BRIDGEND COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

REPORT INTO THE DEATH OF ANNA IN JUNE 2022

Report produced by Rhian Bowen-Davies
Independent Chair and Author

June 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. The pseudonyms used in this report are:

Simon	Anna's ex-partner and father of Child 3
Child 3	Anna and Simon's son, aged 7 months at the time of Anna's death
Child 2	Anna's child aged 16 years at the time of Anna's death
Child 1	Anna's child, aged 20 years at the time of her death
Emma	Anna's sister
Freddie	Anna's brother

[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

Gail	Freddie's partner and Anna's sister-in-law
Hannah	Anna's mother
Ian	Anna's brother

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.

2.3 Anna and Simon had a child together (Child 3), who was 7 months old at the time of her death.

2.4 Anna had two older children - Child 1, 20 years old and Child 2,16 years old - who both lived at home at the time of their mother's death.

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 the baby and was expecting her home that evening, but she did not return. The following day Child 2 rang Anna and Simon could be heard during the call. Child 1 rang South Wales Police concerned for their mother but whilst on the phone to the police was informed by Child 2 that Anna had returned home.

2.7 On her return home Anna was described by her mother and Child 2 as being distressed, tired and having been drinking. Anna's 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 the baby to lie with her whilst she went into the garden. On returning to the house, she noticed that the baby was lying on the sofa and Anna had left the house.

2.10 Within 15 minutes of South Wales Police receiving the call from Child 1 reporting concern for their 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. Confidentiality and Dissemination of the Report

3.1 All information discussed at Domestic Homicide Review Panels is *strictly confidential* and must not be disclosed to third parties without discussion and agreement with the Community Safety Partnership (CSP) / DHR Panel Chair. The disclosure of information outside these meetings (beyond that which is agreed) would be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

3.2 Appropriate confidentiality agreements were signed by all Panel Members and individuals participating in the review.

3.3 All documentation was marked CONFIDENTIAL DRAFT- NOT TO BE DISCLOSED WITHOUT THE CONSENT OF BRIDGEND COMMUNITY SAFETY PARTNERSHIP.

3.4 All agencies were asked to adhere to their Data Protection procedures including the security of electronic data.

3.5 The Panel considered the Overview Report and Executive Summary in line with the requirements of the Home Office Guidance at a meeting in June 2024 and, following agreement, provided a copy of these documents and the Action Plan to Bridgend Community Safety Partnership for scrutiny and sign off at a meeting in September 2024.

3.6 Until it was approved by the Home Office Quality Assurance Panel the report was a final draft and remained confidential.

3.7 At the point of the draft report's completion the only people with whom it was shared were members of the Panel and the family members engaged with the review.

3.8 The draft report, as agreed by the Panel will also be shared with the Coroner for South Wales (Central) to inform the inquest into Anna's death. It is the Panel's view that waiting for quality assurance from the Home Office would result in unnecessary further delay to the Inquest. The draft report will be shared with the Coroner on the understanding that it is draft and confidential and not to be made public in the inquest proceedings.

3.9 On receiving clearance from the Home Office Quality Assurance Panel this report, alongside the Executive Summary and the Action Plan will be shared with participating agencies as final documents.

3.10 The documents will also be shared with the Cwm Taf Morgannwg Safeguarding Board, the regional Violence against Women, Domestic Abuse and Sexual Violence Board, the Police and Crime Commissioner for South

Wales, the Domestic Abuse Commissioner for England and Wales and the Wales Safeguarding Repository[2].

3.11 It was agreed by members of Anna's family and the Panel that the Overview Report, Executive Summary and the Action Plan would be published on the Community Safety Partnership website.

3.12 Panel representatives unanimously agreed that any learning and recommendations identified during the Review would be actioned prior to the report being submitted to the Home Office Quality Assurance Panel.

4. Terms of Reference

4.1 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.

4.2 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 local 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

[22] https://www.gov.wales/single-unified-safeguarding-review-guidance#116873

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 DHRs 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.

5. Methodology

5.1 The Chair contacted members of Anna's family in January 2023, details of which are included in Section 6 below.

5.2 In March 2023, the Chair wrote to Anna's previous employer, but no response was received.

5.3 In July 2023, following discussions with Anna's family and the Panel, the Chair wrote to Simon offering him an opportunity to participate in the review. The letter outlined the purpose of the review, explained the terminology used in the context of the review and offered him the opportunity to participate. No response was received from Simon.

5.4 Requests for Individual Management Reviews (IMRs) and chronologies were made to agencies listed in paragraphs 8.9 and 8.10 below following the first Panel meeting in February 2023. The chronologies were then collated into one overarching chronology, details of which are provided in Section 3.

5.7 Panel members had the opportunity to scrutinise all the information submitted at meetings in July and October 2023 where collectively, challenges and requests for further information / clarification were made and learning, good practice and recommendations identified.

5.8 In addition to the family members detailed in Section 7 the Chair conducted meetings with the following individuals as part of the review;

- Fatality Investigator, British Transport Police
- Social Worker who undertook the Care and Support Assessment with Anna's family in 2022
- Headteacher of the Comprehensive School attended by one of Anna's children

5.9 The Chair, who is also the author, prepared the draft report, which was discussed and agreed by Panel members at a meeting in July 2024.

5.14 Family members were contacted in July 2024 and offered the opportunity to read the draft report and provide feedback. Family members were provided with a copy of the draft report in August 2024 and were then offered opportunities to meet with the chair in September 2024.

5.15 The draft overview report, executive summary and action plan was presented to the Bridgend Community Safety Partnership at a meeting in September 2024.

6. Involvement of Family and Friends

6.1 At the first meeting of the Panel in February 2023, the Chair outlined her expectations that Anna's family and friends would be an integral part of this review and given equal status to the agencies who were participating. This is reflected in the objectives as outlined in the Terms of Reference.

6.2 It is the Chair and Panel's view that Anna's family and friends knew her best and were best placed to help the Panel understand her as a person and provide an insight into how she lived her life.

6.3 In January 2023, the Chair wrote to Anna's mother, her brother Freddie, sister Emma and eldest child, with information relating to the Review and the offer to participate.

This letter:

- Offered the Chair's condolences;
- Explained the DHR process;
- Offered the opportunity to participate in the review through various methods (in writing, via a recording, telephone conversation or a meeting with the Chair / Panel members);
- Outlined the timeline for the review;
- Explained that the review would produce a final report and executive summary;
- Provided information in relation to specialist advocacy service Advocacy After Fatal Domestic Abuse (AAFDA)[3] with an offer to refer;
- Included the Home Office information leaflet and a link to the statutory guidance;
- Outlined the scope of the review and an opportunity to comment /feedback on the initial terms of reference;
- Provided contact details for the Chair with an invitation to contact directly.

[3] https://aafda.org.uk

6.4 Anna's eldest child, brother Freddie and sister Emma all contacted the Chair wishing to participate in the review and initial face to face meetings were arranged with them individually in February and March 2023.

6.5 All were offered the opportunity to meet with the Panel but were happy to liaise with the Chair throughout the process and did not feel that meeting the Panel was required.

6.6 Email and text contact was maintained with Anna's eldest child, Freddie and Emma throughout the review providing updates after each meeting and offering an opportunity to raise any questions at Panel meetings. Updates were also provided in respect of the timeline for completion of the draft report.

6.7 The Chair did not receive a response to her initial letter to Anna's mother and, having discussed with Anna's eldest child, she wrote again in April 2023 offering the opportunity to participate but no response was received.

6.8 Anna's eldest child provided the Chair with contact details for Anna's closest friend. The chair contacted this individual in March and July 2023 offering her an opportunity to participate in the review but no response was received on either occasion.

6.9 Anna's older children, brother, sister and sister-in-law provided invaluable information in respect of Anna as a person, how she lived her life and her relationship with Simon. These contributions are included in the chronology and are detailed further in the Overview and Analysis Section.

6.10 As outlined in paragraph 5.14 above family members were provided with a copy of the draft report in August 2024 and were offered opportunities to meet with the Chair in September 2024. Family members were offered the opportunity to provide feedback to the Chair in person, via email or via telephone. Gail provided feedback via email which was incorporated in to the report however at the time of presenting the report to the CSP no further feedback had been received.

7. Review Panel

7.1 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.

7.2 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.

7.3 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.

7.4 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.

7.5 Members of the Review Panel are listed in the Terms of Reference above (page 8).

7.6 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.

8. Contributors to the Review

8.1 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.

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

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

8.4 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.

8.5 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.

8.6 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.

8.7 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.

8.8 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.

8.9 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

8.10 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 Child 2;
- Education Engagement Service, Bridgend County Borough Council;
- Adferiad, Substance Use Service in Bridgend until 31st March 2022.

9. Appointment of an Independent Chair /Author

9.1 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.

9.2 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.

9.3 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.

9.4 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.

9.5 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.

10. Parallel Reviews

Coroner's Inquest

10.1 On her appointment, the Chair contacted the Coroner's Office informing them of the decision to undertake a Domestic Homicide Review and requesting an update in relation to the Inquest into Anna's death. This initial contact also included an offer to meet with the Coroner during the review process to share emerging themes and learning.

10.2 Following a briefing from the Fatality Investigator at British Transport Police (BTP) the Chair contacted the Coroner's Office to seek permission for BTP to share the statements taken during the course of their investigation with her. This request was initially declined by the Coroner but was subsequently agreed and the statements shared with the Chair.

10.3 At the time of writing this report, no date has been set for the inquest into Anna's death.

10.4 As detailed at paragraph 3.8 above, the Panel has agreed that the draft report be shared with the Coroner to inform the inquest. It is the Panel's view that waiting for quality assurance from the Home Office would result in an unnecessary delay to the Inquest. The draft report will be shared with the Coroner on the understanding that it is draft and confidential and not to be made public in the inquest proceedings.

South Wales Police

10.5 A review of the circumstances relating to South Wales Police's contact with the subjects of the review prior to Anna's death was conducted by the

Professional Standards Department and concluded that the police response and actions taken were appropriate and in line with procedures.

10.6 An internal investigation was undertaken by a Quality Improvement Nurse for Mental Health Services at Cwm Taf Morgannwg University Health Board. The investigation concluded that there were no contributory or fundamental factors in relation to Anna's death. The Chair has not had sight of this investigation report.

11. Equality and Diversity

11.1 The Home Office Guidance asks the Review Panel to consider whether there are any specific considerations around equality and diversity issues such as age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. This section outlines the protected characteristics that were considered as significant factors by the Panel as well as outlining key considerations relating to suicide and experiences of domestic abuse that are critical to this review.

11.2 Sex, pregnancy and vulnerabilities are considered as factors throughout the review and examined within this report. Some of the evidence as to why these are considered is listed below.

Suicide

11.3 Whilst the Coroner is yet to hold an inquest into Anna's death, it is the Panel's working hypothesis that she took her own life.

11.4 Recent research and events have highlighted the link between experiencing domestic abuse and suicide, particularly for women. These are detailed below and have been considered by the Panel throughout this review.

11.5 *Underexamined and Underreported*[4] published in February 2023 provides an analysis on the link between intimate partner violence and suicidality and the ways in which this disproportionately impacts women. It found that;

- Women who experienced abuse from a partner **are three times more likely** to have made a suicide attempt in the past year compared to those who have not experienced abuse.

11.6 The National Confidential Enquiry into Suicide and Homicide Annual Report 2022[5] provides findings relating to people who died by suicide between 2009 and 2019 across all UK countries.

[4] https://www.agendaalliance.org/our-work/projects-and-campaigns/underexamined-and-underreported/
[5] https://sites.manchester.ac.uk/ncish/reports/annual-report-2022/

11.7 It reports that the majority of patients with a history of domestic violence were female. They were more often younger, single or divorced, living alone and unemployed than other women. Self-harm, previous alcohol or drug misuse and personality disorder diagnosis were more common in this group, potentially reflecting previous trauma or abuse.

Its findings include;

- Between 2015 and 2019, there were 532 patients who were known to have experienced domestic violence, 9% of all patients during this time period, 104 deaths per year.
- The average number of deaths in 2016-17 was 101 per year but in 2018-19 this had increased to 149 per year.
- The majority (73%) were female, an average of 76 per year.
- In 90% the domestic abuse was physical, in 28% it was sexual, and in 19% it was both sexual and physical.
- More women with a history of domestic violence had experienced adverse life events in the previous 3 months the most common relating to family issues (21% v. 6%), serious financial problems (22% v. 11%) and loss of job, benefits or housing (19% v. 12%).

11.8 Research published in the Lancet in 2022 aimed to investigate the associations between experience of lifetime and past-year Intimate Personal Violence (IPV) with suicidal thoughts, suicide attempt, and self-harm in the past year[6].

11.9 7058 participants were asked about experience of physical violence and sexual, economic, and emotional abuse from a current or former partner, and about suicidal thoughts, suicide attempts, and self-harm.

11.10 Findings of the research include

- A fifth (21·4%) of the 7058 adults reported lifetime experience of IPV, and that 27·2% of women and 15·3% of men had experienced IPV.
- Among people who had attempted suicide in the past year, 49·7% had ever experienced IPV and 23·1% had experienced IPV in the past year (including 34·8% of women and 9·4% of men).

11.11 Other relevant research findings include;

[6] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(22)00151-1/fulltext Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England https://doi.org/10.1016/S2215-0366(22)00151-1

- A strong association between the experience of domestic abuse and self-harm and suicidality[7]
- Research has suggested that around one third of the number of female suicides could be related to intimate partner violence[8]
- Research by Kent and Medway Suicide Prevention team into domestic abuse and suicide since 2019 has shown that approximately 30% of all suicides in the area between 2019 and 2022 have been impacted by domestic abuse (either as a victim, a perpetrator or as a young person)[9]
- 20% of all the female survivors who entered Refuge's services between April 2020 and March 2021 had previously attempted to take their own life, with a further 42% saying they had experienced suicidal thoughts[10]
- 96% of victims of intimate partner violence who were identified as suicidal suffered from feelings of hopelessness and despair, and these feelings are a key determinant for suicidality[11]
- Of the 38 suspected suicide of victims of domestic abuse recorded by police between March 2020 and March 2021, 90% were female[12]. (It is not known how this number compares with previous years as the data has not been collected before).
- Of the 113 victims considered by the recent DHR analysis for the Home Office 13% (15) victims died by suicide[13]. Nearly three quarters of these victims were female (11)
- Four key contributors to suicidality are identified as; physical and emotional/psychological pain, hopelessness (including

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[7] McManus, S., Walby, S., Barbosa, E. C., Appleby, L., Brugha, T., Bebbington, P. E., & Knipe, D. (2022). Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England. *The Lancet Psychiatry, 9*(7), 574–583. https://doi.org/10.1016/S2215-0366(22)00151-1

[8] Walby, S. (2004), The Cost of Domestic Violence, Women and Equality Unit: DTI.

[9] https://www.local.gov.uk/case-studies/kent-and-medway-highlighting-relationship-between-domestic-abuse-and-suicide

[10] https://www.channel4.com/news/urgent-need-to-act-on-domestic-abuse-and-suicide-link

[11] Aitken R and Munro V (2018) Domestic Abuse and Suicide: Exploring the Links with Refuge's Client Base and Work Force. London: REFUGE. Available at www.refuge.org.uk/wp-content/uploads/2018/07/ domestic-abuse-suicide- refuge-warwick-july2018.pdf

[12] Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021 https://cdn.prgloo.com/media/02d412c416154010b5cebaf8f8965030.pdf

[13] Quantitative Analysis of Domestic Homicide Reviews October 2020 – September 2021 Prepared for the Home Office by Analytics Cambridge and QE Assessments Limited April 2023

powerlessness/helplessness), lack of connectedness (disrupted relationships and isolation) and suicide capability[14]

11.12 The Panel has also given due consideration to the Suicide Sequence[15] developed by Professor Jane Monckton-Smith and applied this as appropriate in its analysis of the circumstances of this case.

11.13 There have been two landmark cases in respect of suicide and domestic abuse in recent years which have been noted by the Panel.

11.14 In 2022, the Coroner in the inquest into the death of Jessica Laverack explicitly recognised the link between domestic abuse and suicide and in a landmark decision concluded that *the underlying cause of her illness was domestic abuse*[16]*.*

11.15 The Coroner further issued a Prevention of Future Deaths report[17] and wrote to the Home Secretary, Justice Secretary and Health Secretary to demand improved training and domestic abuse suicide awareness for frontline police officers and other agencies.

11.16 In 2023, in relation to the death of Kelly Sutton[18], an Inquest Jury overturned the original Inquest verdict of suicide when it concluded that Kelly had been unlawfully killed, in that the domestic abuse that she was subjected to by her partner caused her death.

11.17 The Panel has examined Wales's response to suicide and suicide prevention in Section 5 of this report.

Sex

11.18 In addition to the research data above highlighting prevalence of suicide in female victims of domestic abuse, the Panel also considered the following;

[14] Christie,C., Rockey, J.C., Bradbury-Jones, C., Bandyopadhyay,S & Flowe, H.D. (2023) Domestic Abuse links to Suicide: Rapid Review, Fieldwork and Quantitative Analysis Report. Home Office Report.

[15] Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide https://eprints.glos.ac.uk/10579/16/10579_Monckton-Smith_%282022%29_Home_Office_Report.pdf

[16] https://bhattmurphy.co.uk/files/SRN%20cases/Laverack%20Press%20Release.pdf

[17] https://www.judiciary.uk/wp-content/uploads/2022/11/Jessica-Laverack-Prevention-of-future-deaths-report-2022-0344_Published.pdf

[18] https://bhattmurphy.co.uk/in-the-news/top-stories/jury-conclude-that-kellie-sutton-was-unlawfully-killed-in-self-inflicted-death-following-domestic-abuse

- The United Nations defines gender-based violence in the following way: *The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.* (CEDAW 1992: para. 6).
- Whilst both men and women may experience incidents of inter-personal violence and abuse, women are considerably more likely to experience repeated and severe forms of abuse, including sexual violence. They are also more likely to have experienced sustained physical, psychological or emotional abuse, or violence which results in injury or death.
- There are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2017). Further to that, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours (Dobash & Dobash, 2004; Hester, 2013; Myhill, 2015; Myhill, 2017).
- Over a quarter (27%) of women report experience of intimate partner violence in their lifetimes[19]
- Women living in poverty are especially at risk. Around half of women (47%) who are unemployed or unable to work have experienced domestic abuse from a partner[20]

Pregnancy

11.19 Anna gave birth to her youngest child in November 2021 and the panel therefore considered both pregnancy and the postpartum period as factors in the review.

11.20 Around 30% of domestic abuse begins during pregnancy, while 40–60% of women experiencing domestic abuse are abused during pregnancy[21]

11.21 Taken from Women's Aid Federation England 2019 publication *Supporting women and babies after domestic abuse*[22];

[19] https://www.agendaalliance.org/our-work/projects-and-campaigns/underexamined-and-underreported/
[20] https://www.agendaalliance.org/our-work/projects-and-campaigns/underexamined-and-underreported/

[21] A Cry for Health: Why we must invest in domestic abuse services in hospitals (2016) SafeLives

[22] Callaghan, J., Morrison, F., and Abdullatif, A. (2018) *Supporting women and babies after domestic abuse: A toolkit for domestic abuse specialists*. London: Women's Aid Federation of England. 2019

- For some women, domestic abuse begins or escalates when women are pregnant or have very small children[23]
- Abusers will often increase their controlling and emotionally abusive behaviours during this time, and there is also a higher risk of physical violence[24]
- Prevalence studies suggest that between 20% and 30% of women will experience physical violence at the hands of a partner/ex-partner during pregnancy[2526]
- Control over pregnancy itself can also be used as a tool of abuse – this form of coercive control is called reproductive control. This is because an abuser can use a woman's pregnancy as a way of increasing her dependency and intensifying their control over her.
- Women who experience domestic abuse report a higher than average rate of unintended pregnancy[27]
- The risk that the baby will die during pregnancy or birth are between 2–2.5 times higher when domestic abuse occurs[28], with common causes of death being blows to the abdomen, and soft tissue injury to the baby[29]

[23] Chisholm, C. A., Bullock, L. & Ferguson, J. E. (2017) (Jef. Intimate partner violence and pregnancy: epidemiology and impact. *Am. J. Obstet. Gynecol*. 217, 141–144.

