognising that there are no criminal justice outcomes in respect of Anna's ex-partner, Simon, and his behaviours towards her, it is the panel's view that he was, on the balance of probabilities, the perpetrator of abuse against her and is therefore referred as such throughout the review.

2. Circumstances of the Review

2.1 Anna died in June 2022 aged 38 years old, having been struck by a train in Bridgend County Borough.

2.2 Anna had been in a relationship with Simon for approximately 19 months and it is understood that their relationship had ended approximately 9 weeks prior to her death.

[1] Home Office Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Review para 18 https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

2.3 Anna and Simon had a child together, Danny, who was 7 months old at the time of her death.

2.4 Anna had two older children who both lived at home at the time of their mother's death; her son Ben aged 20 years and her daughter Cara, 16 years old.

2.5 At the beginning of June 2022, approximately 9 weeks after the relationship had ended, Anna met with Simon and went to a house party in a nearby town. Anna's children and family were unaware that she was meeting with Simon that day.

2.6 Anna's mother was looking after Danny and was expecting her home that evening, but she did not return. The following day Cara rang Anna and Simon could be heard during the call. Ben rang South Wales Police concerned for his mother but whilst on the phone to the police he was informed by Cara that Anna had returned home.

2.7 On her return home Anna was described by her mother and Cara as being distressed, tired and having been drinking. Her mum noticed that she had a black eye and when she asked what had happened Anna told her that it was the result of an incident between her and the owner of the house where the party had been held.

2.8 Anna told her mother that she and Simon had argued and he had *kicked her out of his car* and that she had walked approximately 3 miles home. Anna did not have her mobile phone with her and it was believed that Simon had taken it.

2.9 Anna went to bed and Anna's mum put Danny to lie with her whilst she went into the garden. On returning to the house, she noticed that Danny was lying on the sofa and Anna had left the house.

2.10 Within 15 minutes of South Wales Police receiving the call from Anna's son reporting the concerns for his mum, they received a further call from a member of the public at the train station reporting that Anna had accessed the railway line and that she was saying that she was going to kill herself. It was recorded that she was very distressed and had said that she *was done, can't live like this anymore*.

2.11 CCTV shows Anna stepping onto the tracks, standing facing away from the train and looking over her shoulder towards the oncoming train before she is struck causing fatal injuries.

2.12 Simon was arrested later that day on suspicion of common assault based on the injury to Anna's eye that her mother had seen. He was released without charge the following day.

2.13 After Anna's death, handwritten notes were found in her home by family members detailing her relationship with Simon, his behaviours towards her and how these made her feel. A note was also found saying *I'm sorry I love you all. Can't do this anymore.*

2.14 In the absence of the Coroner's verdict the working hypothesis of the Panel is that Anna took her own life.

2.15 South Wales Police notified the Chair of Bridgend Community Safety Partnership of the circumstances of Anna's death in the middle of June 2022.

2.16 Agencies were requested to secure their files on 14th July 2022.

2.17 The Home Office was notified of the decision to undertake a DHR on the 13th July 2022.

2.18 On the 9th November 2022, representatives of the following agencies met to ratify the decision to undertaken a DHR and to receive preliminary information reports from agencies; South Wales Police, Cwm Taf Morgannwg University Health Board, Bridgend County Borough Council, Valleys to Coast Housing, Assia (Domestic Abuse Service), British Transport Police and Bridgend Community Safety Partnership.

2.19 Rhian Bowen-Davies was appointed as the Independent Chair and Author in January 2023 and the Review Panel met for the first time in February 2023.

2.20 The Overview Report, Executive Summary and Action Plan was presented to Bridgend Community Safety Partnership in September 2024.

3. Terms of Reference

3.1 Terms of Reference were discussed by the Panel at their first meeting in February 2023 and amendments agreed. The draft Terms of Reference was shared with family members during meetings in February 2023. No amendments were requested and the Terms of Reference were finalised in July 2023.

3.2 A copy of the Terms of Reference is included below in italics for reference. To avoid duplication, the circumstances of the review and timeline for decision making outlined in Section 2 and confidentiality statements in Section 3 above have not been included.

Purpose of the Review

The purpose of a DHR is to:

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

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

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

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

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

f) highlight good practice.