[24] Knight, M. (2015) *Learning from homicides and women who experienced domestic abuse. in Saving*
Lives, Improving Mothers' Care: Surveillance of Maternal Deaths in the UK 2011–13 and Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–13 (eds. Knight, M., Tuffnell, D., Kenyon, S., Shakespeare, J. & Gray, R Kurinczuk, J.) 62–70. University of Oxford

[25] Devries, K. et al. (2010) Reproductive Health Matters Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries. *Reprod. Health Matters* 18, 158–170.

[26] Bailey, B. A. (2010) *Partner violence during pregnancy: prevalence , effects , screening , and management.* 183–197

[27] Maxwell, L. et al. (2018) Intimate partner violence and pregnancy spacing: results from a meta-analysis of individual participant time-to-event data from 29 low-and-middle-income countries. *BMJ Glob. Heal.* 3, e000304

[28] Meuleners, L. B., Lee, A. H., Janssen, P. A. & Fraser, M. L. (2011) *Maternal and foetal outcomes among pregnant women hospitalised due to interpersonal violence : A population based study in Western Australia, 2002-2008*.

[29] Meuleners, L. B., Lee, A. H., Janssen, P. A. & Fraser, M. L. (2011) Op. cit.

Vulnerabilities

11.22 The findings of the recent analysis of 108 DHRs undertaken for the Home Office[30] state that;

- Fifty-eight (58%) percent of victims had at least one vulnerability. Overall, 31% of victims had more than one vulnerability. 33% of these vulnerabilities were identified as mental health, 27% were problem alcohol use and 18% illicit drug use.
- Coercive and controlling behaviours was recorded as an aggravating factor in almost half of the DHRs (48%)
- Where information was given, 60% of perpetrators were recorded as having a previous offending history
- Slightly over half (55%) of perpetrators were known to agencies as abusers. Of these agencies 44% were the Police, 18% Probation, 7% Children's Social Services and 4% Adult Social Care.

11.23 The Learning Legacies report undertakes a systematic review of DHRs that have been commissioned, completed and published in cases of domestic abuse suicide in England and Wales[31].

11.24 In respect of vulnerabilities the report finds;

- The presence of financial or housing precarity in the lives of victims was a prominent theme, identified in 65% of cases.
- Almost half of victims (47%) had prior experience of abuse as an adult, often in domestic settings.
- In 94% of cases, there was a record of victim mental health issues and in almost half of cases, evidence of a history of self-harm.
- In almost two-thirds of the cases, there was evidence of previous suicidal ideation or attempts.
- Evidence that the victim had difficulties with drug or alcohol misuse in half of the DHRs.

11.25 Adverse childhood experiences are traumatic events, particularly those in early childhood that significantly affect the health and well-being of people[32]. These experiences range from suffering verbal, mental, sexual and physical abuse, to being raised in a household where domestic violence, alcohol abuse, parental separation or drug abuse is present. A growing body of

[30] Quantitative Analysis of Domestic Homicide Reviews October 2020 – September 2021 Prepared for the Home Office by Analytics Cambridge and QE Assessments Limited April 2023

[31] Learning Legacies: An Analysis of Domestic Homicide Reviews in Cases of Domestic Abuse Suicide; Dangar, S, Munro, VE, Andrade, LY; Suicide AAFDA and Warwick University April 2023

[32] https://phw.nhs.wales/topics/adverse-childhood-experiences/

research[33] has evidenced that early childhood experiences can have a significant impact on outcomes in later life. In the absence of resilience factors, exposure to adversity and related trauma during childhood can increase the risk of violence victimisation and perpetration or engaging in behaviours associated with violence. Compared to people with no ACEs, individuals exposed to 4+ ACEs are[34]:

- 15 times more likely to have committed violence against a person
- 14 times more likely to have been a victim of violence

11.26 The intersectionality of Anna's vulnerabilities is evident to the Panel and maintaining a focus on these and relevant protected characteristics throughout the review has enabled the Panel to consider organisational responses and the availability, gaps and barriers to accessing information and services through these lenses.

[33] https://www.violencepreventionwales.co.uk/research-evidence/adverse-childhood-experiences-aces
[34] https://www.violencepreventionwales.co.uk/research-evidence/adverse-childhood-experiences-aces

SECTION TWO – SUBJECTS OF THE REVIEW

In addition to Anna and Simon the following persons are referred to in this report;

Child 3	Anna and Simon's son, aged 7 months at the time of Anna's death
Child 2	Anna's child aged 16 years at the time of Anna's death
Child 1	Anna's child, aged 20 years at the time of her death
Emma	Anna's sister
Freddie	Anna's brother
Gail	Freddie's partner and Anna's sister-in-law
Hannah	Anna's mother
Ian	Anna's brother

1.1 Anna, a White British woman was 38 years old at the time of her death in June 2022. She was a mum to three children, a daughter, a sister and a friend.

1.2 Simon, a White British man, was 36 years old at the time of Anna's death.

1.3 The following narrative is aimed at providing the reader with an understanding of Anna as a person and is based on information provided by family members. It also seeks to provide an insight into how Anna lived her life to provide context for the Overview and Analysis in Section 4.

1.4 These accounts from family members were shared by the Chair with the Panel at their meeting in July 2023. When sharing this information, the Chair also showed photographs of Anna which were invaluable in helping the panel see Anna as a person.

1.5 Anna was the youngest of 8 siblings and her brother and sister describe her as her mother's *golden girl* and *getting away with a lot* because she was the youngest.

1.6 Anna was described as the *life and soul of a party*, she was happy, smiley and fun to be with, but she was also someone who took no nonsense and spoke her mind.

1.7 Anna's older children recalled how their mum loved dancing to Techno and 80's dance music and enjoyed going to music festivals. They spoke about their mum's love of her Staffordshire Bull Terriers and her favourite food, Chinese takeaway, and how she would always order the same dishes.

1.8 Anna had her eldest child when she was 18 years old and her family were a source of support for her, enabling her to continue working and enjoy life as a young mum.

1.9 Anna's eldest child describes how their mum was like a best friend and they would often socialise and go to music events together.

1.10 Anna's siblings and children spoke about how she always put the children first and *would do anything for them*. Her children told the Chair that *she would spend her last on us…..we had the best of everything.*

1.11 Anna and her sister, Emma were described as *inseparable*; they worked together, socialised together and went on holidays together. Emma recalls how they had *so much fun.*

1.12 Family members spoke about the adversities that Anna had experienced from a young age and how these had impacted on her.

1.13 Anna's father left when she was 14 years old and her brother describes how it *broke her heart when he didn't want anything to do with her*.

1.14 Family members spoke about how Anna had never dealt with the feeling of being abandoned by her father and began drinking alcohol as a way to cope. They describe how Anna didn't know her limits when it came to alcohol and didn't know when to stop. They spoke about how she had tried her best to stop drinking and had at times succeeded but events in her life had resulted in her starting to drink again as a mechanism to cope and/or escape. When Anna's brother Ian took his own life in 2014, family members described how she turned to drink to cope with her loss and grief.

1.15 Anna's children spoke about her Obsessive Compulsive Disorder (OCD) and how her behaviours would escalate depending on what was happening in her life at the time. They spoke about how she would always be cleaning and scrubbing the floors and how she would arrange things in colour order in the house.

1.16 When speaking with the Chair, the social worker who completed the Care and Support assessment with Anna in 2022 described her as *a doting mum who loved her children and had a network of family support around her.*

SECTION THREE – CHRONOLOGY

1. Overview

1.1 The combined chronology included in this section sets out relevant events, contacts and agency involvement with the subjects of this review.

1.2 The Terms of Reference set out the scope of the review from July 2019 to the date of Anna's death in June 2022. This scope takes account of the duration of time that Anna and Simon were in a relationship but allowed agencies to submit information that fell outside of this scope if deemed relevant and appropriate. This information has been included in the chronology as it provides relevant context that has been considered as part of the review.

1.3 Where entries have been taken verbatim from agency records these are shown in italics.

Date	Significant Event
14/07/20	Telephone contact with GP. Anna reports feeling anxious, wants to start medication, feels her OCD symptoms are starting again. Recommenced Venlafaxine (anti-depressant). Follow up in 3 weeks.
16/11/20	Telephone contact with GP. It is noted that Anna has a long history of anxiety and depression and is also known to have issues with alcohol and binge drinking. Anna reports that when drunk she does irrational things such as going to the train station to jump on the track. It is recorded that the patient feels the root of the problem is alcohol. Anna is signposted to Wales Centre for Action on Dependency and Addiction (WCADA)
07/12/20	GP attempts telephone contact to follow up previous contact. No reply.
22/12/20	GP attempts telephone contact to follow up previous contact. No reply.
05/01/21	GP contacts Anna via telephone. It is recorded that Anna has been taking Antabuse (a supporting treatment option that acts as a deterrent from drinking alcohol) but has not contacted WCADA. GP discussed the importance of contacting WCADA
29/01/21	WCADA receive and accept referral from GP for Anna.
08/02/21	WCADA complete an assessment with Anna.
25/02/21	Anna is allocated a key worker in WCADA.
16/03/21	Telephone contact with GP. Anna reports that she has been taking Antabuse for the last couple of months. It is recorded that she has contacted WCADA and is awaiting a key worker. She reports that she hasn't drunk any alcohol and that she is still having low days and wonders if she should increase her medication.
18/03/21	Anna does not attend an appointment with WCADA but provides a reason
01/04/21	Anna does not attend an appointment with WCADA but provides a reason
14/04/21	Case note added by WCADA keyworker. Anna has requested closure from services due to her being pregnant, abstinent and having good family support.
21/04/21	Telephone contact with GP. It is noted that Anna is pregnant. Her medication is lowered and the GP makes a referral to the Primary Care Mental Health Team known as ARC (Assisted Recovery in the Community). It is recorded that Anna reports not having drunk alcohol since November 2020.
23/04/21	Anna's maternity notes record her as booking for antenatal care at 12 weeks pregnancy (appropriate booking time). The booking was completed on the telephone due to Covid restrictions. No noted mental health diagnosis, however it was noted that she was being treated for anxiety and depression and is on anti-depressants.
26/04/21	Closure checklist completed by WCADA keyworker. Referral is closed noting *Treatment complete - problematic substance free.*
08/09/21	Routine Ante Natal visit. Anxiety discussed. No concerns noted, however physical symptoms were beginning to present, mostly in the form of a headache which can be a sign of pre-eclampsia.
10/09/21	Child 2 left school site without permission. Contact made with home by Student Support Officer who established that Child 2 was safe and had gone home. Agreed to meet with Anna and Child 2 on 13.9.21 for further discussions regarding truancy and support.
13/09/21	Meeting between the Student Support Officer, Anna and Child 2 to discuss truancy concerns and how school could support. It was agreed during the meeting that if Child 2 left school site without permission they would be classed as truant and reported to the police as well as school consequences put in place. Child 2 stated that there were no issues other than they didn't want to remain in school during the afternoon 10/9/21 and that they and their friend wanted to leave. It was recorded that emotional warmth was displayed between Mum and Child 2 during the meeting and that Mum was supportive of school action and reiterated the importance of staying in school and not leaving the school site.

17/09/21	Child 2 again left the school site without permission. Student Support Officer was not able to get hold of mum on contact numbers and the child was reported missing to the police via 101.
20/09/21	Meeting between Student Support Officer, Child 2 and Mum at school. It is recorded that Child 2 is unhappy in school and does not want to attend. The Student Support Officer offered a reduced/bespoke timetable to help Child 2 manage their days. It was agreed that the Student Support Officer would provide daily check ins and support to Child 2. These check ins were in the form of Child 2 attending the Key Stage office at the start of lesson 1 - going through their daily timetable, assessing how they were feeling and then the Student Support Officer taking Child 2 to lessons if necessary. There was no formal record of this agreement.
28/09/21	Anna contacted the GP via telephone. It is recorded that she had been advised by the Midwife to speak to GP as she was feeling more stressed and anxious. The GP increased her medication.
04/10/21	A Pupil Support Plan (PSP) was put in place for Child 2 including the new timetable as agreed 20/9/21. As part of this plan Red Amber and Green lessons were identified and it was agreed that Red lessons – Child 2 would work with the Student Support Officer in the Key Stage Office. Amber lessons – Child 2 was given a timeout card to use if they felt that the lesson was not going well and would use this card to access the key stage office rather than going off site. Green lessons – Child 2 identified that they would be happy to go to these.
19/10/21	Student Support Officer met with Child 2 and Mum at school to review the new timetable. During the meeting the Student Support Officer explained that Child 2 was presenting with a poor attitude towards staff, was dismissive in their manner and would often walk off and ignore staff. It was stated that Child 2 would be confrontational and rude when spoken to and would often swear at members of staff.
November 21	Child 2 refused to attend their examination. The Assistant Headteacher went to the house to collect Child 2 but they wouldn't get out of bed. Mum repeatedly tried to encourage Child 2, but they still refused.
09/11/21	Meeting at school between Student Support Officer, Mum and Child 2 to review timetable. It was agreed to increase Child 2's time in school by one hour on Wednesdays, Thursdays and Fridays
11/11/21	Targeted Ante Natal contact carried out at 36 weeks. Anna informed Health Visitor that she suffered with Obsessive Compulsive Disorder and Post Natal Depression following previous birth.
12/11/21	Child 2 was struggling to manage the increased time in school so discussions took place and reverted to original reduced timetable. Child 2 stated that they did not want to be in school and didn't want to be there for the increased time. Also stated that they enjoyed the social aspect of school and enjoyed seeing friends but just didn't want to attend any lessons or engage in school work.
15/11/21	Student Support Officer contacted mum regarding Child 2's timetable and arranged to review again on 22.11.21
17/11/21	Child 3 was born
22/11/21	Anna contacted school to say that Child 2 was refusing to attend.
29/11/21	Health Visitor visited home for Primary Birth Visit. Birth experienced reported to be positive. GP following up raised blood pressure. Routine Enquiry asked and Anna disclosed Domestic Abuse with two ex-partners (one being Simon, father of Child 3). Emotional health questions asked.
30/11/21	Student Support Officer made a home visit to see Child 2 and mum as Child 2 was still refusing to come to school. During this meeting mum raised home education as a possible option for Child 2.

07/12/21	Student Support Officer visited Child 2 at home for a welfare check as was still school refusing. Work given to Child 2 to complete to reduce gaps in learning and make reintegration less daunting.
08/12/21	Anna seen by GP to review blood pressure. It is recorded that Anna wanted to restart antabuse as she had one episode of being drunk last week.
13/12/21	Health Visitor visit cancelled by Anna. Recorded that Child 2 positive Covid-19. Another visit arranged.
14/12/21	Student Support Officer visited Child 2 at home for a welfare check as was still school refusing. Work given to complete at home.
13/01/22	Meeting between Headteacher, Mum and Child 2 regarding concerns about attendance. Discussed and agreed a reduced timetable and Child 2 identified lessons they felt would be positive. It is recorded that Child 2 was *reluctant to engage and quite resigned in [their] disinterest*. *Child 2 expressed that home education would be best for [them] and was resolute.* Headteacher asked Child 2 to reconsider this.
14/01/22	Home visit by Student Support Officer as Child 2 was still refusing to attend school. Mum enquired again about home education and the Student Support Officer explained who mum needed to contact in the Local Authority to progress this.
19/01/22	Anna contacted the school with a letter regarding Elective Home Education (EHE). The Student Support Officer visited Child 2 and mum at home and provided a pack of GSCE preparation work. Mum was provided with information to support EHE.
19/01/22	Bridgend County Council Early Help Service receive a referral from Anna requesting support for Child 2 as they were no longer attending school and was presenting low in mood. Anna and Child 2 had attended the GP and they had been advised to contact Early Help services. Assessment completed on same day and family were referred to the Youth Emotional Health team for ongoing support.
27/01/22	Anna contacts GP via telephone wanting to increase her medication to twice a day for low mood.
01/02/22	Initial Elective Home Education pack sent to Anna following Child 2's deregistration from school including EHE contacts, ideas and details of EHE support.
14/02/22	South Wales Police were contacted by Anna via the 999 emergency facility. She was recorded as saying Child 2 had 'locked her in the house'. Anna described Child 2 as being a 'controlling child', who was refusing to let her go out. It was stated that Child 2 was worried about their mother going to get more 'drink'. The Police Log was endorsed at 01:59hrs by the Police Operator, who recorded the Reporting Person had been drinking on her own admission and she sounded 'Intoxicated'. At 02:09hrs the incident was linked to another call to Anna's address. On this occasion it was recorded that 'Child 2 is drunk'. The Operator recorded hearing a disturbance in the background and a female shouting. It was reported, '*She is trying to leave and walk the streets'* and it was said the incident had been ongoing since 19:00hrs. The call was ended by the Reporting Person. Officers were deployed to the incident at 02:09hrs and were shown to have arrived at 02:26hrs. It was noted there was a child at the address. The officers ascertained that Anna was at the address with Child 2, Child 3 and Anna's mother. Officers spoke with Anna's mum who explained that Anna was extremely intoxicated and she had been involved in a verbal argument with Child 2. Both she and Child 2 informed the officer that Anna had been drinking all day and was intoxicated and had intended to leave her home, leaving three (3) month old Child 3 at the address. As she was about to leave, Child 2 prevented her from doing so which resulted in the verbal argument. The officers also established that Anna's current boyfriend was Simon which both Child 2 and Anna's mother believed to be an unhealthy relationship, which they suggested was attributing to Anna's heavy drinking. Child 2 added that they had not wanted their mother to leave their home, as on a previous occasion she had attempted to 'lay on the tracks' at the local railway station and also visited the grave of her deceased brother who had passed away some seven (7) years previously. Anna was spoken to separately by officers. She was described by the Officer to be 'Calm' and wanting to go to sleep. Anna admitted to the Officer to having consumed alcohol and engaging in verbal arguments with both Child 2 and her mother. She had intended leaving her home to go to the cemetery to visit her brother's grave. When the officer challenged Anna about the care of her young child if she was to leave

	her home, she explained that she was aware of the child's routines and would be able to leave the child sleeping and return from the cemetery, before her child woke. Anna added that she was only able to attend her brother's grave when she had been drinking because of her emotions and could not do so when sober. She also suggested both her mother and Child 2 were present at the address and could take care of her child whilst she went for a walk. Anna was advised about leaving her home and engaging in any further arguments with Child 2. She was informed that positive action would be taken against her should she not heed the advice provided. The Officer recorded that Child 3 was left in the care of the grandmother and Child 2 in order to safeguard them. The Officers resumed from the incident after notifying Child 2 and Anna's mother to contact the Police should they encounter any further issues.
14/02/22	South Wales Police were again contacted by Anna's mother in respect of the earlier incident. She informed the police operator that Anna was now in possession of a bottle of vodka which she had taken into the bedroom. At 03:29hrs Officers were re-deployed to the incident and were recorded as having arrived at 03:37hrs. They conferred with Anna's mother who confirmed her daughter had obtained a bottle of vodka which she was consuming. When Child 2 attempted to prevent their mother from drinking, Anna became abusive and argued with her. An officer attended Anna's bedroom and observed Anna laying on the bed and next to her was an opened bottle of vodka. The Officer had concerns for the safety of the vulnerable persons at the address who required protection from Anna and she was therefore arrested to Prevent a Breach of the Peace. Once Anna had been arrested and was being taken to the Police Custody Suite Child 2, in the presence of their grandmother, disclosed their mother had assaulted them by slapping them across the face during the evening. This was corroborated by Anna's mother and Anna was therefore further arrested for the assault upon Child 2. A statement was obtained from Child 2 by the investigating officers, which was timed at 04:19hrs. Child 2 alleged their mother had slapped them following a verbal altercation prior to the Police attending the home. Child 2 confirmed they had not sustained any injuries and would not provide the Officers with any further information. Neither were they prepared to attend Court and give evidence against their mother and did not wish for the Police to prefer any charges on their behalf. Anna's mother also provided a statement to the Police at 04:21hrs and she corroborated Child 2's allegation adding she had witnessed the incident. Like Child 2, she did not wish to attend Court or support a Police prosecution against Anna. Anna was interviewed and she admitted to hitting Child 2. Anna confirmed the details of the incident as reported by Child 2 adding when Child 2 attempted to prevent her from getting more alcohol they took hold of Anna's arm causing Anna to lash out at Child 2, which she considered to be a natural reaction to anyone grabbing another person's arm. Anna did not suggest Child 2 had assaulted her in any way, adding they had a good relationship. With regards to her drinking, Anna explained she had consumed four (4) cans of lager and two (2) glasses of vodka – one with a mixer. However, she had not consumed alcohol for fifteen (15) months, but since Child 3 had been born, she drank alcohol twice a week. A Detective Sergeant reviewed the incident and decided that the matter was suitable for Community Resolution incorporating Restorative Justice and a referral was made to the Woman's Pathfinder (Whole System Approach). Anna was released from custody. A Public Protection Notification (PPN) in relation to Child 3 was submitted. In the 'Observations Section' of the PPN the officer noted that Child 2 had explained they had arrived home at 19:00hrs and noted their mother, Anna was 'already intoxicated'. This was of concern as Anna was the sole carer of Child 3 aged three (3) months. Child 2 added that their mother

	continued to drink throughout the evening and became further intoxicated. Child 2 made efforts to stop their mother from drinking and at some stage Anna attempted to leave the home which Child 2 also tried to prevent. This resulted in an argument and Anna assaulting Child 2. The Officer noted on the PPN that *the home conditions were good, it was warm and the children were well presented*. Anna was described as suffering from depression since the death of her brother some seven (7) years ago. It was noted by the officer that Anna was believed to be taking medication for her drinking and according to Child 2 she drank heavily whenever she argued with her boyfriend. When drunk it was recorded that Anna attends her brother's grave, usually in the early hours of the morning. The PPN Form was recorded as having been received and assessed at the Central Safeguarding Unit and shared with Children's Services and Health.
14/02/22	A PPN was also submitted in respect of Child 2 which contained details of the incident and details extracted from Child 2's statement to the police. The officer noted that the Domestic Abuse, Stalking and Honour Based Abuse (DASH) assessment had not been completed as Child 2 would not provide further information to the investigating officers. The PPN was assessed as 'High Risk' and acknowledged how Child 2 may not be wishing to make a complaint due to the potential fear of their mother. Child 2's age was also taken into consideration. The PPN was shared with Bridgend Social Services, Early Help, Health and the Assia IDVA service (Domestic Abuse Service) A referral to the MARAC Co-ordinator was made and the case listed for discussion on 18th February 2022. Warning markers were created for Anna including two (2) x 'Ailments' one in respect of her issues with 'Alcohol' and the other for 'High Blood Pressure'. Also, a warning marker for 'Mental Health' was created *Depression* and the other for '*Self-harm'* – Cut herself when 20yrs of age.
14/02/22	Bridgend County Borough Council (BCBC) Children's Services received PPN from Police. Strategy Discussion took place and a decision taken to undertake a Section 47 Children's Act 1989 - Single agency investigation. A Social Worker was to attend the home and safeguarding measures implemented with the possible assistance of the grandparents. Attending the strategy meeting were representatives of South Wales Police, BCBC Children's Services, Health representative – all co-located at the Multi Agency Safeguarding Hub. Social worker visits Anna's home.
14/02/22	Assia receive High Risk PPN for Child 2. Contact is made by the IDVA who speaks to Child 2 and states that *now wasn't a good time to call*. Child 2 asked for a call back in the morning which was agreed.

15/02/22	An officer within the South Wales Police Domestic Violence Abuse Unit contacts Anna's mum with the purpose of conducting a welfare check on Child 2 who had been staying with her whilst Anna was in custody. Officer was informed that Child 2 was sleeping but was expected to return to their mother's home later in the day.
15/02/22	Whole System Approach (WSA) receive a Diversion referral from South Wales Police and attempt contact with Anna - unsuccessful
16/02/22	Assia call Child 2 as arranged. Child 2 stated that they had been out on the evening that the incident occurred and when they returned home their mother had been drinking so they began arguing about her mother's drinking. Child 2 says their grandmother was at the address and was looking after the baby, Child 1 also lives at the address but was not present at the time. Having been arguing for most of the evening Anna went up to bed, but she then came back down and they began arguing again. Child 2 stated that there was no physical abuse during the incident, but they did push Anna out of the way at one point. When the noise and arguing escalated her grandmother called the police to try and calm the situation, the police attended and calmed Anna down. Child 2 went on to say that Anna went to bed at the request of officers but when they left came back downstairs about 10 minutes later and was trying to go out and obtain alcohol. The police were called again by her grandmother and Anna was subsequently arrested to avoid a breach of peace. Child 2 explained that when Anna was released from custody and returned home the following day she was quite angry that police had been involved. Child 2 denied that there was any aggression towards them from their mother upon her return but went to stay at their grandmothers for the night to allow things to settle down. Child 2 explained that they had returned home on 15/02/22 and stated that they and their mother had sat down and talked about what happened and that Anna had said she understood why police were called and recognised her behaviour was wrong. Child 2 stated that Anna thought she was being bullied by the family on the night of the incident but they are now speaking and there have been no further issues since the incident. Child 2 denies any previous similar incidents and advised that their mother has been suffering from depression since having the baby. Child 2 stated that Anna has only had alcohol on 2 occasions since having the baby. They believed their mother was using alcohol to self -medicate and that she does not have any medication for depression. Child 2 also stated that they left school recently and had been getting into trouble when at school and that they had no energy or motivation to attend classes. IDVA asked if there was any particular reason for this and if there is anything we can do to support them. Child 2 stated that there wasn't really any reason, and was just being "naughty". Child 2 is planning to go to college in September to study Travel & Tourism and is intending to seek employment between now and then. Child 2 does not have income but says their mother provides everything they need and that they are happy at home, saying their grandmother is an important part of their support network and they have a close relationship with Child 1.

	IDVA discussed if Child 2 would like support from Assia or Children and Young People's Service but they stated that they do not feel this is needed. Child 2 accepted the Assia and All Wales Live Fear Free Helpline numbers and details of Hollie Guard & Bright Sky apps. IDVA discussed safety planning in the event of any future incidents and asked what Child 2 would do if alone with their mother and felt the situation was becoming unmanageable. Child 2 stated that they would probably not contact police but would contact their grandmother or Child 1. IDVA discussed safety with Child 2 and encouraged them to ring police if they feel unsafe and that they are there to help, not to punish. IDVA suggested Child 2 contact Assia or Helpline if they feel they needs support.
16/02/22	Anna contacts GP practice requesting further medication for anxiety. She reports an incident on the weekend that she argued with her partner and lashed out at Child 2. Recorded that no thoughts of self-harm. GP refers to Peri Natal Response and Management Service (PRAMS) and advises Anna to contact WCADA.
17/02/22	Anna attends clinic with the baby. It is unclear what was discussed at clinic as limited documentation however the result was that the Health Visitor contacted Anna the next day via telephone as a follow up.
17/02/22	Phone call to Anna by Children's Services following the recent Police referral.
17/02/22	Whole System Approach (WSA) contacted Anna by telephone and discussed service provision and areas of support. Anna advised that case will be allocated to case worker in the area. On initial contact Anna stated that she didn't have any urgent support needs but that she did want some support from Women's Whole System Approach. She advised that Social Services were involved due to the offence she was arrested for. Anna also advised that on the evening of her arrest she had had an argument with her partner. Case worker asked if there was a history of domestic abuse in their relationship and she stated there was none. Anna advised that she had been suffering with Post Natal Depression and although she didn't feel like it was really bad, she had been to the GP who increased her medication. She also advised she had been referred to PRAMS. Anna advised she may need some support around alcohol as she had stopped drinking 15 months ago and had drunk 2 times lately both which ended negatively for her.
18/02/22	Child 2 is discussed at the multi-agency Daily Discussion meeting and a risk management plan agreed – decision to progress to MARAC.
18/02/22	Health Visitor calls Anna following attendance at clinic the previous day where she had been upset about the PPN relating to incident with Child 2. No further documentation around this.
22/02/22	Referral received by Perinatal Services from Anna's GP requesting the following: *I would be most grateful for your help with this 35 year old lady. She has a three month old baby as well as an older [child]. She has been experiencing periods of low mood, followed by irritability and lashing out. She has been on Venlafaxine for depression for some time. Her symptoms pre-date her pregnancy but she has certainly felt that things have become considering worse since she has had the baby. She has a history of alcohol abuse and has been under WGCADAD for this. Unfortunately things deteriorated over the weekend where she has had an altercation with her partner. She started drinking alcohol again after an abstinence of about fifteen months and was arrested. Social services have been involved and the lady is desperate to have help for her mood swings. She is currently taking 75mg of Venlafaxine BD.*
23/02/22	Telephone call from Social Worker to Health Visitor sharing information that Health may not have been aware of including that Anna lost her brother 7 years ago, she had started to drink alcohol again and that her current relationship had broken down due to domestic abuse. Social worker requesting referral to PRAMS.
23/02/22	WSA – Anna allocated to Case Worker for community support.

	Actions identified by supervisor : Case worker to check notes, complete risk assessment and agree date for initial engagement
24/02/22	Perinatal Service Multi-Disciplinary Team (MDT) discussion after receiving Anna's referral from the GP. Noted that an Edinburgh Post Natal Depression document was not included with the referral. Outcome of the discussion: Offer assessment to Anna.
28/02/22	Perinatal Mental Health nurse attempted to contact Anna to complete an assessment but no reply. No message left.
28/02/22	Anna self-referred for WCADA support.
01/03/22	Perinatal Mental Health Nurse attempted to contact Anna to complete an assessment but had no reply. No message left. A letter was sent to Anna offering a telephone assessment on 21st March at 13:30.
01/03/22	Home visit by Health Visitor. Anna states she has been referred to PRAMS by GP and that she's happy to accept support from WCADA. She reported difficulty with contact between ex-partner. No concerns are identified regarding child.
01/03/22	Education Engagement Coordinator attempts to contact Anna by phone to check if EHE pack had been received. No answer on mobile and a message left requesting a call back.
03/03/22	Perinatal Mental Health nurse contacted Anna via telephone to see if she was available to complete her assessment today as the nurse had a cancellation, however the time was not convenient, and Anna asked to keep to her original appointment on 21/03/2022.
03/03/22	Health Visitor had safeguarding supervision actions of which are recorded as • *Await outcome of Care and Support Assessment.* • *Monthly contact from HV and to encourage to attend baby groups*.
04/03/22	Education Engagement Coordinator visits home. It is recorded that mum wasn't certain regarding deregistration but felt that school could not offer any more and had exhausted provision. Child 2 did not turn up for English exam. Coordinator left a revision book for Child 2 as they had stated that they would have like to have sat their English exam. It was agreed that Child 2 would be considered on the transition course at Bridgend College for EHE +16 and that the Coordinator would add their name to this course.
08/03/22	IDVA from Assia attempted to make contact with Child 2 for an update prior to MARAC meeting 09/03/22. Unable to make contact.
08/03/22	WSA attempted contact with Anna – unsuccessful. WSA case worker completed risk assessment based on information available on NICHE system (police system). WSA case worker sends email to Social Worker *I have been allocated Anna's case for diversion. What this means is, the offence is low level and if she engages in an assessment with me will be diverted and will class as NFA and no criminal record for the offence.* *I was allocated the case this week, the offence took place on the 14.02.2022. I noticed she had a [child]. I can see the case will be discussed at MARAC tomorrow but I could not see a PPN submitted so I thought I would check SS had details of the situation.* *When I called they informed me you were the social worker. I will offer support above the assessment and diversion but it will be on a voluntary basis, I will let you know when Anna engages and keep you posted. Let me know if you need anything.*
09/03/22	Incident 14/02/22 discussed in MARAC – it is noted that WSA are involved and that Anna is awaiting support from WCADA

09/03/22	Anna contacts GP reporting a headache. *Anxiety discussed. Sounds in a panic.* Treated with one off prescription for diazepam.
10/03/22	WCADA self-referral triaged and accepted.
11/03/22	WSA case worker contacts Anna and an initial appointment booked for 17/03/22
13/03/22	Anna contacted South Wales Police via the 999 Emergency Call Facility at 04.30hrs. Anna wished to report that she was having issues with her ex-partner whom she stated was refusing to 'Leave'. It was also said, there was a four (4) month old baby at the address. Officers were recorded as having been deployed at 04:42hrs and officers attended at 04:51hrs. It was immediately ascertained that Simon had left Anna's address prior to police attendance. Anna informed police that Simon had been drinking before driving off in his vehicle and was able to provide the officers with limited information regarding his vehicle. A search was made for Simon and his vehicle but this was to no avail. It was recorded the officers later conferred with Anna via the telephone. Anna informed the officers that she and Simon were in an 'On/Off' relationship. He had been drinking throughout the day and attended her home for approximately thirty (30) minutes. She and Simon had a 'Verbal Argument' regarding him wanting to drive his motor car after consuming intoxicating liquor. Simon insisted on driving and Anna attempted to take possession of the keys to prevent him from doing so. This caused them to argue resulting in Simon taking his keys and driving off in his vehicle. The Officer recorded, 'No offences' had been disclosed against Anna, who did not wish to provide details of her child or assist with the DASH Questionnaire. A PPN Form was submitted which assessed as 'Medium Risk'. It was recorded that Anna was not a 'Repeat Victim'. Simon was identified as being a 'Serial Perpetrator'. The information was shared with the MARAC coordinator for 'Information sharing' purposes. The information is shown as having been shared with Bridgend Social Services, Health and Early Help. A task was created for consideration being given for a Clare's Law Disclosure to Anna regarding Simon's antecedence and Domestic Violence matters.
17/03/22	Perinatal Mental Health nurse contacted Anna via telephone to offer an earlier telephone assessment today however there was no answer. No message left.
17/03/22	Anna could not attend clinic with Child 3 – no documentation as to the reason given.
17/03/22	GP referral to the Local Primary Mental Health Team received.
17/03/22	Anna cancelled appointment with WSA case worker. Date options for next appointment provided.
21/03/22	Perinatal assessment completed over the telephone: *Anna reports things have not improved despite her Venlafaxine being increased to 150mg daily.* *Feels she is not getting better and is struggling to cope generally.* *Admits to feeling manic at times, having lots of energy, with no time to think and cannot rest even when the baby rests and is constantly on the go. Reports to have OCD in relation to cleaning her home.*

	Anna feels she has not been an easy person to live with in the past due to jealousy issues and stated that any little thing can cause her to be irritable, frantic and tearful but feels different when it is just her and the baby are together. Feels then she is a different zone feeling happy, as she stated she adores him and is totally besotted with him and thinks of nothing else, but when he is asleep, her low mood returns. *Is aware she is reacting badly to things and feels unable to trust anyone, feeling suspicious and anxious, particularly in relation to her partner.* *Reported that she has had issues with her mental health since the age of 14 years but has never been this bad and although having had an alcohol problem since the age of 14 too she has never turned to drink to cope with things before, but since the baby has arrived she has on 3 separate occasions she has drunk alcohol to excess which has now, had consequences.* *Three weeks ago she stated she was arrested after being told that her partner has been having an affair which she has learnt since being able to rationalize this, that it was not true.* *Also on one occasion her partner physically removed her from his property because of her behaviour, but during that incident she fell therefore raising further concerns with Children's Services* *Anna also admitted to drinking to excess also last Friday which again led to a confrontation with her partner.* *Anna is now under the observation and support of Children's Services who have made referrals to WCADA for her. Anna is no longer allowed to see her partner, with the baby, without supervision from a family member.* *Also discussed: Mental Health History, Current Mental Health, Trauma/Abuse, Substance/Alcohol Abuse, Physical Health, Parent/Infant Relationship, Obstetric history, Social Circumstances* Outcome – Anna to be discussed within the Multi-Disciplinary Team due to the requirement that she possibly needed a psychiatrist review. Initial discussion scheduled 24/3/22. Anna's GP was notified of the assessment and outcome. A risk assessment and an Edinburgh Post Natal Depression Score was completed following the assessment which scored 26 (a score of 20 qualified for Perinatal Mental Health referral).
21/03/22	Social Worker made referral for Anna to Assia. Referral received by Assia and put on list for assessment call
22/03/22	Consideration of Clare's Law Disclosure being provided to Anna as a 'Right to Know' under the Domestic Violence Disclosure Scheme. The Officer recorded that Anna had been spoken to and she confirmed being in a relationship with Simon. Anna was aware of Simon's previous Criminal Offending but was not aware of any Domestic Incidents with previous partner(s). Anna agreed for the Officer to share with her the details of Simon's previous Domestic Violence Incidents under Clare's Law. The Officer therefore commenced the process for this procedure and arrangements were to be made with Anna to provide her with the appropriate details when authorised under a 'Right to Know'.
22/03/22	Initial engagement for WSA diversion completed face to face at Anna's home. Anna and case worker agreed areas of focus: debt and understanding alcohol consumption. Support going forward was on a voluntary basis. Service informed that the following agencies were involved in support: Welsh Centre for Action on Dependency and Addiction (WCADA) and PRAMS.
24/03/22	Referral 'opened' by the Local Primary Care Mental Health

29/03/22	Anna contacted the PRAMS team in a panic type state reporting that she could no longer cope and wanted to "take herself" to Ward 14. After some decompression and grounding Anna explained that her medication is not working and she wants help. It was explained to her the recommendation made by team's assessing nurse regarding an appointment with the team's Consultant Psychiatrist. Anna explained that she had contacted the Crisis team on two occasions this morning and left a voice message. Perinatal Nurse contacted the Crisis team who stated they had been in an assessment but had picked up Anna's voicemail and would be contacting her for an assessment today. A copy of the perinatal assessment was forward to the Crisis team for information. Anna was informed of the above and she was happy with this outcome. Anna was able to converse a lot better after being told this and explained that Child 3 was in the care of her brother. It is recorded that Anna could not identify a trigger for her current mood and stated that she needed a rest yesterday and her brother offered some time with the baby. She went shopping and began feeling anxious on return. PLAN: to discuss Anna in Thursday's MDT.
29/03/22	Anna self-referred to the Single Point of Access Team (Crisis). She reported experiencing thoughts to go onto the train track and stated she had done previously. Her brother completed suicide by this means. Anna stated "I can't cope", "I am a bad mum", "I am hurting people". It was noted the she lives with her three children; 21, 17 & 4 months. She stated that last night she took the baby to her brothers where he remains. Noted history/ risk of violence & forensic history when under the influence of alcohol, has been violent to ex-partner. Noted history of deliberate self-harm, overdoses and has laid on the train track for 40 minutes. History of alcohol misuse; denied daily use, admitted to drinking last night but none today. Medication: Venlafaxine 150mg, propanol 3 x 40mg, 2 weeks ago she was prescribed 2 weeks' worth of Diazepam with nil effect. It is recorded that Anna was distressed/ tearful, experiencing feelings of hopelessness and worthless and was actively seeking help. Anna categorised as *B* (very urgent and to be seen within 4 hours) and a face to face appointment was arranged for 2pm the same day.
29/03/22	Assessment undertaken by Crisis team with Anna 14.00hrs. Assessment recordings as follows *IMMEDIATE RISKS IDENTIFIED:* *Recent é aggression.* *Recent binge drinking.* *Impulsive behaviours particularly if intoxicated.* *Mother to young dependant baby.* *SUMMARY OF IDENTIFIED NEEDS BY CLINICIAN:* *Ongoing assessment and risk formulation by CRHT.* *PRAMS input.* *Support from Health Visitor and Social Services.* *PATIENT'S SUMMARY OF NEEDS:* *Want everything to stop.* *Hospital.* *Improved relationship with partner.* *FORMULATION PLAN:* *Discharge home with CRHT support and ongoing assessment.*