Principles

The review will be conducted in line with the following principles;

i) An inquisitive, diligent and thorough effort to learn from the past to make the future safer
ii) With honesty and humility
iii) With professional curiosity and an open mind – going beyond focusing on conduct of individuals and whether procedure was followed to evaluate whether policy / procedure was sound.
iv) The review will be situated in the home, family, workplace and community of Anna, with the narrative articulating life through her eyes; enabling the reviewers to understand her reality
v) Understanding the context and environment in which professionals made decisions and took (or did not take) actions e.g. organisational culture, training, supervision and leadership
vi) The status of family and friends as integral to the review
vii) A willingness to learn and to place this learning in the "here and now".

Objectives of the Review

- *To better understand the life, relationships and context for the death of Anna*
- *To examine patterns of abuse and coercive and controlling behaviours experienced by Anna*
- *To examine the actions/responses of relevant agencies, services and professionals to Anna, Simon and children within the agreed timeline*
- *To ensure that Anna's family, friends and wider support networks are given the opportunity to make a meaningful and effective contribution to this review and are offered and provided with appropriate specialist support to enable them to be an integral part of the process*

- *To produce a chronology and initial summary which will seek to identify any actions already taken or changes implemented.*
- *To consider relevant research and lessons learnt from previous DHR's where there are similar characteristics*
- *To consider potential gaps in service provision, alongside potential barriers to accessing services*
- *To produce a comprehensive, honest and balanced analysis of circumstances to inform organisational / agency learning and influence change.*

Key lines of enquiry

- *Identify and examine patterns of abuse and coercive and controlling behaviours experienced by Anna*
- *Identify which agencies/organisations had involvement with Anna, Simon and the children within the timeline of the review and examine the appropriateness/effectiveness of responses provided*
- *Review the extent to which agencies/professionals worked together when responding to the needs and circumstances of the subjects of this review and the effectiveness of these responses*
- *Determine whether decisions and actions in this case comply with legislation and national guidance and how these may have changed since the period in question; ensuring that learning is considered in the "here and now"*
- *Consider Anna's sex as a factor throughout the review*
- *Consider whether, and to what extent, mental health and substance use contributed to the circumstances of this case*
- *Examine whether, and to what extent Anna's previous experience of services influenced her decisions in terms of disclosures and engagement*
- *Examine how agencies respond to cases where bi-directional violence is a factor; the tools used to support decision making and pathways to support*
- *Examine existing approaches to identifying risk indicators of suicide including experiences of domestic abuse, first 12 months post birth of a child and other suicides in family*
- *Review existing pathways to and support available to families and communities following suicide*
- *Examine the impact of Covid 19 on an individual's ability to access information and support and agency's ability to provide services*

Membership of the Review Panel

It is the responsibility of the Panel to provide rigorous oversight and challenge to the information that is presented and to make an honest, diligent and thorough effort to learn from the past.
The following representatives have been agreed as Members of the Review Panel

Raeanna Grainger	*Interim Group Manager for Safeguarding, Bridgend CBC*
Bryan Heard	*Statutory Review Manager, South Wales Police*

Anna Taylor	*Housing Service Manager, Valleys to Coast*
Mark Lewis	*Group Manager, Family Support, Bridgend CBC*
Wendi Briggs	*Manager, Assia Domestic Abuse Service*
Kirsty Williams	*Manager, Bridgend Community Safety Partnership*
Nicola Jones	*Senior Nurse Multi Agency Safeguarding Hub Cwm Taf Morgannwg University Health Board (CTMUHB)*
Lucy Holifield	*Safeguarding Nurse, Health Visiting, CTMUHB*
Daisy Wilcox	*Perinatal Response and Management Service, CTMUHB*
Fiona Cox	*Engagement and Low Intensity Team Leader , BAROD, Substance Use Service*
Emma Jones	*Managing Director, Include*
Ceri Fowler	*Regional Suicide and Self-harm Prevention Coordinator*
Deborah Evans	*Cwm Taf Morgannwg Violence against Women, Domestic Abuse and Sexual Violence Regional Adviser*
Rhian Bowen Davies	*Independent Author and Chair*

Nichola Summerill from the Cwm Taf Morgannwg Safeguarding Board's Business Unit will provide co-ordination support to the Panel.