	Prescribed Diazepam 5 mgs b.d. – 6 tablets and Zopiclone 7.5 mgs nocte 3 tablets. *Sister updated of outcome.* *Ongoing Social Services and Health Visitor.* *Awaiting further WCADA input (had initial assessment).* ***Baby is in care of brother and partner**.* *SPOA No /Information leaflet provided- YES*
29/03/22	Crisis Resolution and Home Treatment (CRHT) received information from SPOA in respect of Anna's referral and the assessment undertaken.
29/03/22	WSA case worker endorses the NICHE occurrence log that initial assessment has been completed and details the support agreed with Anna.
30/03/22	CRHT support Telephone call made to Anna to arrange a home visit this afternoon. She was appropriate throughout the call, engaging well. She reported that she did not taken the medication she was given last night as she wanted her baby back home instead she took half of her partner's prescribed Mirtazapine before going to bed as she has done this to good effect in the past as she wanted to be able to sleep. Advised against doing this and advised her to only take the medication she is prescribed in the future. Anna states that she feels much calmer today however she is afraid that she may have another 'meltdown'. She wants to start new medication and is awaiting a call back from her GP today. Explained that she can discuss medication further when the team visit later. Anna explained that she has been trying to keep herself busy today, looking after the baby and doing some cleaning. Agreeable to a visit from the team at 3pm this afternoon.
30/03/22	Home visit as arranged, by CRHT Nurse and Nurse Practitioner who record *Anna was at home with [Child 3] (4 months old). She was pleasant and welcoming, calm and settled throughout and rapport easily established. She was interacting appropriately with her baby and you could see how much she loves [them]. She reports that her moods have been erratic since about 4 weeks after [the] birth and she is worried about how her mental health is impacting on her partner and family. As a result of her behaviours she feels guilty and that the children would be better off without her but she denied any current suicidal intent today. She feels that her main concern is that her medication is not working and she would like this reviewed. She minimised the impact alcohol has on her stating she is erratic without consuming alcohol but did agree that it exacerbates things and she has to deal with more consequences as a result. Agreed we would contact Perinatal Mental Health Team (PNMHS) to determine if they have discussed an appointment in their MDT and let her know the outcome. She is using PRN Diazepam but she reports this has had no benefit. She was not noted to be anxious during the visit. She appears to have good insight into her mental health and felt that having her baby with her is a good distraction and that if he wasn't with her then she would worry more. The lady is currently having a new kitchen which is also adding to her stress as well as the ongoing uncertainty of the Social Services involvement. The lady states that she hasn't heard from her Social Worker for 2 weeks and is unsure of the ongoing safeguarding plan. Agreed we would contact Children's Services to share information and clarify ongoing input. The lady is due to see the Health Visitor tomorrow.* *Plan Telephone tomorrow. May need further prescription. Liaise with Children's Services.*
30/03/22	CRHT make a telephone call to PNMHS to determine outcome of MDT discussion, no answer so message left asking them to contact team.
30/03/22	CRHT receive a telephone call from PNMHS team manager. She advised that initially Anna has been booked into clinic for May but agreed that due to current presentation she would discuss in MDT tomorrow and request that the Consultant Psychiatrist would liaise with ourselves to discuss a medical review as soon as possible and undertake joint working until Anna's mental health is more stable. Agreed that PNMHS team manager would contact us further tomorrow to discuss this following MDT discussion.

31/03/22	Anna was discussed with Perinatal MDT. It was noted that she had had a Crisis assessment this week and was currently under the care of the Home Treatment Team. PLAN: Anna to be allocated to Perinatal nurse within the team and would be booked an appointment with the team's Consultant Psychiatrist by the end of April. Perinatal team manager informed the Crisis team of MDT discussion and the plan put in place (via email)
31/03/22	Perinatal team nurse contacted duty desk at Bridgend Children's Services. *Allocated social worker wasn't in the office today. Informed the person on the duty desk that nurse was looking for some information regarding the lady's [child]. Informed that only allocated Social Worker would be able to provide information, therefore agreed to ask Social Worker to return the call.*
31/03/22	Home visit by CRHT to deliver prescription for Zopiclone 7.5mg x 3; Diazepam 2mg x 6 tablets. Was advised by workman who answered the door that the lady was out; handed prescription to Child 2.
31/03/22	CRHT received email from PNMHS team leader: *We discussed the lady today in MDT Background of recent contacts* *Perinatal Assessment completed on the 21/03/2022* *Crisis Assessment on 29th of March following a phone call to Perinatal Team Leader* *Now under the care of the HTT* *Outcome* *Allocated to Perinatal nurse* *Perinatal Nurse, please complete joint working with HTT.* *Pending medical review with PNMHS Consultant Psychiatrist however medication advice can be provided in the interim via email. Baby has been born which increases medication options.*
31/03/22	CRHT Team nurse made a telephone call to Anna who reported that *she was doing much better, she put this down to her taking the medication that the team has provided for her along with her kitchen being finished and she was able to put all the stuff back in the kitchen cupboards. She is utilising Diazepam 2mg TDS however she has not used the Zopiclone 7.5mg as she is reluctant to do so as she has her baby at home with her.* *The majority of the call was regarding Anna's involvement with the PNMHS team. She is keen to know when her medical review with the team's Consultant Psychiatrist will be. Explained that we don't, as yet, have a date however the team will inform her as soon as they are aware of a date. The lady was concerned as it is Friday tomorrow and then the weekend. Explained to the lady that realistically the medical review will not be before next week and she understood this. Offered the lady a home visit tomorrow however she declined as there are painters coming to paint her kitchen. Agreed to a home visit Saturday afternoon at 4pm and a telephone call from the team tomorrow 1/4/2022.*
31/03/22	Assia attempted to contact Anna following social worker referral 21/03/22. No answer, voice mail left and text message sent advising of attempted call and contact details for Assia.
31/03/22	Assia record the following contact with Anna;

	Contact was made with Anna today and a RIC assessment was completed, the assessment scored 8 and deemed as medium risk, however when discussing risks Anna felt she was a risk to herself and didn't feel that Simon posed a risk to her. In the referral it stated that when Anna drinks a lot she goes to her brothers grave, we discussed this and looked at the possibility of Anna needing bereavement counselling, Anna declined counselling as her brother had her brother died 8 years ago. Anna stated she has been in a relationship with Simon for almost 2 years she said that during the relationship he's never been abusive she said they have always had a good relationship until she had the baby and then her mental health had gone downhill, and this is why she turns to drink. Anna said she trusts Simon but has doubts in her head, Anna said that before she met Simon he was seeing his best friend's girlfriend. His friend recently called Anna telling her he's seeing his friend's girlfriend behind her back but Anna didn't believe it to be true. Anna went on to disclose the issues are around her drinking, she said she sometimes goes shopping but ends up in a pub and she said that going to the pub is what started it all off. Anna has been on maternity leave up until now and intends to return to work next week to her job, as a cleaner. Anna went on to say that [Child 1] and her mother will watch the baby for her. Anna has said she's become paranoid but believes that is because of her mental health she also said she recently called the police because Simon was outside, he wanted to go into her property however she's been told by social services that he's not allowed. She said she was worried that he was there and it would go against her with her children so she called the police because he wouldn't leave, she said Simon had left by the time the police arrived. *Anna stated that she is still in a relationship with Simon, she has stated that he can see her and the baby but it has to be in a public place and a nominated family member has to be there too.* *We also discussed the issues between her and [Child 2] as per the recent referrals in relation to Anna allegedly hitting [Child 2], she stated that [Child 2] was in her face and she pushed [their] face away with her hand.* *We discussed target hardening for the property however Anna felt safe at home so declined the target hardening. Anna was adamant that there was no domestic abuse going on in the relationship, we discussed the different forms of abuse such as controlling behaviour however she said Simon isn't controlling nor is he abusive. Anna maintained the problem is her mental health and drinking, however she said she wasn't alcohol dependant.* *Anna said she has been referred to WCADA and PRAMS by her GP.* *We weren't able to offer NT any support at this point as she was adamant there is no domestic abuse in the relationship*.
31/03/22	WCADA Bridgend service transferred to new provider Barod. All clients transferred to new provider.
01/04/22	CRHT make further telephone call to Children's Services to speak to social worker who is not in the office. Team to contact on Monday.
01/04/22	CRHT make telephone call to Anna to inform her of the home visit tomorrow at 4pm. There was no answer therefore a message was left regarding the home visit.
01/04/22	Assia send the following email to the allocated Social Worker *Thank you for the referral for Anna, I contacted Anna yesterday to discuss support however when completing the CAADA DASH RIC referral with Anna it only scored 8 which is low and many of the questions she answered was about herself rather than Simon and they all related to when she consumes alcohol. Anna stated during our phone conversation she feels safe in her home, she's not afraid of Simon and there's been no domestic abuse taking place. Anna did acknowledge the incident between her and [Child 2], Anna alleges that [Child 2] was close to her face so she pushed [their] face away she states she didn't slap [them].* *Anna completely realises that the issues and incidents are always alcohol related when then impacts on her mental health, Anna said she*

	definitely wants support around this her problems and I know she has already accessed help for her alcohol issues and mental health. *Anna is adamant there is no domestic abuse in the relationship, I explored this further with Anna and discussed the different types of abuse a perpetrator uses against the victim, Anna said he's not controlling nor is he aggressive.* *I spoke about the loss of her brother, she said her brother died 8 years ago, I asked Anna if she would like bereavement support but she declined saying it was a silly thing to do and it was because she had been drinking.* *Anna is adamant there's no domestic abuse in the relationship and it's because she suggests this that we can't support her. However Anna has my contact details and I've reiterated that she can call me anytime if anything changes.*
02/04/22	CRHT record *Telephone call message from the lady asking for a phone call back.* *The lady has phoned back, she said is ok, she was quiet emotionally expressed, on the phone, she was concerned that nothing has been done regarding her medication review and wants this to happen ASAP. I have explained that PNMHS was discussing her in their meeting on Friday and we are waiting for the outcome regarding her medication. The lady said she doesn't want to go back to the way she was feeling the beginning in the week and wants the medication changed, I have explained that we are waiting for the outcome and medication would not instantly change the way she is feeling. The lady stated she isn't taking the zopiclone as she needs to get up for her child. She said she is taking the diazepam, but feels she is still having emotional outbursts. The lady said she is going to run out of the Diazepam tomorrow, it was explained that the team will get her a script of Diazepam and a staff member can take it with them when they review her this afternoon. The lady stated she has had a letter from Assisting Recovery in the Community (Local Primary Mental Health) to contact them to arrange an appointment. I have explained the difference between ARC and PNMHSS as the lady didn't understand why she was having involvement from both.* *PLAN: Home visit this afternoon at 4pm. Script needed.*
02/04/22	CRHT Home visit as arranged. *The lady was dressed in her pyjamas and dressing gown however was well kept. She engaged well, there was good eye contact and a good rapport was established. She was waiting for her brother to collect the baby as he was going to stay overnight with her brother and his partner as the lady had plans to go to the local pub with her sister. Observed the lady with the baby and she was appropriate and loving at all times. The lady was concerned about the delay in her ongoing follow up with PNMHS as she is keen to start a new medication. Lots of reassurance given to the lady around this which she appeared to understand. Spoke to the lady at length about accessing talking therapies which she would benefit from. She has received a letter from ARC and will ring them on Monday. The lady queried whether she had Bipolar disorder. Explained that only a Doctor could give a diagnosis but explained the similarities around Bipolar and Emotionally Unstable Personality Disorder (EUPD). The lady feels that she ticks a lot of the EUPD boxes. The lady plans to go for Sunday lunch with her [eldest child] tomorrow so will contact the team, if needed. Telephone call on Monday and chase PNMHS appointment.*
03/04/22	CRHT Home Visit to deliver script no reply script posted through letterbox.
03/04/22	Simon contacted South Wales Police via the 999 Emergency Call Facility to report a burglary at his flat. Simon suspected his ex-partner; Anna was responsible for committing the alleged offence. He listed the property stolen from his home. Simon also accused Anna of attending his home in the early hours of the morning and was said to be making life hell for him. Simon stated he had received information from 'Other People' who advised him, Anna was posting messages on social media in which she was making false allegations against him. Some of the messages were said to be abusive and relate to Simon being involved in drugs.

	Initial response of officers was delayed due a high number of 'emergency calls'. Simon was visited by officers on 04/04/22. He was unable to provide any evidence to substantiate his allegation that Anna was responsible for a Burglary/Theft from his home and was also unsure whether he wished to make a formal complaint. At 23:58hrs on 04/04/22 Simon completed a Statement to the investigating officers in which he explained he did not wish to make a formal complaint against Anna. Simon did however, express that he would have welcomed Anna being spoken to by the Police and for her to be warned about attending his address and posting messages on social media about him. The officer attended Anna's home address, where she was spoken to about Simon's allegations. Anna admitted to posting messages regarding Simon on 'Facebook', which she regretted and had since removed. Anna explained she had posted the messages as retribution towards Simon as he had been cheating on her with his ex-partner, when they were in a relationship. This was also at a time when Anna was pregnant with Simon's child. A PPN Form was submitted as the incident was considered to be a Domestic Incident between Simon and Anna. The Form was received and assessed with a 'Medium Risk' recorded. The matter was not referred to MARAC and it was noted Simon had not consented for details to be shared and he declined any 'Referrals'. The incident was discussed at the MASH Joint Screening.
03/04/22	PPN received by Bridgend Early Help team – no further action. No role for Early Help and consent declined.
04/04/22	Perinatal nurse attempted to contact CRHT team for an update of their involvement with Anna. There was no response therefore an email was sent to CRHT team asking them to contact Perinatal team to discuss joint working options.
04/04/22	WSA case worker undertook a home visit to Anna and support provided for council tax debt. Case worker contacted local authority (04.04.22) & local hub (05.04.22) on Anna's behalf and discussed options available around managing debts. Case worker also looked into options available to wipe debt.
04/04/22	Anna was discussed as part of Perinatal MDT. It was noted that *Perinatal assessment was completed on 21/03/2022, the lady then contacted CRHT before being discussed in MDT. The lady has now been allocated a perinatal mental health nurse. A notification of MDT outcome was sent to the lady's GP. It provided details and recent input and support from mental health services. The notification stated the following plan and support was in place for the lady:* *1. Booked in for a psychiatric review on 06/04/2022 at 09:15am.* *2. Allocated a Perinatal mental health nurse who will arrange joint working with the CRHT to clarify and address perinatal needs.* *3. Ongoing assessment and support offered by the perinatal mental health service.* *4. For the lady to engage with Social Service's and Health Visitor for ongoing support.* *5. To engage with WCADA for substance misuse support* Copy of Anna's assessment with the Perinatal nurse also shared with Anna's Social Worker and Health visitor.
04/04/22	Telephone call made by CRHT to Anna

	The lady was pleasant and appropriate. She said she is not too bad. She went out for breakfast this morning and had an appointment with Pathways (WSA) to help with council tax forms etc. I advised the lady that a Perinatal nurse has been allocated to her and we plan on arranging a joint home visit for the Perinatal nurse to meet her. Same agreed by the lady and she was thankful for our support. *PLAN: Telephone call tomorrow*.
05/04/22	CRHT sent email sent to Social Worker requesting information regarding their current involvement.
05/04/22	CRHT telephone call to allocated Perinatal Nurse. *There is a cancellation tomorrow with Perinatal team's Consultant Psychiatrist, Perinatal Nurse will contact the lady today to see if she is available. Perinatal Nurse said she is happy to take the lady's care over.* *Informed Perinatal Nurse that the lady's allocated Social Worker at Children's Services has been emailed for more information and CRHT will forward any information received, Social Worker's contact details will also be provided.*
05/04/22	
05/04/22	Perinatal services received a phone call from CRHT nurse who stated that Anna had been under the CRHT for the past week and now no longer appears to require input from CRHT as she is not expressing suicidal ideation or requesting hospital admission. Anna is keen to discuss her medication with a Doctor; perinatal services explained there was a cancellation tomorrow which could be offered to Anna to which CRHT agreed this would be suitable. CRHT stated they had contacted the Social Worker for an updated social services plan. Discussed that a joint visit from CRHT and Perinatal not required as likely that Anna is likely to be discharged now that a psychiatric review has been arranged. PLAN: CRHT to discharge from their care as now handed over to Perinatal services. Booked in for Perinatal Consultant Psychiatrist review on 06/04/2022. The lady to be contacted via phone to be informed of clinic appointment tomorrow and then be followed up by Perinatal nurse.
05/04/22	Allocated Perinatal nurse contacted Anna via telephone to confirm she was available for arranged appointment tomorrow. Records as follows *She confirmed she would be available and expressed how keen she was for medication to be changed. The lady became tearful and explained that "things have got worse since the weekend". She went on to explain that there had been domestic incidences between her and her partner. The lady's partner had been sending her messages of him talking to other women and claiming to spend the day with one of these women he is talking to. The lady has found this to be greatly distressing and put her "over the edge". The lady reported that on Saturday she went to a local pub that her sister [and eldest child] work in so that she was not alone in the house. Since Sunday the lady has now blocked her partner/ ex-partner on the phone after arguing and has not spoken to him since then. She stated that such partner has no interest in their 4 month old baby and it was an unplanned pregnancy. The lady stated that she has not been fully truthful about her relationship and has been "playing things down" to "how bad they really are". She stated that she was now ready to be open and honest with professionals as she feels her partner has been blaming the lady's mental health for what has gone on recently, but that he is also to blame. The lady stated that she has recently had an assessment with Calan DVS/ Assia (domestic violence charities) however she lied on some of the questions about him asking for "sex" every day and becoming verbally aggressive if she refused as well as constantly talking down to her or knocking her so her glasses fell off. The lady confirmed that his behaviour towards her is not a current safety concern because she has blocked him, nurse explained he is in the local area*

	and knows her address. However she stated she did not think he would approach her because there is an agreement with Social Services that that both parties are not to be around each other and their baby without a third party present. The lady was advised to contact the Police immediately to report any incidents of domestic violence or harassment. Also discussed the possibility of having a further assessment with domestic violence support services but answering the questions truthfully, the lady was allusive around this and kept changing the subject. The lady did not appear to take on advice or information provided to her and instead kept changing the subject. She stated that everyone kept talking about her having to go to "Ward 14" where she went for a CRHT assessment and she does not feel that she can trust or rely on anyone at the moment. The lady stated she had had an "alright" day today going out, with her sister helping her with childcare. The lady denied experiencing any thoughts of deliberate self-harm or suicide and also stated that she currently feels safe in her house. She was reminded again to ring the Police if she experienced any harassment from her partner. The lady reported her Social Worker was due to visit her on Thursday, nurse asked if she could attend the visit also to make introductions, the lady agreed. The lady was provided with the office number to contact services if she requires and CRHT number in the event of any emergency. *PLAN:* *1. Consultant Psychiatrist appointment confirmed for 06/04/2022.* *2. Social worker to be contacted to arranged joint assessment on 07/04/2022.* *3. Her phone number to be updated on clinical portal.*
05/04/22	CRHT received an email from allocated Perinatal Nurse informing the team that Anna had been booked into clinic the following morning. CRHT provided background information and ensured correct details updated on FACE. CRHT informed perinatal nurse that Anna keen to change her medication. The email also referenced social issues and a request will be made to see if the Perinatal Nurse can attend a visit with the lady's Social Worker on Thursday at 12pm as she does not feel that she was truthful in her ASSIA assessment regarding her ex-partner.
05/04/22	Perinatal mental health nurse made contact with Social Worker via email and made arrangements to undertake a joint visit at Anna's property at 12pm Thursday to make introductions and develop relationships. Perinatal nurse informed Social Worker that during telephone contact the lady had disclosed she had not been fully truthful when answering Assia assessment and the nurse felt she may require another assessment from them. The lady's Social Worker later replied, confirming Perinatal Nurse could attend upcoming visit on Thursday.
05/04/22	CRHT team nurse sent an email to Perinatal nurse thanking them for being involved with the plan. CRHT team nurse asked if Perinatal would be happy if CRHT discharged care over to Perinatal now that Anna is no longer in crisis or at the point of hospital admission.
05/04/22	CRHT received an email from Perinatal nurse agreeing that Perinatal would take over Anna's care. Informed that Perinatal assessment/MDT summaries had been placed in notes and on computer drive and Perinatal would update their records to say that Anna would be discharged from CRISIS team.
05/04/22	Crisis team received an email from the Social Worker *The family are open to social services for a care and support assessment due to Mum being drunk and getting involved in an argument with [Child 2] and she was taken away by the police. She has been referred to PNMHS and she has phoned WGCADA and wants more support with her mental health. I am due to visit her on Thursday. I also referred her to ASSIA but this was closed straight away. I referred her in relation to Mum having issues with her boyfriend who doesn't live with her but seems to be a trigger for her drinking. How are you involved please? Are you able to offer any further support?*
05/04/22	CRHT replied to the social worker with the following email

	We are a crisis support service who offer short term support whilst the person is in crisis or at the point of hospital admission. *The lady self-referred via the single point of access service. She was tearful and in a distressed state. She expressed suicidal thoughts of going to the train track, feelings of worthlessness and hopelessness. She gave birth 4 months ago, previous excessive alcohol use and increased use since birth of [child] which has resulted in police and social services involvement. She was seeking admission to hospital. Home Treatment Team support was offered as an alternative to hospital admission.* *The HTT have been involved since 29/03/2022. She is no longer in crisis or at the point of hospital admission. She has been discharged from our care today to the care of a Perinatal nurse within PNMHS.*
06/04/22	CRHT attempt to call Anna. No answer. Voice mail left to contact the team.
06/04/22	Perinatal Consultant Psychiatrist appointment records: *DIAGNOSIS: Emotionally Unstable Personality Disorder with Obsessive Compulsive Disorder Traits.* *CURRENT MEDICATION: Venlafaxine 75mg BD, Propranolol 40mg BD, Diazepam 5mg PRN.* *CHANGE OF MEDICATION: Increase Venlafaxine to 150mg mane and 75 mg in the evening. No change to Propranolol or Diazepam dose. Initiate on Promethazine 25mg BD.* *The lady was reviewed in Perinatal clinic via telephone. The lady reported that her baby was born on 17th November 2021 and she said she stopped drinking alcohol before her pregnancy and kept her abstinence during her pregnancy. Currently she is not breastfeeding and she said that she is looking after her baby and [they are] "her life". She said her baby is her main focus otherwise she would have relapsed with her alcohol dependency. She said her mood has been low for the past 4 months and her mood was better two weeks ago for 4 days. She said she is overthinking and that is causing her to have poor sleep. She said she is not eating very well and some days she will eat and some days she will avoid eating. She reported that her relationship broke on 2nd April 2022, and since then she has been thinking about how she is able to manage her baby without his father. She has a longstanding history of emotionally unstable personality disorder and alcohol misuse. She works as a cleaner and she has 2 grown up children who are living with her. She said she cleans her home all the time and can't tolerate any small unclean space. She said cleaning is her obsession and has been since early adulthood. There are no thoughts of contamination or history of washing hands or cleaning of clothes. Although she said she does wash clothes a bit more frequently than many other families. The lady states she needs to put her glasses in the same order and keep things in order, any change makes her restless and she needs to put them back in order. She said she plans her money 2 months ahead otherwise she can't cope. Currently she is looking forward to starting work in Porthcawl as a cleaner in a weeks' time. She reported that she had had alcohol a week before when she attended a party and she said it was a minimal amount and at that time her baby was with her mother. She said she has been taking Venlafaxine medication for the last three years and it helped in the past but since the baby was born it is not helping. It was explained that it could be because of her recent relationship breakdown but she would like to increase her medication.* *PLAN:* *Change of medication as above. Follow up by CRHT/ Home Treatment Team as she is already under HTT and on discharged it has been*

	requested Perinatal team refer her to ARC services for an emotional resilience course. No further appointments have been made but if they are required allocated perinatal nurse can arrange in due course. GP was notified of changes made to medication.
06/04/22	Anna contacts CRHT via telephone. Record as follows; *The lady stated she had spoken with the Psychiatrist from the Perinatal team today who has agreed to change her meditation. She has a nurse going to visit her tomorrow from the team. Explained to the lady that Perinatal services will now take over her care and she will be discharged from the home treatment team. Anna was happy with this and confirmed if she needs support that she will contact PNMHS or the Single Point of Access. The lady was thankful for home treatment team's support. Discharge paperwork to be completed.*
06/04/22	CRHT Discharge Summary *INTERVENTION* *The lady was referred for home treatment support following a self- referral to the SPOA service.* *The lady was in a tearful and distressed state. She was expressing suicidal thoughts of going to the train track and had feelings of worthlessness and hopelessness. She gave birth to a baby 4 months ago. There is a history of excessive alcohol use and this has increased since the birth of [child] which has resulted in police and social services involvement following an altercation with [another child] whilst intoxicated. She was seeking admission, however, HTT was offered as an alternative.* *ENGAGEMENT* *The lady engaged well with HTT support. She was referred to the Perinatal team and was reviewed by the Consultant Psychiatrist. Some changes were made to her medication (see below). She has been allocated a Perinatal nurse who will be her key worker.* *Children's social worker and Perinatal Nurse will be reviewing the lady jointly today.* *MEDICATION ON DISCHARGE:* *Venlafaxine 150mg Mane and 75mg Nocte.* *Promethazine 25mg BD.* *No change in Propranolol and Diazepam dosage.* *DISCHARGE PLAN* *ADVICE AND / OR INFORMATION GIVEN.* *Advised she can contact allocated Perinatal nurse if she needs help and advice. She can also contact the SPOA number.* *REFERRALS* *No referrals made.* *FUTURE APPOINTMENTS* *Appointments with Perinatal nurse and Children's Social worker.* *RELAPSE INDICATORS* *Low mood.* *Suicidal thoughts.*

	Increased alcohol use. *PART 3 Discharge Leaflet sent in post.*
06/04/22	Health visitor home visit – *Child not present sleeping over brothers, confirms that the crisis team are seeing her. Reports that she feels her partner is controlling, continues to drink but not reported to be excessive. Advised to attend groups and to discuss issues with PRAMS and WCADA.*
06/04/22	Letter from PRAMS received by Health Visitor regarding recent assessment and noted EPDS as 26
07/04/22	Summary of Consultant Psychiatrist feedback noted in Anna's file for the PRAMS team: *Emotionally Unstable Personality Disorder (EUPD) with Obsessive Compulsive Disorder (OCD) traits.* *Partner left her last weekend, struggling with the loss of the relationship* *Anxious, agitated* *Contacted CRHT and came under HTT* *4 month old [child]* *Prescribed Promethazine 25mg BD, Venlafaxine 150mg mane, 75mg nocte* *Allocated Perinatal nurse to see the lady in 2 weeks* *Encouraged to complete self-referral to Primary Mental Health services – ARC.*
07/04/22	Perinatal nurse visits Anna at home with the social worker and records the following; *Joint visit undertaken with the lady's Social Worker. She was having a new kitchen, planned to be finished next week, she stated however the workmen present did not cause her anxiety. The lady's baby was present and sat on her lap during the visit, presented as clean and appropriately dressed, was content and looking around with interest. Lovely interaction of bonding and attachment witnessed between mother and baby, good eye contact between both and displays of soft affection by the lady. The baby appeared happy and content in mother's presence. The living room was well present with no risk to children/ others identified. The lady was provided with a prescription from HTT which she is happy to collect from Pharmacy. She is aware that she has been discharged from HTT and is okay with this, feels that initial crisis point is over and thoughts and feelings of suicidal ideation have started to improve. Discussed appointment with Consultant Psychiatrist yesterday and is happy to change her medication, explained that it could take 4-6 weeks for the medication to have a therapeutic effect. The lady expressed that her main concerns are to do with her partner which she says worsen her anxiety. The lady showed nurse and social worker photos on her phone which she stated her [child] has taken of the lady's injuries which her partner has given her, including bruises to arms and face. Social worker agreed to re-refer to domestic violence agencies and the lady has agreed to re-engage for another assessment. The lady stated she is feeling slightly better since the weekend now that she has blocked her partner on Facebook and has not spoken to him in a few days. She is willing to be more open and honest with professionals and her family regarding their relationship. The lady has also self-referred to WGCADA for support with alcohol misuse. The lady reported that her mental health has always been up and down but became worse when things started to get worse in her relationship. The lady stated that when she met her partner he had nothing, and relied on her to turn his life around, she gave him everything. She also reported feeling "trapped" when she became pregnant as it was unplanned. She stated she experienced Post Natal Depression with her [second child] 16 years ago but that this didn't feel the same as she loved being her baby's mother and felt protective and love towards [them]. The lady went on to report that she wonders if it was her partner that was suffering with Post Natal Depression and not her as he did not bond with their [child] at all during the pregnancy or after [they were] born and seemed completely uninterested of being a father. Nurse discussed with the lady what could be offered from Perinatal Mental Health services however identified that her main issues are related to*

	domestic and social circumstances which may be having an impact on her mental health and therefore require support and monitoring which the lady was accepting of. Discussed poor coping strategies, agreed to have resources sent to her via post. Also offered to refer the lady to the Postnatal Support Group in ARC for her to interact with peers and looking at managing low mood during the postnatal period, however the lady is unable to attend as she does not drive. The lady is appreciative of the support offered to her from mental health services and is willing to engage as much as possible. *PLAN:* *1. Follow up arranged for 3 weeks' time (26/04/2022)* *2. Social worker to re-refer to ASSIA suite, domestic abuse services* *3. The lady was encouraged to contact perinatal services or CRHT if she requires any mental health support during appointments.*
07/04/22	Children's Services record the joint visit that took place with social worker and the Perinatal Mental Health Nurse. It is recorded that Anna stated that she had been dishonest previously with the worker from Assia and stated that Simon had strangled her and used coercive and controlling behaviour. Social Worker agreed to speak with Assia and re-refer Anna for support.
08/04/22	South Wales Police were contacted at 00.28hrs via the 999 Emergency Call Facility by Simon's new partner. She reported an offence of Criminal Damage to her Motor Vehicle. The Operator recorded: 'Someone just put my car window through, Back Rear Passenger side. She keeps walking up and down, still in the street. A description of the assailant was provided, who was said to be wearing glasses and a yellow puffer coat with the hood up'. Anna's details were linked to the police log. Officers were deployed to the incident at 00:32hrs and were recorded as having attended at 00:51hrs. It was recorded upon their arrival 'No suspect was seen and area was searched'. The damage to the reporting person's motor car was noted and her complaint was recorded. Following a search of a nearby alleyway, a brick was located and it appeared to be linked to the marks on the window of the motor car. House to House and C.C.T.V. enquires were identified to be conducted to assist the investigations. The reporting person provided a statement to the Police timed at 01:42hrs. The Police Log was endorsed at 09:54hrs with instructions, 'The Log does not need to remain open, the Reporting Person has given a statement stating she believes Anna to be responsible but has not actually seen her cause such damage, this incident has been left open for CCTV and house to house enquiries which can be done through NICHE by Neighbourhood Policing Team and then the original attending officers can pick up any actions from the outcome of the CCTV and house to house'. From the Lines of Enquiry identified, it was noted CCTV Footage of the incident had been obtained from the H-2-H enquiries. Arrangements were made to collect this evidence, which was recorded at 18:34hrs as having been conducted. Police Sergeant endorsed the Occurrence to indicate the inquiry had been to progress. It was noted a statement had been obtained and the 'Suspect' to be interviewed / Voluntary Attendance for the offence.

	The next update on the Occurrence is at 07:25hrs on 12th June 2022 after Anna's death.
10/04/22	Local Primary Mental Health Team close Anna's referral stating that she is receiving a service from PRAMS.
11/04/22	Anna contacted South Wales Police at 07.30hrs. She reported her ex-partner, later identified to be Simon, had contacted her the previous evening. He was said to be accusing Anna of breaking into his flat last week. Simon also informed Anna that he was not going to see their baby unless she returned his property which Anna denied having. Anna added her child was four (4) months old and she was feeling distressed having received Simon's messages and wanted them to be stopped. The Police Log was endorsed at 07:39hrs with additional information. It was noted Simon's home was broken into the previous weekend and he suspected Anna to have committed the offence. Officers recorded the number of attempts which were made to contact Anna throughout the day, but this was to no avail. At 23:08hrs officers endorsed the Occurrence on 11/04/22 to indicate Anna was eventually contacted. She informed the officer, she only wished to have the incident recorded and she was not prepared to make a formal statement. Anna did not want the Officers to contact her ex-partner Simon neither did she want the Police to call at her home. The officer explained to Anna that a 'Negative Statement' would be required from her and arrangements were to be made with her to complete this task. On 6th May 2022 the Officer in Charge endorsed the Occurrence with an update of contact with Anna. The Officer made reference to interviewing Anna on 22/04/22 in relation to Simon's allegations of burglary etc. as recorded within NICHE Occurrence *118732 dated 03/04/22. Therefore the two Occurrences were linked and it was noted a PPN Form had been submitted in relation to the incident on 03/04/22. The officer added that Anna appeared to be making a counter allegation against Simon, because he had accused her of committing a burglary at his flat and to posting abusive and malicious messages about him. Anna denied the allegations and was not wishing to pursue a complaint against Simon. The officer stated that Simon was of the belief Anna had committed the offence at his flat although would not provide a statement. He had admitted to sending messages to Anna to request his property be returned. Therefore, the officer was of the opinion that Simon's contact with Anna did not constitute an offence of 'Malicious Communications' and the incident was finalised.
12/04/22	WSA Case Worker contacted Anna regarding her debt to advise Anna to contact Citizens Advice (CAB) as they needed to speak with her directly. Case worker provided Anna with availability for further appointments & offered to take her to CAB.
13/04/22	Anna made a self-referral into the Drug and Alcohol Single Point of Access. The referral was sent to Barod Low Intensity Team for allocation and the Community Drug and Alcohol Team (CDAT)
14/04/22	Email from Social Worker to Assia *Hi, Can I please refer Anna again if possible? I have met with on Thursday last week along with a worker from PRAMHS and she said that she has been dishonest to you and now would like further support and would be open and honest. She said that she has been strangled by him and he has had used coercive control. Thanks*

	Email was sent to the assessment team to contact Anna
14/04/22	Assia attempted to ring Anna prior to sending the referral to the assessment team but were unable to contact her and the call went to voicemail.
14/04/22	Anna attended clinic with baby. Clinic records not recorded in SOAP (Subjective Objective Assessment Plan)
15/04/22	South Wales Police were contacted via the 999 Emergency Call facility at 03.15hrs by a female reporting a disturbance at a neighbour's address stating 'There sounds like a possible fight ongoing, with raised voices'. The female reported hearing a loud bang. The incident was graded as a G1-Emergency Response with officers being deployed at 03:18hrs. Officers were recorded as attending the incident at 03:46hrs and it was noted, all was quite upon their arrival. The female occupant, girlfriend of Simon was spoken to by officers and stated she had been with a few friends at her home address. Amongst these friends was her new partner, Simon. She added, Simon appeared to be in a 'Mood' and he was responsible for the shouting and swearing but he had since left her home. The Officers ascertained from the female that there had not been any 'Domestic Incident' and no offences were disclosed. There were no other person's present at the address however whilst the Officers were present the female's uncle and nephew attended and were to remain with her. The officers submitted a PPN Form and it was noted she had been offered a referral and encouraged to speak to an IDVA but she declined this course of action. The risk assessment recorded as 'Medium'. The Form was shared with the MARAC Co-ordinator for information purposes. The assessor of the PPN recorded that Simon was identified as being a 'Serial Perpetrator' and noted his offending history. It was also noted that the DASH had not been completed and no consent had been obtained to share the details contained within the PPN. With regards to the safeguarding measures the assessor recorded the PPN would be shared with Health and with MASH for Joint Screening. A task was also created for a consideration for a Clare's Law Disclosure to the female regarding Simon's antecedence.
19/04/22	Anna's referral accepted by Barod and the Team Leader allocated the case to a Low Intensity Worker
21/04/22	Low Intensity worker attempted to make contact with Anna but there was no answer. Voice message left on Anna's phone explaining that he wanted to book assessment with her.
23/04/22	Children's Services completed the Care and Support Assessment and a post strategy discussion held following completion of the Section 47. Decision to proceed to Initial Child Protection Case Conference (ICPC).
25/04/22	Joint Allocation Meeting (JAM) took place between Barod, Dyfodol and Community Drug and Alcohol Team (CDAT) to discuss referrals via the Drug and Alcohol Single Point of Access. Anna's referral to CDAT discussed and deemed suitable.
26/04/22	Low Intensity Worker phoned Anna and an appointment arranged for the 05/05/22 to complete the assessment
26/04/22	Telephone contact as arranged with Perinatal allocated nurse. The records state that *The lady reported she was "doing great" and had no current concerns regarding her mental health. She stated that her and her partner officially separated around 3 weeks ago and he is now seeing another women. The lady stated she was very upset around the time of the breakup however did not enter crisis point and was able to deal with this emotional response after a day or two. The lady has had a phone call with WGCADA today and has an appointment arranged for two weeks' time. She has still not heard from ASSIA service for domestic violence*

	support, it was discussed that she may benefit from the Freedom Project with women's aid to build up confidence and learn for future healthy relationships. *The lady reports she is still taking medication, no issues reported and is happy to continue taking it. The lady reported taking the baby out for a walk to the park yesterday and enjoyed it. She reported going to the pub where her sister works in the week and only drinking two cans of pop. Her brother and his partner looked after the baby overnight which went well and she was pleased to have a break and some support. Agreed to follow up in 4 weeks' time to review mental health and discuss transfer to primary mental health services for long term support if no perinatal needs are identified.* *PLAN:* *1. Contact Social Worker to request chase up of Women's aid referral.* *2. Invite received for case conference 09/05/2022.* *3. Follow up arranged for 24/05/2022 at 11am via phone.*
27/04/22	Allocated perinatal nurse contacted Anna's Social Worker to update regarding yesterday's contact. Social worker was informed that it had been agreed Anna would be kept on as perinatal case for another 4 weeks and review and if her mental health remains stable and there are no concerns she would be transferred to Primary Mental Health Services with longer term support and access to group work. It was highlighted that the lady had stated she would be having involvement from WCADA but they hadn't been invited to the case review so nurse suggested they were invited. Also stated that the lady had not heard from ASSIA yet and when would contact be likely. Social worker replied to the email stating they had asked BAROD to attend the case review and contacted ASSIA again. Perinatal nurse replied informing the social worker of Anna's next appointment which is when she will be reviewed as to what ongoing support will be needed. It was noted she would have needed 4 – 6 weeks for new medication to take effect so by next appointment nurse would expect to see some benefits from this.
27/04/22	Child 2 and Anna attend an induction session at Bridgend College
01/05/22	Simon contacted South Wales Police at 14.48hrs to report harassment from his ex-partner, Anna. He stated there had been ongoing issues between him and Anna which he had previously reported to the Police. Simon explained he and Anna had ended their relationship, but they had a five (5) month old child together. Anna was alleged by Simon to have sent him a Bank Transfer of £1:00p on 29/04/22, and a message saying, 'Fuck K Money, you wait'. Simon also alleged that Anna had been contacting friends of his much to his annoyance. The Police Log was endorsed at 15:00hrs with details of the contact made with Simon. He informed the Officers that he did not wish for any Police involvement. Simon explained he had only reported the matter wanting his complaint recorded but not escalated at that stage. His reasoning he added, was because he and Anna had a child together and Court action was in progress regarding his contact with his child. Simon considered Anna's actions to be low level threats and he did not expect any further issues with her. The Officers advised Simon they may need to take matters further should there be any additional reports of incidents between him and Anna. Simon was said to fully appreciate the Police response but still declined to make a formal complaint. An Inspector conducted a 'Review' of the incident on 04/05/22 and considered all the circumstance. The officer concluded, it appeared to be a low level offence and the reporting person was reluctant to make a complaint. Instructions were recorded for a PPN Form to be completed with any updates included.