The membership has been agreed to ensure that relevant expertise in relation to the particular circumstances of this case is represented. Should further expert advice be required it is agreed that this will be sought, as appropriate, by the Chair.

Requests for Individual Management Reviews

Individual Management Reviews (IMRs) will be requested from the following organisations;

- *South Wales Police*
- *Bridgend County Council (Children's Services, Education and Family Support)*
- *Assia Domestic Abuse Service*
- *Cwm Taf Morgannwg University Health Board (all contacts including Mental Health Services, Primary and Secondary Care, Health Visiting)*
- *BAROD Substance Misuse Service*
- *Valleys to Coast Housing*

The IMRs will be completed in accordance with Home Office Guidance and the expectations of the Chair.

If, during the course of the review the Panel identify individuals / organisations outside of those listed above who should be contacted, it will be for the Panel to agree who is best placed to make this contact on their behalf.

Scope of the Review

The review will consider events and agency involvement with Anna between July 2020 and her death in June 2022. This timeline covers the period that Anna was in a relationship with Simon.

If deemed necessary, information outside of this timeline may be requested from relevant organisation.

Parallel Reviews

At the time of drafting the Terms of Reference no date has been set for the Coroner's Inquest.

Timescale, Report Author and Final Report

- *It is our intention that this Review takes no longer than 6 months to complete from February 2023, the date of the first meeting of the Review Panel.*
- *The DHR will be chaired by Rhian Bowen-Davies who will also be the Report Author.*
- *The Report produced will be an honest, open and comprehensive analysis of circumstances to inform learning and influence change.*
- *In accordance with Home Office guidance, any recommendations for improvement will be outcome focussed and SMART.*
- *The Review Panel will consider and agree any learning points to be incorporated into the final report and action plan. Where actions or learning points requiring immediate implementation are identified these will be highlighted to the CSP Chair and shared without delay, prior to Home Office approval of the Report.*
- *The Cwm Taf Morgannwg Safeguarding Board Business Unit will send the final report and action plan, on behalf of the Chair of the CSP, to relevant agencies for final comment before sign-off and submission to Home Office.*
- *The Cwm Taf Morgannwg Safeguarding Board Business Unit will provide a copy of the overview report, executive summary and action plan to the senior manager of each participating agency following Home Office approval, on behalf of the Chair of the CSP.*
- *The Chair of Bridgend Community Safety Partnership, in agreement with the Review Chair will send a copy of the final report to all relevant forums in order to share learning and, where appropriate shape priorities and programmes of work.*
- *The Cwm Taf Morgannwg Safeguarding Board Business Unit will publish an electronic copy of the overview report and executive summary on the Safeguarding Board website and arrange for a copy to be published on the local CSP web page.*
- *Subject to the recommendations of the Panel, Bridgend Community Safety Partnership may hold a learning event.*
- *Bridgend Community Safety Partnership will monitor implementation of the Action Plan in accordance with the guidance.*

Legal advice and costs

Each statutory agency should inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

Should the Independent Chair, Chair of Bridgend Community Safety Partnership or the Review Panel require legal advice then Bridgend CSP will be the first point of contact.

Media and communication

The Chair of Bridgend Community Safety Partnership will be responsible for making all public comment and responses to media interest concerning the review until the process is completed. On completion of the review a discussion will be held between the Chair of the CSP and Chair of the review in response to media requests on a case by case basis. This will be supported by the Cwm Taf Morgannwg Safeguarding Board Business Unit Engagement and Communications Officer.

Revision of the Terms of Reference

The Terms of Reference may need to be revised and agreed by the Review Panel as the DHR progresses and for this purpose they can be considered at subsequent Panel meetings to ensure continued relevance.

4. Review Panel

4.1 In accordance with statutory guidance, a Review Panel was established. It is the responsibility of the Panel to provide rigorous oversight and challenge to the information that is presented and to make an honest, diligent and thorough effort to learn from the past.

4.2 Membership of the Panel was agreed to ensure that appropriate and relevant expertise in relation to the particular circumstances of this case was represented. It was also agreed that should further expert advice be required during the review that this would be sought, as appropriate, by the Chair.