	Simon was spoken to again by officers on the 4th May. He reiterated his intentions to the officer for initially contacting the Police which was to have his complaint recorded but did not wish for any further action to be taken on his behalf. Simon was described as being vague, but it was established, the reference to the initial 'K' in the message from Anna to him related to the name of their child. Anna was said by Simon to be making it difficult for him to have contact with their child on a regular basis. The Officer also recorded he made contact with Anna, who was described as being emotional. She explained that in her opinion Simon did not want anything to do with Child 3 and had not at that stage seen the child for six (6) weeks. Neither was Simon making any financial contribution towards the child's upkeep and he was in a new relationship. Anna informed the Officer that she would make attempts to encourage Simon to take a more active role in their child's upbringing. She had hoped to do so by making contact with Simon's mother. Anna was advised to contact her Social Worker regarding Simon's involvement with Child 3 and her financial issues. The officer did not consider any offences had been disclosed and therefore no further police action was required. PPN completed following discussion with Simon on 4th May. In reviewing the PPN the previous incident 3/4/2022 was noted. Medium risk was recorded – no referral to MARAC and it was noted that Simon had not consented for his details to be shared. submitted and shared with Early Help services The incident was discussed at the Joint Screening Meeting and it was shared with Children Services, Health and Early Help. The MASH was aware of the persons involved. The Occurrence was updated on 05/05/22 and recorded details of a telephone call from Anna. She stated she was still attempting to contact friends and family with regards to the money Simon owed her. Anna added that she had contacted Simon the previous week which had resulted in Simon reporting Anna to the Police for harassing him. Anna wanted this report to be recorded and added she had complied with all the advice provided to her.
03/05/22	Anna contacts Assia to self-refer. Record as follows; *NT contacted the Assia suite to self-refer, I stated we did attempt contacts following new referral from social worker. NT stated she hadn't disclosed everything last time so wanted to do a new assessment.* *Anna stated she was with Simon for 20 months, separating in April 22. they have a 6 month old [child] together. Anna said when together Simon was controlling and emotionally abusive, he would take her out of the area if they were out socially so that she would not know anyone. "he would spend all my time together so i did not see anyone else and when i did go out he would message me constantly". Anna stated that in January when she went to his property drunk "he threw her out of bed after an argument, attempted to strangle her from behind and in front, dragged her through the house and kicked her in the back" this has not been reported. Anna also stated since having her baby Simon has hit her over the head and strangled her on another occasion. Anna stated she had not spoken to Simon recently as she was trying to arrange child contact through her sister however Simon has not committed to anything and became abusive via text message so her sister has now blocked him. Anna stated that Simon takes valium and cocaine, Anna said that social services were are aware of physical incidents, Anna also mentioned Simon's mother supervising contact however this has not been discussed yet. Anna has not really spoken to Simon's mother before. Anna believes Simon will not apply to court as he has other children he does not have contact with. Anna has asked Simon for child maintenance but he does not give her any we discussed contacting CSA. Simon has also contacted the police stating Anna has harassed him which she states is*

	untrue and is now concerned about what else Simon will say or do. Anna has mental health issues and is on antidepressants and has been referred to PRAMS, she stated her mental health is under control at the moment and she has recently had a review with GP. *Anna would like to do some one to one work involving tactics/warning signs as suggested by social worker, we agreed to refer for further support and complete V2C TH referral. Advised Anna to block Simon, have no contact and report to the police, download bright sky app. Anna also has our contact number.* Needs assessment and safety planning completed. DASH RIC completed – medium risk (10) Anna referred to waiting list for community IDVA support Target hardening referral sent to Valleys 2 Coast Housing.
04/05/22	Health visitor completed 6 month contact. No entry on PIMS (case recording system). Basic documentation available only.
05/05/22	Allocated perinatal nurse completed a report for the Initial Child Protection Conference scheduled for 09/05/2022. Perinatal nurse contacted Anna via telephone and went through the report with her. It is reported that she was happy with it and wished to make no changes. The report provided information relating to Anna's background, housing situation, family history, employment, income. It included perinatal services assessment of parenting capacity of which there were no concerns and it stated there was good bonding and attachment during interactions the team had had. It included a chronology of events with perinatal services. The report summarised Anna's perinatal mental health as requiring emotional support whilst reaching a therapeutic dose of medication and that there were no identified perinatal mental health needs at present. It stated that there were no present identified risks and that Child 3 is a protective factor. It identified that a referral to primary mental health services for emotional coping strategy/support long term would be beneficial and that a discharge/transfer appointment had been booked and that Anna was aware. Anna's strengths were identified as being able to seek help and support from professionals. She demonstrates and describes a close loving bond with Child 3 and is able to meet the child's needs physically and emotionally. She has started to request more social support from family such as her brother and sister. Her eldest child is also a supportive factor particularly in helping to look after the baby so that she has periods of rest and self-care which will improve her mental state. Anna is prescribed a therapeutic dose of anti-depressant which she is taking regularly. It notes that Anna has engaged well with known services and has kept on top of appointments. Her children are strong protective factors against acts of self-harm or suicide. The report identified Anna's needs stating she requires continued support from her close family to help look after her mental wellbeing and baby so that she does not become overwhelmed. She needs to continue taking her medication as prescribed and have it reviewed regularly. It states that Anna would benefit from some support from services such as WGCADA and Assia to work on areas of concern such as alcohol misuse and domestic violence and that she would also benefit from ongoing input from Primary Care Mental Health Support Services. The report also identified and highlighted Anna's risks being; *risk of recent and previous alcohol misuse, if relapsed into alcoholism there is a risk towards self and others including children in her care and also impulsive behaviour whilst under the influence of alcohol. Also risk due to contraindication with prescribed medication. Previous risk of fleeting suicidal thoughts, no active plans. Risk of victim of domestic abuse including coercive control and physical violence from ex-partner.*
06/05/22	Early Help Services receive PPN re incident 1st May (harassment reported by Simon) – decision to No Further Action based on no role for Early Help and consent declined.

	PPN received by BCBC Children's Services
09/05/22	Initial Child Protection Conference held. Both children placed on the Child Protection Register under the category of Physical and Emotional Abuse. Meeting conducted via Teams and in attendance; Chairperson, Conference Clark, Social Worker, South Wales Police, School Health Nurse, Education Engagement Co-ordinator, Health Visitor, Perinatal Mental Health Nurse and Anna.
09/05/22	Perinatal Mental Health Nurse makes a record of discussions at the ICPC and records the following Plan of actions for Perinatal Mental Health Services PLAN 1.Perinatal Mental Health Services to follow up appointment already arranged for 24/05/2022 for discharge review. 2. The lady already has an appointment with Primary Mental Health Team tomorrow with the view to transfer from Perinatal Mental Health Services in order to attend Emotional Coping Skills Course and receive bereavement for her brother's suicide. It is recorded by the Perinatal Mental Health Nurse that *Reported from the Police that the lady has accessed Clare's Law (this designates several ways for Police officers to disclose a person's history of abusive behaviour to those who may be at risk of such behaviour). The lady's ex-partner was highlighted as a serial domestic violence perpetrator. Domestic Violence markers were placed on the lady's house for her own protection.*
09/05/22	South Wales Police create 'Warning Flags' in relation to Child 2 and Child 3 to indicate their details had been included on the Child Protection Register under the Category of 'Emotional and Physical' Harm.
09/05/22	A Detective Inspector 'Reviewed' the application for the Clare's Law Disclosure to Anna and declined. The rationale was recorded upon the Occurrence on 9th May 2022 and was based on the grounds that Anna and Simon were no longer in a relationship. It was noted that Anna had been provided with Safeguarding Advice. The Officer recorded the attempts made to contact Anna but to no avail. A message was therefore e-mailed to Anna's Social Worker, with the Officers decision regarding the Clare's Law Disclosure was not applicable and requested for Anna to be appraised. It was also noted Simon's pre-convictions had been shared at a recent I.C.P.C.
09/05/22	Joint Allocations Meeting (JAM) - CDAT requested more information on Anna's referral as felt that it lacked information for them to make a decision for acceptance.
10/05/22	Allocated Perinatal Mental Health nurse received the following email from Primary Care Mental Health Liaison Nurse: *Hi *****, we received this referral off the GP into the LPMHSS, I contacted Anna today as she was booked in for an assessment with me, I did not know she was under perinatal, she thought she was having a referral for therapy or a diagnosis??* *Explained that she was already under Perinatal services and I would not be assessing her as she could be referred by yourself if you have any concerns, think the referral has come in and was wrongly re directed by the single point of access.*
10/05/22	WSA Case Worker attempted to contact Anna - no reply.
13/05/22	Home Visit by Social Worker. Positive visit, no concerns identified. Social worker asked to speak with Child 2 alone but was refused.
16/05/22	JAM Meeting – Anna's referral to CDAT was discussed and further information provided. Minutes state Anna – Low Intensity and CDAT referral - CDAT declined post-natal depression, craving meds, CP involvement.

17/05/22	Initial Core Group meeting held. Anna attended and representation from Children's Services, Barod, Education Engagement Coordinator. Allocated perinatal nurse informed Social Services that they were unable to attend Core Group meeting and sent following email: *I have a follow up appointment with Anna on 24/05/2022 at 11am to review her mental health and discuss transferring her to Primary Care Mental Health Services. I believe she recently had an assessment with the ARC centre but they have contacted me to ask that as Anna is still open to Perinatal, I make a direct referral to them once she is discharged as they did not want to overlap services. I feel that given Anna's good engagement with services and improvement in mental health this is a suitable plan and will keep you updated.* Agreed that a safety plan would be finalised and shared at the next Core Group 21/06/22
17/05/22	Barod Assessment case note- assessment carried out on 05/05/2022, case note added later due to oversight. Case note reads: *Contact- 1 hour telephone appointment to carry out Comprehensive assessment,* *Participants: Barod case worker and Anna* *Substance use: Anna describes using alcohol in a binge drinking pattern, commencing at age 13. Anna states she has never been able to 'control her drinking'.* *She has come to the attention of Social Services and there is a core group meeting on 17/05/2022.* *Summary of contact- Child 3 was born Anna was feeling afraid of her ex-partner due to domestic abuse. Ex-partner has now moved out and house has been marked and client referred to Assia. Started drinking due to fear around domestic abuse -client drinking to blackout and 'getting into trouble'. Anna states that she has never been able to control her drinking Family opened to social services and there is a meeting on Tuesday 17th May at 11.00* *Actions- Barod to attend core group meeting. Next contact Thursday 19th May at 09.30 at Celtic Court.*
17/05/22	Barod case worker recorded that they had attended the Core Group 17/5/2022 and notes state that they *Updated the group that an Initial Assessment has been completed and Anna has a further appointment this Thursday 19th at 09.30. The case worker stated that in those appointments he would be examining the triggers and addressing the binge drinking. Social worker noted that if Anna was drinking around Child 2 or felt unsafe then [they] could call the police and Anna agreed with this.*
17/05/22	Health visitor recorded that they had attended the Core Group
18/05/22	Missed call from Anna to the WSA case worker. Case worker sent text to ask when best to call back. No reply
19/05/22	Barod Low Intensity worker sent following email to social worker

	Just a quick update on Anna. She attended a telephone appointment today. She did say she went out last Friday night and drank alcohol, after getting a babysitter. We are working on her controlling her drinking, preferably to abstinence. I'm just checking that is your goal for her as well. I have referred her to CDAT for possible medication, but I'm aware that their waiting list is some months.
20/05/22	Record of appointment Barod Low Intensity worker and Anna on 19/05/2022 *Type of contact-telephone appointment, 1Hr via telephone.* *Substance use-Anna reports going out last Friday and drinking around 12 units of alcohol although she cannot remember exactly.* *Contact Summary-case worker and Anna reviewed her alcohol use. Anna reports that she has drunk since being a teenager and often loses control and describes a personality change where she gets very argumentative and often drinks to blackout. She was abstinent for 16 months in total before and during her pregnancy. She reports being prescribed Disulfiram by the PRAMS team but drank on those so didn't find them helpful. She has been assessed by the ARC and they will continue monitoring her mental health when the PRAMS team discharge her. Anna reports drinking to cope with the difficult relationship with her ex-partner Simon. They are now no contact and she has been advised to call the police if he contacts her. Anna reports that she hasn't drunk alcohol in the house for 1 month and is aware she cannot do so when alone with her children. Anna stated that she has a family history of alcohol misuse with her brother taking his own life. On Friday Anna reports getting a babysitter and going to the pub that her [eldest child] and sister work in. Anna reports only planning to drink soft drinks but had one drink and then carried on. Case worker and Anna talked over her not having that first drink and asking her family to support her with that if she goes to that pub and looked at alternatives to going to the pub. Anna states that most of her friends drink but are supportive. Anna provided her email address so that Drink Diaries could be sent to her.* *Next contact-June 16th at 11.30 so that Anna can attend Celtic Court.* *Actions* *Case worker to send out drink diaries* *Email social services* *Refer to CDAT for ?Naltrexone.*
21/05/22	Anna contacted South Wales Police at 23.06hrs via the 999 Emergency Call Facility. Anna explained to the Police Operator that she was a little drunk and she had lost her keys and could not gain entry into her house. Anna's eldest child was said to be in the house but was reluctant to open the door to her. She did not explain why they would not open the door. The Operator could hear Anna taking to another person and when checked she was speaking with her seventy-three (73) year old mother who was with her and they were both attempting to gain entry into Anna's home. They were requesting Police assistance. It was suggested to Anna that she required the services of a Locksmith and at this point Anna informed the operator that her six (6) month old child was in the house. For that reason, Anna was wanting to gain an entry to her home because of her concerns for her child. There was a conversation between the Operator and Anna regarding her older child being in the house and her having left her home to go drinking. Anna's

	retort was to explain she had only been away from her home for twenty (20) minutes and could not give an explanation as to how she had mislaid her house keys. Anna was provided with the contact details for a Locksmith.
21/05/22	At 23.09hrs a neighbour contacted South Wales Police. She reported Anna had just smashed in the door of her house. The reporting person believed Anna's older child was in the house together with Anna's newborn child. They described Anna as standing in the street shouting into her phone. A further update indicated that Anna had remained outside her property and the neighbour reported hearing the sound of 'smashing' and it appeared to the caller that there was glass everywhere. Officers were recorded as being deployed at 23:17hrs and shown as having attended at 23:24hrs. The Occurrence Log was endorsed at 04:53hrs on 22nd May 2022. It was recorded that Officers attended Anna's home address where they ascertained that her eldest child had been babysitting his younger sibling and had misplaced the front door key. They were therefore unable to open the front door to their mother who had also lost her keys to her property. Anna therefore attempted to force an entry by smashing the outer double glazed panel to the front door, but was unsuccessful. She therefore gained access to her property via back door. The officer added that all persons were 'Safe and Well' within the property, no offences were disclosed or apparent.
22/05/22	Anna contacted South Wales Police at 13.49hrs to report that Simon had been driving his motor car, when he brought his vehicle to a stop at the kerb side alongside her eldest child who was walking to work. Simon was said to have shouted at Child 1 to get into his car and he told them that Anna had prevented him from 'seeing' their baby. Anna added that she suspected Simon was 'under the influence' at the time. At 14:06hrs the Police Log was endorsed with further information provided by Anna. Details for Simon's vehicle as known by Anna were noted and she added that Simon would continue to Drink and Drive. The original incident was said to have occurred two hours previous and Child 1 was wishing to make a complaint against Simon for harassment. Observations for Simon and his vehicle were circulated via the Police airwaves. On 29th May 2022 the NICHE Occurrence was endorsed by the officer in the case to indicate he had assumed responsibility for the inquiry relating to Simon's alleged harassment towards Anna's eldest Child. The Officer recorded how a number of attempts to contact Child 1 were conducted, but at the time were to no avail. Anna had however, contacted the officer and it was ascertained from her how she had been in a relationship with Simon but they had separated two (2) months previous. They had a child together although Anna was refusing Simon to have access to their child and Children's Services were involved. She provided the details of the incident as reported to SWP at 13:49hrs on the 22/05/22 and added that Simon was not Child 1's father. Anna was requesting that Simon be spoken to by the Officer and instructed to leave Child 1 alone. A telephone number for Child 1 was provided to the Officer by Anna. The Officer made further attempts to contact Child 1, but again this was to no avail. On 31/05/22 the Officer recorded that Child 1 had been contacted and confirmed the report made to the Police on 22/05/22 by their mother. Simon was said by Child 1 to be repeatedly asking them to persuade Anna to allow him to see their baby. Simon had not made any threats towards him and had not assaulted him in any way. He requested the Officer speak with Simon and instruct him not to approach him.