4.3 Panel membership included agencies with specialist knowledge and expertise relevant to this case including substance use, suicide and self-harm prevention and perinatal mental health.

4.4 All members of the Panel were independent of the case itself and did not hold direct line management responsibilities for practitioners involved in the case.

4.5 Members of the Review Panel are listed in the Terms of Reference above (page 9).

4.6 The Review Panel met on 4 occasions in February, July and October 2023 and June 2024 before the draft report, executive summary and action plan was presented to the Bridgend Community Safety Partnership.

5. Contributors to the Review

5.1 The Chair and Panel sought to maximise the contributions of all relevant agencies throughout the review. Contributions were sought through requests for Individual Management Reviews (IMR) and chronologies.

5.2 Individual Management Reviews are a crucial first step to establishing an understanding of timescales, the course of events and responses of agencies.

5.3 Each organisation was asked to provide details for a Single Point of Contact for the purpose of the DHR.

5.4 A written briefing and template for responses were provided to all organisations asked to complete an IMR. These documents were based on Appendix Two within the Home Office Guidance document.

5.5 The Chair outlined her expectations for the completion of IMRs in the first meeting of the Panel in accordance with the aims within the statutory guidance, in that IMRs should;

a) allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standards

b) identify how and when those changes or improvements will be brought about.

c) identify examples of good practice within agencies.

5.6 In accordance with Home Office Guidance the Chair stated her expectations in relation to the authors being independent of the individuals subject to the review and their families, not having line management of the case and that IMRs would be quality assured by sufficiently senior managers. Both of these elements were required to be signed off in the IMR return.

5.7 The Chair also requested reference to source documents within the IMRs to enable her and the Panel to rigorously scrutinise the information provided, seek clarification and challenge where appropriate.

5.8 The Chair facilitated an IMR briefing event for authors and Panel members in April 2023 and there was an offer of support from the Chair to all organisations asked to submit an IMR.

5.9 The following IMRs, as listed in the Terms of Reference were initially requested;

- South Wales Police
- Bridgend County Council (Children's Services, Education and Family Support)
- Assia Domestic Abuse Service
- Cwm Taf Morgannwg University Health Board (all contacts including Mental Health Services, Primary and Secondary Care, Health Visiting)
- BAROD Substance Misuse Service
- Valleys to Coast Housing

5.10 As information was submitted to the review, additional organisations outside of those originally considered were identified. Information was requested and received from;

- Whole System Approach (Women's Diversionary Service) delivered by Include;
- Comprehensive School attended by Cara, Anna's daughter;
- Education Engagement Service, Bridgend County Borough Council;
- Adferiad, Substance Use Service in Bridgend until 31st March 2022.

6. Appointment of an Independent Chair /Author

6.1 The Home Office Guidance requires the Community Safety Partnership or the Review Panel to;

appoint an independent chair of the panel who is responsible for managing and coordinating the review process and for producing the final overview report based on evidence the review panel decides is relevant.

6.2 Rhian Bowen-Davies was approached by the Business Manager of Cwm Taf Morgannwg Safeguarding Board in December 2022 and asked to submit an expression of interest. She was commissioned to undertake the review in January 2023.

6.3 Rhian has a strong combination of practice, leadership and policy-based experience in the field of violence against women, domestic abuse and sexual violence. In 2015, she was appointed Wales's first National Adviser for tackling Violence against Women, Domestic Abuse and Sexual Violence. Prior to this she held senior management roles within the specialist domestic abuse sector and earlier in her career was an Independent Domestic Violence Adviser and Police Officer.

6.4 Rhian has no connection with any of the organisations represented on the Panel or the Bridgend Community Safety Partnership. Whilst Rhian was employed as a police officer with South Wales Police between 2001 and 2008

this is over 15 years ago and it was not deemed to influence her independence to undertake this review.

6.5 She has completed both the Home Office and Advocacy After Fatal Domestic Abuse (AAFDA) DHR Chair's training. She is also a member of the Domestic Homicide Review Chair's Network facilitated by AAFDA.

SECTION TWO - CHRONOLOGY

1.1 The Terms of Reference set out the scope of the review from July 2020 to the date of Anna's death in June 2022. This scope takes account of the duration of time that Anna was in a relationship with Simon but allowed agencies to submit information that fell outside of this scope if deemed relevant and appropriate. This information is included in the chronology provided in the Overview Report as it provides relevant context that has been considered as part of the review.

1.2 The chronology included in the overview report is extensive in volume and complexity and amounts to nearly 30 pages. For these reasons, the chronology has not been included in this Executive Summary document.

SECTION THREE - LEARNING AND CONCLUSIONS

1.1 It is the Panel's view that Anna experienced a continuous and sustained level of abuse, coercion and control from Simon including physical, emotional and sexual abuse. From her handwritten note and the accounts given to professionals in the months leading up to her death it is apparent that she knew she was in an abusive relationship and recognised the impact it was having on her life.

1.2 Anna was very aware of how she used alcohol. She recognised the negative consequences in respect of her behaviours and proactively sought help on numerous occasions to address her mental health, alcohol use and the domestic abuse she experienced. Her efforts, however, were not always responded to in a timely way which left her frustrated, waiting for services and having to re-refer. The lack of connectivity within and between services on occasions, as identified in this Review, was not equal to her needs.

1.3 The Panel do wish to acknowledge however, the response of mental health services including Perinatal Mental Health and the Crisis and Home Treatment teams who worked together effectively to respond to Anna's needs, in particular at the point of crisis and escalation.

1.4 The review highlights examples of good practice relating to information sharing in particular within mental health services and between some services. However, as detailed elsewhere in this report, the information sharing practice of some agencies meant that not everyone was sighted on all relevant information or had an opportunity to be part of multi-agency discussions. More effective inter agency working may have provided practitioners with scope for more meaningful and targeted responses, and the review has considered practical measures that can be taken to improve information sharing practices between agencies.

1.5 There were occasions within the scope of the review when Anna spoke with practitioners about her relationship with Simon and disclosed abusive behaviours that she had experienced. It is the Panel's view that Anna regarded these practitioners as trusted individuals and felt safe speaking to them despite being aware of potential consequences of her disclosures. These occasions presented opportunities for the practitioners to explore Anna's disclosures and to effectively assess the risk to her. The Panel considered whether it was a lack of knowledge or confidence on the part of the practitioners which resulted in Anna being referred onwards for a risk assessment, rather than this being done by the practitioner that Anna had chosen to share this information with. In practice these onward referrals resulted in delays and lost opportunities to assess risk, and potentially also resulted in Anna withdrawing her trust, losing confidence in services and managing things herself for fear of consequences for her children or her

family. These missed opportunities highlight the importance of all practitioners feeling able and confident to provide a proactive, timely and appropriate response to disclosures.

1.6 The Panel recognise how fear appears to be a constant factor in this Review; Anna's fear of Simon as described by her children and wider family, her fear of consequences of service involvement and her fear for her family as a result of Simon's threats towards them. The Panel also recognise how fear may also have been a factor in Cara's behaviours particularly in relation to her concern of leaving her mum at home with Simon which resulted in her not feeling able to attend school. Cara's fear of agency involvement and possible consequences for her mum, herself and her sibling may also have contributed to her attempting to manage the situation in her own way by keeping agencies at a distance and minimising/not wishing to speak to anyone about what was happening at home. There is a need for agencies to fully grasp that these behaviours are typical and predictable responses in situations of domestic abuse and to embed this understanding in their actions and responses.

1.7 Cara's account of experiencing abuse within her family home and the steps she took to protect her mum are a stark reminder to the Panel of how young people experience domestic abuse and the importance of their voices being heard and responded to. It also makes the case for the resourcing of equitable and consistent availability of specialist support services for young people.

1.8 The review has identified that there are no resources/approaches being applied by agencies in Bridgend to inform professional judgement in respect of who is causing harm within a relationship, thus enabling services to identify the most vulnerable person and appropriate pathways for support. This is a gap in existing practice that has been identified in another review and evidences a need for agencies to collectively agree an approach, ensuring that relevant practitioners have the necessary knowledge and a shared understanding which results in a coordinated and consistent response to those causing harm.