	The Officer submitted a PPN and recorded the attempts made to contact Simon. The PPN was assessed and details of the incident and Simon's antecedence were identified and noted by the assessor who recorded a 'Standard Risk' and Simon being a 'Serial Perpetrator'. No MARAC referral. The incident and persons involved were shown to have been discussed at the Joint Screening Meeting. Children's Services and Health were made aware and details were shared with Early Help. Simon was spoken to by the Officer on 31/05/22 and he was warned as to his behaviour and unwanted approaches towards Child 1. No further police action.
22/05/22	Simon's new partner contacted South Wales Police at 17.16hrs to report she had been made aware of threats made towards her property by Anna. Officers were initially allocated to the incident at 17:32hrs however, because of Priority Incidents they were not able to be deployed until 19:04hrs. They were shown to have attended at 19:32hrs and the Officer conferred with the reporting person. She explained she had experienced previous issues with Anna as she was currently in a relationship with Anna's ex-partner, Simon. During the day a third party had informed her that Anna had been making threats to cause damage to her home. These threats were alleged to have been made via text messages. Screen shots of these messages were said to have been saved. The officer viewed the messages which they described as a conversation between Anna and a 'Third Party'. Contained with the content of the message, Anna was making reference to attending at the address and 'Smashing her back windows'. It was apparent from the messages that Anna was aware there was a CCTV facility at the front of her house. The messages appeared to have been sent a 'Couple of days' previously, but it was only that day the reporting person had been informed of their existence. The reporting person only wished for Anna to be spoken to and instructed to leave her alone and not to send such messages in the future. The officer recorded that Anna was seen at her home address and the allegations were put to her. Anna admitted to sending the messages but had only done so as she was drunk. Anna explained that she had no intention of carrying out any of the threats and apologised for her actions. The Officer warned Anna about her behaviour and advised her accordingly. The Officer contacted the reporting person and informed her of the conversation with Anna and how she offered her apologies.. The officer did not consider a PPN was necessary and no further action was to be taken.
23/05/22	Home visit by Social Worker. Social worker observed a window in the front door to be smashed. Anna said she had been out drinking and lost her keys. A Working Agreement signed by Anna and consideration given to arranging a Family Group Conference. Child 2's bedroom was seen by the Social Worker and they were asked to speak to the Social Worker alone but they said they didn't want/need to. Social Worker spoke to Child 2 about the Child Protection Register and what this means and whether they want to attend the Core Group meetings. Also spoke about Child 2's interests and some feelings of anxiety
24/05/22	Perinatal mental health allocated nurse made contact with Anna as arranged via telephone and recorded the following; *She sounded bright and positive in conversation. No issues with cognition and mood appeared stable, no signs of anxiety evident. The lady reported that her mother had been around to visit her and she was receiving good support from her family and friends. The lady also stated that Social Services had been out to visit her yesterday and there had been no concerns. Her health visitor had also been in touch and is offering support. The lady's mental health was reviewed; she reported "my mental health is fine", and went on to say that she thinks the main reason for*

	her mental health deterioration was down to the relationship with her ex-partner and now that she is not with him anymore and things have calmed down she is doing a lot better. Sleep and appetite are normal, there are no issues with functioning or motivation. The lady stated she is happily going out shopping with her sister and has also attended messy play mother and baby group with flying start last Friday. Booked [Child 3] in to take [them] to a music group. She denied any thoughts of harm towards herself or others including her children. No suicidal ideation. Described her mood as "getting there", and went on to say she was looking forward to the future and enjoying her time with [Child 3] and being a mum. There were no concerns with bonding or attachment with her baby, she is able to meet all [their] needs and [the child's] growth and development are thriving. She describes strong feelings of love and care towards her [child] and stated she has always felt this towards [them] and thought that it was her ex-partner who struggled to bond with [the child] as he has never wanted anything to do with [the baby]. The lady is thinking about returning to work as a cleaner however has decided not to do this until after the summer holidays so that she can enjoy more time with her family and also feels that she does not want to add any extra stress of working too soon in case this impacts on her mental health. The lady is currently taking prescribed medication: Venlafaxine 150mg morning and 75mg at night. Propranolol 40mg BD. Promethazine 25mg BD. No issues with side effects from medication and feels that it is currently working well for her and is beneficial. She does not wish to make any changes to prescribed medication. The lady has had no contact with her ex-partner, he is still living in the same area so she stated that she does occasionally see him driving past her but states that he looks away and does not make eye contact. There was an incident where her ex-partner followed her oldest [child] in the car whilst [they were] walking and was trying to talk to [them], he appeared intoxicated, the Police were informed and the lady believes he has been drink driving on a number of occasions, she stated Social Services are aware also. Discussed the nature of the relationship between the lady and her ex-partner; she appeared to have good insight, she stated he is now in another relationship and that she does not want any contact with him and wants to "move on with my life". She stated she can see how controlling and negative he was over her but at the time she could not see it, she stated she feels stronger now. The lady has still not heard anything from Assia DVS yet, she was encouraged to chase this up and she was informed about the Freedom Project which she could access. Nurse discussed the importance of engaging with domestic violence services to help build her confidence and self-esteem as well as help protect herself and her family with future relationships to be able to recognise healthy/unhealthy behaviours. The lady has had an initial assessment with WGCADA, awaiting next appointment. She denies having any cravings for alcohol and stated that she did have a drink on Saturday night whilst her eldest [child] looked after the baby. She admitted she had had about 4 or 5 "shandys" between 7 and 10pm. She stated she stopped drinking at 10pm and went home without any concerns, the baby stayed with her oldest [child] until the morning. Safe sleeping advice was reiterated to the lady, she confirmed she does not co-sleep. Also given advice about the effects of alcohol whilst taking her prescribed medication advised against this. Discussed the implications of drinking alcohol and particularly the effect it has on the lady by making her angry as she has previously lashed out on [Child 2]. The lady was in agreement and demonstrated and understanding that using alcohol was a negative coping strategy. Explored alternative coping strategies she could utilise such as relaxation and mindfulness techniques as well as talking openly to others, which she admits she has formally struggled to do. Discussed if the lady would wish to consider some counselling as a way of talking confidentially, advised that domestic violence counselling through Assia would be most appropriate however also provided the lady with details of Ty Ellis to self-refer too if she wishes. Discussed the suitability of discharging the lady from Perinatal Mental Health Services as there are no further specific identified perinatal needs, the lady was in agreement with this and asked what further mental health support she could have. Discussed a plan of referral to Local Primary Mental Health Services who would be able to provide the lady with ongoing and general mental health input particularly with offering a range *of courses. It was recommended that the lady would benefit from Emotional Coping Skills course which she states she would be happy to engage with and also any anger management courses. The lady is aware of the local CRHT contact number and has contacted them previously, and is confident she would contact them again in the event of a mental health crisis.*

	PLAN: *1. Discharge from Perinatal Mental Health Services2* *2. Provided with the number for self-referral to Ty Ellis counselling service* *3. Refer to Local Primary Mental Health Services for Emotional Coping Strategy and Anger Management courses.* *4. For the lady to continue to engage with involve services: WGCADA, Social Services, Assia DVS and Health Visitor* *5. GP to continue with prescribed medication and offer review and monitoring as required* *6. Send discharge summary to involved professionals and close to Perinatal Mental Health Services.*
24/05/22	Complaint made to Valleys to Coast (V2C) Housing about Anna alleging that she was harassing another V2C tenant who was now dating Anna's ex-partner. It was alleged that Anna had damaged their car, had been sending threatening messages and made threats to damage the property.
30/05/22	Valleys to Coast Housing Officer met with the local police and discussed the allegations made against Anna. Housing Officer was informed that police had visited Anna who told them that the messages were not sent directly to the individual but to someone else on Facebook and then forwarded on. Anna advised that she was drunk and had no intention of carrying out any threats. The police advised that there had been no further complaints and that there was no further action being taken against Anna.
31/05/22	Text received by WSA case worker from Anna saying sorry for the late reply (following last contact 18/5/22). Text message recorded by the case worker.
June 2022	Child 1 contacted South Wales Police via the 999 Emergency Call Facility. Child 1 reported that their mother, Anna had been out for the day drinking and had not returned home. Child 1 stated that their sibling had been trying to look for their mother and had rung her but that the call was answered by her mum's ex-partner, Simon. Whilst on the phone to the police Child 1 is contacted by Child 2 to say that Anna has returned home stating that she had been 'kicked out of Simon's car' resulting in her having to walk home. It was noted that Anna had what was described as a 'black eye'. Anna had not disclosed how she sustained this injury however, because of previous incidents, Child 1 suggested Simon may have been involved as he had assaulted Anna before. Child 1 stated that their grandmother was currently at Anna's home and able to care for her and that they did not consider that Simon would attend at the home address. It was alleged that Simon had taken Anna's mobile phone and would not return it to her.
June 2022	South Wales Police were contacted via the 999 Emergency Call Facility by a person reporting that Anna was running down the tracks and saying that she was going to kill herself. Anna was described as being very distressed and that she had said '*she was done, can't live like this anymore*'. The reporting person described hearing the sound of the train horn indicating a train was nearing and was concerned that Anna wouldn't be able to get off the tracks from her location. The reporting person witnesses Anna being hit by the train.

June 2022	South Wales Police made enquiries to trace and locate Simon. Initially this was for safeguarding measures as it had been reported a 'Group of Males' were suspected of seeking to take retribution against him. This was believed to be because of the alleged incident between Simon and Anna, where she was said to have been 'kicked out' of his car and at some stage she had sustained a 'Black eye'. South Wales Police also considered that Simon may attend Anna's home to return her mobile telephone. Simon was located and arrested for the alleged assault on Anna. When interviewed Simon provided the following account; He felt that Anna's mental health had deteriorated since she had the baby and that she was paranoid and accusing him of doing things and lying. He stated that they hadn't spoken for 9 or 10 weeks but that Anna had contacted him asking to go out with him the following day. He had picked her up and they had gone to the pub where Anna drunk a couple of lagers and a few vodkas. He had driven them back to his house where they had spent a couple of hours. They then went to his cousin's house and Anna had been hugging his cousin when they had fallen to the floor and Anna had injured her eye. They had then returned to Simon's house and spent the night there. Simon described Anna as emotional and said that she had admitted to breaking into his house and taking his mobile phone. The next morning Anna said that she wanted to return his phone to him so he drove her to her sisters and she returned his phone. Simon stated that he told Anna to go home but she stated she couldn't as she was still drunk and couldn't be around the baby. He then drove to Port Talbot and during that drive he stated that Child 2 had called and was abusive towards him. He told Anna he didn't like Child 2 speaking to him like that and he said that Anna didn't like this and tried to open the car door as he was driving. He stopped the car and she closed the door but as he drove off again she opened the door again. She grabbed her bag and got out of the car but left her phone there. This was the last time he had seen her. He had received a phone call from Anna's sister asking him to return Anna's phone which he intended to do. Simon told police that Anna said she had been finding it hard to cope and missed being with him. Anna told him that she hadn't spoken to her family much and felt alone. He told police that when she had been emotional in the past she had laid down on a train track but he hadn't seen her do this.
June 2022	Phone call received from Head of Nursing to inform the team that Anna had passed away. Head of Nursing enquired about staff wellbeing and offered support.
June 2022	"Notification of discharge" form was completed in full by allocated perinatal nurse. The discharge summary included in-depth details on "reason for perinatal mental health service and input", "current presentation", "mother and infant relationship", "medication", "risks", "support from other services", "family planning", "contraception", "EPDS". It was noted that the lady's EPDS on assessment was 26/30 (Q10:0) and on discharge 7/30 (Q10:0), clear improvement on mood and mental health. The plan that was discussed during last contact on 24/05/2022 was clearly detailed with the same actions.
June 2022	Email sent from social worker to Assia and Barod advising that Anna had passed away on the weekend
June 2022	WSA Case Worker attempted to call Anna as no contact since 31/05/22

SECTION FOUR – OVERVIEW AND ANALYSIS

1. Introduction

1.1 This section examines the events and content detailed in the chronology to provide an overview and analysis. In addition, it considers the Key Lines of Enquiry to identify good practice, learning and recommendations. Each of the following subject headings is set out in two parts; an overview followed by an analysis;

- Patterns of behaviour and abuse perpetrated by Simon against Anna in particular coercive and controlling behaviours
- The impact of these behaviours on Anna
- Whether, and to what extent, Mental Health and/or substance use contributed to the circumstances of Anna's death
- Impact of Covid on Anna's ability to access information and services
- Children as victims of domestic abuse

1.2 The information referred to in this section is taken from family accounts provided to the Chair, Anna's own notes and agency records.

1.3 Mini chronologies are used where they are deemed to be useful and readers can refer to the main chronology where further information is required.

1.4 There is some repetition in this section and whilst the Author has attempted to minimise this, it is necessary in parts to avoid readers having to scroll up and down through the document.

2. Patterns of Behaviour and Abuse Perpetrated by Simon Against Anna in particular Coercive and Controlling Behaviours

<u>Overview</u>

a) Anna's Note

2.1 The note found after Anna's death provides an insight into her experiences of abuse and Simon's coercive and controlling behaviours. Anna's note, in full is included below and from the references it would appear that she wrote this at the beginning of May 2022, a month before her death;

He would beg me back every time promise to change but I found myself back in the same position the week after, during my pregnancy Simon have punched my [child's] bedroom door and my downstairs toilet door. He had pulled my hair from behind when was lying in bed because I was ignoring him due to a jealous outrage. Simon wouldn't allow me to have my space, he would make me stay there in his company and if I left the bedroom to go

downstairs he would follow me, In the end I would have to escape the house just to have some breathing space resulting in me walking the streets 6 months pregnant in the rain. I had a conversation with Simon and mentioned I felt I was being isolated and he agreed as if we went out anywhere it wasn't around friend it was away places I've not been before.

At end of September Simon has stopped drinking and doing cocaine and we didn't have one argument until December, I gave birth in the November, Simon's jealousy started back up. I went out 2 weeks after giving birth and he constantly rang, txt and checked my underwear when I got home.

While in a relationship with Simon I seen it as normal until now I'm separated I can see that it wasn't normal.

We met in July. Simon would show signs of jealousy regarding my past. We argued about this from July to November where I decided something needed to change we either separate or give up drink so we decided to give up drink to improve our relationship. Things got better but the jealousy was still present but was manageable while dealing with it without alcohol. I offered my passwords to Simon to help him with his jealousy and his insecurities and overthinking. He had my social media account on his phone and I didn't mind that as I am an honest, loyal person and had nothing to hide.

Our relationship was ok from November – February when Simon started work, he started back drinking and doing cocaine and he would behind my back. The jealousy was still happening where he would take my phone and wake me up when I'm sleeping to ask me who's is this number on my dialled call list. He would look at my browser history he would be there for a while swiping through my phone. Most weekends he would leave me on a Friday and block me and go partying while I was in the house pregnant. This happened from Feb – Sep.

We argued Simon went to the shop got alcohol and brought it back we both had one can, he wouldn't let me drink anymore he said if I do he will go. I had another one which resulted in Simon in a rage and tipping the can of lager in the bathroom whilst I was bathing [the baby]. I removed [the baby] straight away and Simon left.

After the arrest me and Simon got back together but living separate. Our relationship just got worse and worse. Simon was drinking and doing cocaine more, and more and would tell me he was asleep in bed. The incident Simon mentioned about darts was in March where he said goodnight I'm going to sleep at 9pm and he wasn't he was playing darts, drinking and doing cocaine. Things escalated pretty quickly where Simon would accept girls requests on social media resulting in me getting upset.

For the last 19 months I haven't been able to as it because of his jealousy at was at this point my mental health drastically went downhill.

In the January I took my passwords off Simon as this wasn't helping his jealousy and wanted to eliminate the arguing. At the end of January we went to Porthcawl for one shandy and when we got home I caught Simon doing cocaine. He left the day after is when the first incident took place. I had gone there upset drunk and crying Simon got nasty and was throwing and dragging me around his bedroom. He strangled me from behind and on the bed he had kicked me in the back whilst I was on the floor and dragged me throughout his house and threw me out of his front door. I had a cut to my lip. 2 days later I had a body full of bruises, up my legs and arms, bruises to my neck from being strangled. We split up for a week and we got back on the condition we seek relationship help.

2 weeks later 13th Feb was the second incident when his best friend contacted me to say he'd been sleeping with his wife. Simon went out a week later and didn't come home that weekend. Again he begged me to go back saying he can't live without me, he needs me. He would send me photos of himself with a cut wrist and a blade.

Due to him being high on drink and drugs he would tell everyone our business. He would txt my [child] and tell[them]r stuff when at the beginning of the relationship I asked for 2 things

1. *Don't cheat*
2. *Never interfere with me and my children*

Simon done this I believe all throughout and used my past to emotionally abuse me. I felt that Simon was using this to play games. Simon started blaming me for cheating and jealous he would say look at you your (sic you're) scatty.

These games carried on until we finally split up on April 2nd.

Regarding money he blocked me, met girl and is still with her now and I've been blocked since that day.

I believe my mental health have been played with by Simon from day 1. He has never been an honest person and I feel like he has the personality of a narcissist.

5 weeks we been split up Simon has shown me a very cold emotion. He's still to this day trying to trigger my emotions.

1. *Sex everyday (arse)*
2. *Call me slut and slag*
3. *Fat useless cunt*
4. *Kitchen when he slapped me across my head*
5. *Took all my time, wanted to be with me all the time, no space*
6. *Constantly texting and sending photos*

Simon has told me he bought 3000 street Valium and was selling them and also using them to escape the arguments we was having.

By the end of the relationship I was tired, drained and empty that's when I felt suicidal and was experiencing emotional breakdowns.

Simon's never really bonded with [the baby]. He don't see his other 2 children and he drives past them and turns his head.

Anna's written note reference patterns of abusive behaviours which are examined further below in addition to accounts provided to the Chair by Anna's family and information from agencies.

b) Physical abuse

2.2 In Anna's handwritten note she references Simon pulling her hair and him slapping her across the head. She writes about an incident at Simon's home in January 2022 where he *was throwing and dragging me around his bedroom. He strangled me from behind and on the bed he had kicked me in the back whilst I was on the floor and dragged me throughout his house and threw me out of his front door.* Anna writes that this assault resulted in bruising to her body and neck.

2.3 On the 5th April 2022, during her phone contact with the perinatal mental health nurse Anna references Simon *knocking her so her glasses fell off.*

2.4 On the 7th April 2022, during a joint visit by the perinatal mental health nurse and social worker Anna shows them photos of injuries including bruises to her arms and face which she states Simon had caused. During this visit the social worker records that Anna discloses that Simon has strangled her and used coercive and controlling behaviour.

2.5 During her assessment with Assia on the 3rd May 2022, Anna speaks about the incident in Simon's house and also discloses that since having the baby he had hit her over the head and strangled her on another occasion.

2.6 Child 1 and Child 2 told the Chair that Simon assaulted Anna in their home and they had tried to get between them to protect their mum.

c) Emotional abuse

2.7 Anna writes in her note how Simon would call her names and *play with her mind*. She recognises this as emotional abuse.

2.8 Anna told her sister about the emotional abuse and she told the Chair that *he would tell her that she was fat, ugly and that no man would want her.*

2.9 Anna's sister spoke about Simon sending Anna photos of himself with other women and how he would block Anna from contacting him on weekends which caused her anxiety and paranoia.

d) Coercive and Controlling behaviours

2.10 Anna's note references how Simon would:

- Always be with her, that she had no space away from him;
- Constantly call and message if she went out;
- Check her phone, her call logs and browser;
- Wake her to ask her who she'd been in contact with;
- Check her underwear when she came home;
- Access her social media accounts on his phone as he had all her passwords;
- Isolate her from family and friends;
- Be possessive, jealous and lose his temper;
- Accuse her of cheating;
- Damage her property.

2.11 When Anna meets with the perinatal mental health nurse and the social worker on the 7th April she reports feeling trapped in the relationship when she became pregnant as it was unplanned. It is also recorded that Anna stated when she met her partner he had nothing, he relied on her to turn his life around, she gave him everything.

2.12 It is recorded by the Health Visitor during a home visit on the 6th May that Anna reports that she feels her partner is controlling.

2.13 In the record of the Initial Child Protection Conference on the 9th May it is recorded that Simon was jealous of Anna's previous relationships and they would argue about these.

2.14 During her contact with Assia on the 3rd May it is recorded that Anna said that when together, *Simon was controlling and emotionally abusive, he would take her out of area if they were out socially so that she would not know anybody…..he would spend all my time together so I did not see anyone else and when I did go out he would message me constantly.*

2.15 The Panel note Anna's references to Simon's behaviours during her pregnancy when he caused damage at her home by punching doors and also how, having given birth, she refers to the fact that his *jealousy started back up*.

2.16 Anna's family spoke to the Chair about Simon's controlling and coercive behaviour towards Anna:

- They stated that *Simon wanted Anna for himself, he isolated her from family and friends and he would kick off if she wanted to go out……he had a hold over her…..he controlled her and he knew that…..he wanted to be with her 24/7….he wanted it to be just him and her;*
- They spoke about his extreme jealousy; Anna wasn't able to speak about Child 2's dad at all if he was around;
- They knew that Simon had access to Anna's phone and social media accounts and he would often contact them pretending to be Anna;
- All family members spoke to the Chair about how Simon would constantly message and call Anna if she wasn't with him and described it as *constant and relentless;*
- Child 1 and Child 2 told the Chair that Simon would argue with their mum every night over petty things which created a tension in the home and cause upset and distress to Anna;
- Anna's sister-in-law spoke about an occasion when she had gone to pick Anna up in Swansea one night after Simon had thrown Anna out of his car and left her there;
- Anna's family spoke about the threats that Simon made if Anna was to tell anyone about his behaviours. He threatened to harm her brothers and family members reported to the Chair that Simon had threatened to burn Anna's house down in the days before her death.

e) Sexual violence and abuse

2.17 Anna writes in her note *sex everyday (arse).*

2.18 In her contact with the perinatal mental health nurse on the 5th April when speaking about her previous assessment with Assia it is recorded that *she lied on some of the questions about him asking for sex everyday and becoming aggressive if she refused.*

2.19 In the DASH completed with Assia in May Anna responds *yes* to the question *Does the abuser(s) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else?* The practitioner adds the following information to this response *made me feel guilty, would be stroppy and moody until we had sex.*

f) Simon's responses to Anna when she tried to end the relationship

2.20 In her note, Anna refers to Simon's behaviours when she had tried to end the relationship, how he would *beg her to take him back and promised to change*. She also references how he would threaten to harm himself and sent photos

of himself with a blade, which Child 1 and Child 2 also spoke about to the Chair.