1.9 The review has highlighted an inconsistency in respect of the extent to which agencies hold perpetrators to account for their behaviours.

1.10 The Panel welcome the changes implemented by agencies since Anna's death to improve practice and policy. There is a need to embed these changes at a strategic and operational level to promote a culture of continuous learning and improvement in order to be able to proactively respond to the range and complexity of the needs presented in cases such as Anna's.

1.11 The Panel acknowledge that Anna's death brought an incomprehensible grief and despair to her family who were bereaved once again by suicide. The Panel notes the intention of Welsh Government to reduce the number and rates of suicide deaths in Wales by establishing a pathway to support for people who self-harm or who are suicidal and to improve support for those

bereaved by suicide. The Panel recognises however, that the success of these national intentions depends on translating strategic intent into effective implementation at the frontline, operational level, and ultimately improved outcomes for individuals including timely, accessible and effective support.

1.12 It is the Panel's view that Anna was most at risk when all of the factors – mental health, alcohol and her experience of abuse – were prominent and present at the same time, as was the situation at the time of her death. It appears to the Panel that the immersion back into spending time with Simon, a time that she thought she had left behind was a trigger which exacerbated her anxiety, her sense of hopelessness and despair and feeling trapped in the re-emergence of patterns of behaviour.

1.13 Anna's vulnerabilities were significantly exacerbated by, and inextricably linked with her experiences of abuse and together they presented a combination of factors that grew in intensity and complexity which, ultimately, led to her taking her own life.

SECTION FOUR – RECOMMENDATIONS

The recommendations listed below are those included in individual agency IMRs and agreed with the Panel.

Single Agency Recommendations

South Wales Police

- Establish a system to effectively quality assure and scrutinise all Domestic Violence Disclosure Scheme applications
- Training of police resources to appropriately share information through Operation Encompass report systems

Cwm Taf Morgannwg University Health Board

Primary Care

- Monitor compliance of the following practices with evidence of measures made to address areas of poor compliance to be reported to the CTMUHB Safeguarding Board;
  - Midwifery and Health Visiting recording standards
  - Routine Enquiry
  - Level Three Safeguarding and Violence against Women, Domestic Abuse and Sexual Violence training within Primary Care
  - Use of information sharing communication tool within Primary Care settings
- Develop 7 minute briefing which identifies learning from this review and share with all relevant practitioners
- Embed consistent, Health board wide, IT case management system

Mental Health Services

- Develop a 7-minute briefing for all Mental Health staff highlighting the learning from this review
- Importance of detailed case recordings including rationale for decision making to be communicated to staff and monitored through supervision
- WARRN[2] (all Wales risk formulation tool) to be embedded as routine practice across CTMUHB mental health services
- Provide access to FACE for the MASH coordinator to ensure that all relevant PPNs can be shared with PNMHS
- Promote awareness of the perinatal mental health duty line to professionals and the public

[2] https://orca.cardiff.ac.uk/id/eprint/125368/

- Establish links between mental health services and the Domestic Abuse liaison role within the Health Board
- Embed DASH RIC as standard practice within PNMHS to be monitored through supervision
- Monitor compliance of the following practices with evidence of measures made to address areas of poor compliance to be reported to the Quality, Safety and Risk meeting of the Safeguarding Group
    - Level Three Safeguarding and Violence against Women, Domestic Abuse and Sexual Violence training

Bridgend CBC Children's Services

- To ensure that learning from this DHR is disseminated to inform practice specifically the learning related to intersectionality of vulnerabilities, accountability of abusive parent, children's lived experiences, multi-agency working and information sharing
- Promote an understanding of and increased application of professional curiosity and challenge
- Ensure an effective and robust supervision framework
- Establish an effective monitoring mechanism for the quality assurance of child protection plans
- Establish a mechanism which ensures most up to date agency information brought to conferences/core groups
- Provide frontline practitioners with information and resources to improve knowledge, understanding and confidence in respect of completion of Domestic Abuse Stalking and Honour based Abuse Risk Indicator Checklist

Barod

- Increase the knowledge and awareness of staff as it relates to domestic abuse, risk assessments, information sharing and the links between domestic abuse, mental health, suicidal ideation and substance use
- Embed DASH RIC as standard practice within Barod to be monitored through case reviews and supervision
- Evaluate the effectiveness and impact of the domestic abuse roles

Include

- Review organisational approach to risk assessment in respect of new mothers to ensure that identification and appropriate consideration being given to risk factors including post-natal depression, domestic abuse, mental health and substance use
- Develop a seven-minute briefing to be shared with all staff highlighting the learning from this review including the importance of case recordings and case reviews, follow up actions to calls/text messages and establishing contact with all relevant agencies
- Work with South Wales Police to establish a mechanism which will allow relevant and appropriate information to be shared in respect of individuals

receiving support from WSA including notifications of PPNs and key events/activities

Valleys to Coast

- Develop and implement a workforce development plan for Domestic Abuse and Sexual Violence (including increased awareness, links between domestic abuse, suicidal ideation, substance use and mental health, risk assessment, referral pathways, safeguarding)
- Work towards the Domestic Abuse Housing Alliance (DAHA) Accreditation[3], **the UK benchmark for how housing providers should respond to domestic abuse in the UK**
- **Undertake a peer review of Domestic Abuse Policy**
- **Review existing MARAC guidance to ensure robust safeguards in place in the absence of MARAC leads**
- **Introduce a standard procedure whereby Housing Officers are automatically notified when there are any requests for repairs or lock changes**

Commissioners of support services in Bridgend CBC

- To proactively monitor the transfer of comprehensive client information when services are transferring from one provider to another

Partnership Recommendations

Cwm Taf Morgannwg Suicide and Self-Harm Prevention Strategy Group

- Ensure widespread suicide prevention training to organisations and communities in Cwm Taf Morgannwg to increase suicide prevention awareness and competence, confidence and ability to undertake safety planning.
- Increase the knowledge and awareness of practitioners of the links between domestic abuse and suicidality and the associated risk factors.
- Families and other parties to receive information re postvention support in a timely and supported manner
- Establish a mechanism whereby all agencies working with an individual are notified in a timely manner of a death by suicide and provided with resources to access support

Cwm Taf Morgannwg Safeguarding Board and the Violence against Women, Domestic Abuse and Sexual Violence Board

- Review the consistency and sustainability of existing multi agency arrangements for safeguarding high-risk victims of domestic abuse operating across the region

[3] https://www.dahalliance.org.uk/membership-accreditation/what-is-daha-accreditation/

- Facilitate the implementation of a resource/assessment framework that can be used by practitioners to support decisions in relation to who is vulnerable and who is causing harm within a relationship
- Evaluate the effectiveness of Operation Encompass in the region
- Facilitate the development and implementation of an information sharing protocol between South Wales Police and Housing providers in respect of incidents of domestic abuse
- Promote accessible resources and information for family and friends worried about an individual's safety
- Identify sustainable funding options from relevant authorities[4] and wider partners to embed the following as core, equitable provision across the region
    (1) system wide approaches/ interventions to reduce harm caused by perpetrators of domestic abuse as core
    (2) Services for children and young people experiencing domestic abuse
- Provide frontline practitioners with information and resources to improve knowledge, understanding and confidence in respect of;

    a) Domestic Violence Disclosure Scheme 'Clare's Law'
    b) Completion of Domestic Abuse Stalking and Honour based Abuse Risk Indicator Checklist
    c) Identifying and responding to Non-Fatal Strangulation
    d) Responding to counter allegations

National Recommendations

<u>Welsh Government</u>

- IRIS to be mandated across all GP practices in Wales and resourced by Welsh Government in line with its commitments to early intervention and prevention in the National Violence against Women Domestic Abuse and Sexual Violence Strategy

<u>Royal College of General Practitioners (Wales)</u>

- Promote and include links to VAWDASV /Ask and Act training on its learning platform
- Promote resources that support GP learning in respect of links between domestic abuse, mental health, substance use and suicidality

<u>Home Office</u>

- Develop statutory guidance to support implementation of Operation Encompass
- NPCC and Home Office to ensure consistency of DVDS application forms across all Police Forces

[4] As defined by the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015

- Undertake a national review of MARAC effectiveness and sustainability
- Provide a statutory framework for MARAC including statutory guidance