2.21 Anna's brother and sister-in-law spoke about how Anna had tried to end the relationship *time and time again but that Simon would buy her back*. *She loved perfume and he would buy that for her to get her back.*

Analysis

2.22 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.

3. The Impact of the Simon's Behaviours on Anna

Overview

3.1 Anna's own words in her note describe the impact that Simon's behaviours had on her;

By the end of the relationship I was tired, drained and empty that's when I felt suicidal and was experiencing emotional breakdowns.

3.2 Anna is also able to articulate the impact of her relationship with Simon to professionals;

- She tells the perinatal mental health nurse on the 7th April that *her main concerns are to do with her partner which she says worsen her anxiety.*
- It is recorded by Barod on 17th May that Anna *was feeling afraid of her ex-partner due to domestic abuse* and that *she had started drinking due to fear around domestic abuse.* This is repeated in the records of her appointment on the 19th May when it is recorded that *she reports drinking to cope with the difficult relationship with her ex-partner.*
- The record of Anna's appointment with the perinatal mental health nurse on the 24th May states *Discussed the nature of the relationship with her ex-partner and she appeared to have good insight……she stated that she can see how controlling and negative he was over her but at the time she could not see it, she stated she feels stronger now.*

3.3 Family members described the changes they saw in Anna when she was in the relationship with Simon;

- She lost a lot of weight
- Child 1 and Child 2 described how her character changed, *the fun went out of her*
- Anna no longer went out with friends as Simon would *kick off*

- Anna's family saw her with bruises and a swollen lip but when asked she would cover for Simon and minimise the abuse
- Anna's brother spoke to the Chair about how Anna would text him when things got bad in the relationship and the further into her pregnancy the more frequent her texts became
- Anna's sister described how Simon's behaviours impacted on Anna's mental health – his actions caused Anna's anxiety and paranoia to worsen
- Anna turned to alcohol to cope with the relationship
- Anna told her sister in law; *I don't know who I am anymore*

3.4 Family members spoke to the Chair about how Anna was frightened of Simon, that she was frightened of the threats he made to harm her brothers which is likely to have resulted in her managing the information she shared with Freddie to prevent him confronting Simon.

3.5 They spoke about how Anna was also frightened that people who Simon owed money to would come after her and she was frightened for her and her children.

3.6 Anna's sister-in-law told the Chair that Anna was scared of not being able to get away from Simon and the control he had over her.

3.7 Child 1 and Child 2 told the Chair that Anna was frightened to be alone in the house with Simon.

3.8 Anna's family all refer to the change they started to see in her after the relationship with Simon ended at the beginning of April 2022. They spoke about how they began to see glimpses of the *old Anna.* They describe her as *doing better, her happy self back and she was doing things with us and the baby.* Furthermore, the minutes of the Core Group held on the 17th May record Anna saying *I feel like a new woman, I haven't cried for about two weeks, I feel happy, I am moving on.*

3.9 Family members believe that Simon had contacted Anna in the days before her death wanting to meet. It is at this point that they believe that he threatened to burn the house down if she did not meet with him. During this meeting they believe she told him that she was intending to change the baby's surname from Simon's to hers.

3.10 The note that Anna left on the day of her death and the account of the witness at the train station of Anna's distressed state further highlight the despair and helplessness that she felt at the time she died.

Analysis

3.11 It is the Panel's view that the nature of the relationship and the behaviours described above had a significant impact on Anna. By looking at the words in her note and what she told professionals in the months leading up to her

death it is apparent and significant that she recognised the behaviours as abusive and the impact these had on her own behaviours and mental health. These patterns of behaviours have also been articulated by family members and evidenced in agency records.

3.12 When considering Anna's experiences of abuse and the circumstances in which she took her own life the Panel considered the Suicide Progression/Sequence[35]. This study aims to develop understanding of the interactions between perpetrators of coercive control and intimate partner stalking and their victims, and how these interactions may be linked to escalating and de-escalating potential risk of serious harm or homicide.

3.13 The study highlights how *previous research has found that there are notable consistencies in the characteristics of victims who take their own lives in the context of Intimate Partner Abuse (IPA), and these include experiences of control, intimidation, stalking, isolation, threats to themselves or others, threats and assaults with weapons, entrapment, and failure of services (Aitken and Munro 2018). It was also found that 96% of victims of IPA who were identified as suicidal suffered from feelings of hopelessness and despair, and that these feelings are a key determinant for suicidality (Aitken and Munro 2018).*

3.14 It is the Panel's view that Anna experienced many of the elements of control and abuse referenced above and that her note and statements immediately before her death clearly demonstrate her feelings of hopelessness and despair with regards to the situation she found herself in.

4. Anna and Simon's Relationship

Overview

4.1 In addition to the abusive and controlling behaviours detailed above the following chronology entries contribute to our understanding of the nature of the relationship between Anna and Simon.

13/03/22	Anna contacts the Police at 04.39hrs reporting that she was having issues with her ex-partner and that he was refusing to leave. Simon has left before officers attend but Anna reports that he had been drinking all day and had attended her home for approximately 30 minutes. It is recorded that they had a verbal argument as Simon was insisting on driving and Anna attempted to take the keys from him to prevent him from driving.

[35] Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide https://eprints.glos.ac.uk/10579/16/10579_Monckton-Smith_%282022%29_Home_Office_Report.pdf

	It is recorded that Anna did not wish to provide details for the DASH nor details of the child. Anna was assessed as medium risk but not a repeat victim. Simon was identified as a serial perpetrator. Warning markers for both Anna and Simon were noted including markers for Simon for domestic abuse towards a previous partner. A task was created for consideration of Clare's Law disclosure to Anna based on Simon's antecedence.
03/04/22	Simon contacted South Wales Police to report a burglary at his flat. Simon suspected his ex-partner; Anna was responsible for committing the alleged offence. He listed the property stolen from his home. Simon also accused Anna of attending his home in the early hours of the morning and was said to be making *life hell for him.* Simon stated he had received information from 'Other People' who advised him, Anna was posting messages on social media in which she was making false allegations against him. Some of the messages were said to be abusive and relate to Simon being involved in drugs. Simon was unable to provide any evidence that Anna was responsible for the alleged burglary. He provided a statement that he did not wish to make a formal complaint but would welcome Anna being spoken to and for her to be warned about attending his address and posting messages on social media. When spoken to by officers, Anna admitted to posting messages regarding Simon, which she regretted and had since removed. She explained that she had posted the messages as retribution as Simon had been cheating on her with his ex-partner when they were in a relationship and this was also at a time when Anna was pregnant with Simon's child. A PPN was submitted as this was considered a domestic incident and was assessed as Medium risk. This referral was discussed at the MASH joint screening meeting.
08/04/22	South Wales Police were contacted at 00.28hrs by Simon's new partner. She reported an offence of Criminal Damage to her Motor Vehicle. The Operator recorded: *Someone just put my car window through, Back Rear Passenger side. She keeps walking up and down, still in the street*. A description of the assailant was provided who was said to be wearing glasses and a yellow puffer coat with the hood up. Anna's details were linked to the police log and the reporting person provided a statement to the police. It is noted on the occurrence that the suspect, Anna is to be interviewed/voluntary attendance for the offence. Anna is interviewed on the 22nd April in relation to the allegation of burglary during which she denied the allegation.
11/04/22	Anna contacted South Wales Police at 07.30hrs. She reported her ex-partner, later identified to be Simon, had contacted her the previous evening. He was said to be accusing Anna of breaking into his flat last week. Simon also informed Anna that he was not going to see their baby unless she returned his property which Anna denied having. Anna added her child was four (4) months old and she was feeling distressed having received Simon's messages and wanted them to be stopped. The police log noted that Simon had previously reported that his home had been broken into and that he suspected Anna to have committed the offence.

	Anna informed officers that she only wished to have the incident recorded and was not prepared to make a formal statement. She did not wish for Simon to be spoken to and she did not want police attending at her home. Simon admitted to sending messages to Anna to return his property. The officer was of the opinion that this did not constitute an offence of Malicious Communications and the incident was finalised.
01/05/22	Simon contacted South Wales Police at 14.48hrs to report harassment from his ex-partner, Anna. He stated there had been ongoing issues between him and Anna which he had previously reported to the Police. Simon explained he and Anna had ended their relationship, but they had a five (5) month old child together. It was alleged that Anna had sent Simon a Bank Transfer of £1:00p on 29/04/22, and a message saying, 'Fuck K Money, you wait'. Simon also alleged that Anna had been contacting friends of his much to his annoyance. He informed the Officers that he did not wish for any Police involvement. He explained that he had only reported the matter to have his complaint recorded. His reasoning he added was because he and Anna had a child together and Court action was in progress regarding his contact with his child. Simon considered Anna's actions to be low level threats and he did not expect any further issues with her. The Officers advised Simon they may need to take matters further should there be any additional reports of incidents between him and Anna but Simon did not wish to make a formal complaint. Simon is spoken to by officers again on the 4th May where he reiterated his wish that the incident be recorded but that he did not wish for any further action to be taken. The Officer also recorded he made contact with Anna, who was described as being emotional. She explained that in her opinion Simon did not want anything to do with his child and had not at that stage seen the child for six (6) weeks. Neither was Simon making any financial contribution towards their child's upkeep and he was in a new relationship. Anna informed the officer that she would make attempts to encourage Simon to take a more active role in their child's upbringing. She had hoped to do so by making contact with Simon's mother. Anna was advised to contact her Social Worker regarding Simon's involvement with Child 3 and her financial issues. The officer did not consider any offences had been disclosed and therefore no further police action was required. A PPN was completed and medium risk noted. The incident was discussed at the Joint Screening Meeting and the PPN was shared with Children Services, Health and Early Help.
22/05/22	Anna contacted South Wales Police at 13.49hrs to report that Simon had been driving his motor car, when he brought his vehicle to a stop at the kerb side alongside her eldest child who was walking to work. Simon was said to have shouted at them to get into his car and told them that Anna had prevented him from 'seeing' their baby. Anna added that she suspected Simon was 'under the influence' at the time. Officer spoke to Child 1 on the 31st May who confirmed the incident and stated that Simon had not made any threats towards them and had not assaulted them. They requested that officers speak with Simon and instruct him not to approach them. A PPN was submitted and assessed as standard risk. The incident and persons involved were shown to have been discussed at the Joint Screening Meeting. Children's Services and Health were made aware and details were shared with Early Help. Simon was spoken to by the Officer on 31/05/22 and he was warned as to his behaviour and unwanted approaches towards Child 1. No further police action.

22/05/22	Simon's new partner contacted South Wales Police at 17.16hrs to report she had been made aware of threats made towards her property by Anna. The reporting person explained she had experienced previous issues with Anna as she was currently in a relationship with Anna's ex-partner, Simon. During the day a third party had informed her that Anna had been making threats to cause damage to her home. These threats were alleged to have been made via text messages. Contained with the content of the message, Anna was making reference to attending at the address and 'Smashing her back windows'. The reporting person only wished for Anna to be spoken to and instructed to leave her alone and not to send such messages in the future. The officer recorded that Anna was seen at her home address and the allegations were put to her. Anna admitted to sending the messages but had only done so as she was drunk. Anna explained that she had no intention of carrying out any of the threats and apologised for her actions. The Officer warned Anna about her behaviour and advised her accordingly. The Officer contacted the reporting person and informed her of the conversation with Anna and how she offered her apologies. The officer did not consider a PPN was necessary and no further action was to be taken.

Analysis

4.2 The Panel notes that involvement of the police is often triggered by events and changes/shifts in the relationship:

- No reports were made to the police by Anna or Simon in respect of their relationship until after Anna's arrest for the assault on Child 2 in February 2022 and Children's Services becoming involved with the family;
- Anna wrote in her note that her relationship with Simon became worse after the February incident, they were not living together but still in a relationship;
- It is likely that the involvement of Children's Services was a factor in Anna's report to the police in March;
- Subsequent events reported to the police could be seen in the context of wider events; Anna and Simon's relationship ends on the 2nd April immediately before the incident reported by Simon on the 3rd April relating to the alleged burglary and Anna attending at his home;
- The reports by Simon's new partner relating to Anna damaging her car and threats to cause damage are made after Anna becomes aware of the new relationship;
- Simon not paying towards his child, how Anna responds and Simon's report of harassment.

4.3 The actions and behaviours of both individuals signify an intense, volatile and unstable relationship. Anna's actions in contacting the police may be interpreted by some as being fuelled by the ending of the relationship and jealousy at Simon starting a new relationship. It is the Panel's view however that her behaviours should be seen in the context of her mental health diagnosis of Emotionally Unstable Personality Disorder including impulsive behaviours, poor self-image and her fear of use of alcohol and Simon's abusive and controlling behaviours. Furthermore, her reports to the Police should also be considered in the context of the involvement of Children's

Services, the responsibility placed on her to safeguard her children and her fear of consequences to her and her children if these matters were not reported.

5. Whether, and to what Extent Mental Health and Substance Use Contributed to the Circumstances of Anna's Death.

5.1 It is apparent from the chronology that alcohol and mental health were significant factors in Anna's life and her relationship with Simon. A separate overview is provided in respect of alcohol and mental health analysis for each area below and a combined analysis for both factors is set out at the end.

a) Alcohol

Overview

5.2 Anna is aware that her use of alcohol is problematic and she actively seeks help from agencies to support her as detailed below:

16/11/20	The GP recorded that *when drunk she does irrational things such as go to the train station to jump on the track. Patient feels the root of the problem is alcohol.* It is recorded that Anna is to contact WCADA
05/01/21	Record of a telephone contact between the GP and Anna states that Anna has been taking antabuse but has not contacted WCADA. Following this contact the GP makes a referral to WCADA.
16/03/21	Record of telephone contact with GP *Taking antabuse for last couple of months. Has contacted WCADA and awaiting key worker. Hasn't taken any alcohol.*
14/04/21	WCADA case worker record that's that Anna has requested her case be closed due to her being pregnant and abstinent.
	From Anna's own accounts to professionals and those of her family she does not drink alcohol for the duration of her pregnancy.
08/12/21	It is recorded by GP that Anna wanting to re-start Antabuse *as she had an episode of being drunk last week*
14/2/2022	Alcohol is central to the incident that results in Anna being arrested for the assault on Child 2. It is reported by both Child 2 and Anna's mum that she had been drinking all day and was extremely intoxicated. When Anna attempts to leave the house to get more alcohol Child 2 tries to stop her which is when Anna assaults Child 2 and the police are called. When police are called on the second occasion Anna has obtained a bottle of vodka and Child 2 has tried to stop their mother from drinking which resulted in Anna becoming abusive and an argument ensued between her, Child 2 and her mum. Child 2 and Anna's mum tell officers that Anna is in an unhealthy relationship and they suggest that this is contributing to her heavy drinking. During her interview with the Police Anna tells officers that she hadn't drunk alcohol for 15 months but that since Child 3 was born in November 21 she had drunk twice a week.
14/02/22	At the strategy discussion Health representative reports that Anna had been alcohol dependent since 2014

17/02/22	During her first contact with the WSA Anna *advised that she may need some support around alcohol as she had stopped drinking 15 months ago and had drunk 2 times lately both of* which ended negatively for her.
22/02/22	Anna's use of alcohol noted as factor in the GP's referral to Perinatal Mental Health services
28/02/22	Anna self-refers to Adferiad (substance misuse service in Bridgend until 31/03/22). Anna's referral is triaged and accepted on the 10th March.
21/03/22	During her assessment with Perinatal Mental Health services it is recorded that Anna *has had an alcohol problem since the age of 14 too she had never turned to drink to cope with things before but since the baby has arrived she has on 3 separate occasions drunk alcohol to excess which has now had consequences*. These three incidents are recorded as the incident 14th February when she was arrested, the incident at Simon's property when she was assaulted and a further incident which led to a confrontation with Simon.
29/03/2022	During her contact with the Single Point of Access Team is it noted that Anna has a *History of alcohol misuse* but denied daily use. It is noted that Anna had drunk alcohol the night before her contact with the team. She tells CHRT that her alcohol use has increased since the birth of Child 3.
30/03/22	The record of the visit by the CRHT Team Nurse and Nurse Practitioner states *She minimised the impact alcohol has on her stating she is erratic without consuming alcohol but did agree that it exacerbates things and she has to dela with more consequences as a result*
31/03/2022	Record of contact with Assia states In the referral it stated that when Anna drinks a lot she goes to her brother's grave. Anna tells the Assia worker that her mental health has gone *downhill since having the baby and this is why she turns to drink…..Anna went on to disclose the issues are around her drinking…..Anna maintained the problem was her mental health and drinking however she said she wasn't alcohol dependant.* In the follow up email from the Assia worker to the social worker it is stated that *Anna completely realises that the issues and incidents are always alcohol related*
06/04/22	During the appointment with the Perinatal Consultant Psychiatrist it is recorded that *She said her baby is her main focus otherwise she would have relapsed with her alcohol dependency*
13/04/22	Anna self-refers to the Drug and Alcohol Single Point of Access – referrals sent to Barod and Community Drug and Alcohol Team
19/04/22	Anna's case allocated to the Low Intensity Worker at Barod. Contact attempted 21/04/22 and a message left for Anna. 26/04/22 contact is made with Anna and an assessment arranged for 05/05/22/
03/05/22	During her contact with Assia Anna tells the worker that she was drunk when she went to Simon's property in January when she was assaulted by him.
05/05/22	The report prepared by the Perinatal Mental Health Nurse recognises the risks of Anna relapsing in her use of alcohol both in respect of risk to herself and others and of impulsive behaviours whilst under the influence of alcohol.
05/05/22	In her assessment with Barod it is recorded that *Anna describes using alcohol in a binge drinking pattern, commencing at age 13. Anna states that she has never*

	been able to 'control her drinking' ….started drinking due to fear around domestic abuse - client drinking to blackout and 'getting into trouble'
19/05/22	Records of Anna's telephone contact with Barod worker *Anna reports going out last Friday and drinking around 12 units of alcohol although she cannot remember exactly. ….Anna reports that she has drunk since being a teenager and often loses control and describes a personality change where she gets very argumentative and often drinks to blackout.* *Anna reports drinking to cope with the difficult relationship with her ex-partner Simon.* *Anna reports that she hasn't drunk alcohol in the house for 1 month and is aware that she cannot do so when alone with the children.* *Anna reports that she has a family history of alcohol misuse with her brother taking his own life.* The record further refers to Anna going out on the previous Friday and whilst planning to only have soft drinks had one drink and carried on.
21/05/22	Anna tells the Police operator that she was a *little drunk* and had lost the keys to the house. This is when she breaks the glass to gain entry.
22/05/22	Following the report to police by Simon's new partner that Anna had been making threats against her property, officers speak to Anna who admits sending the messages but had only done so as she was drunk and had no intention of carrying out the threats.
24/05/22	Telephone contact with the Perinatal mental health nurse records that *She (Anna) denies having any craving for alcohol and stated that she have a drink on Saturday….she admitted she had 4 or 5 'shandys' between 7 and 10pm. She stated that she stopped drinking at 10pm and went home without any concerns……given advice about the effects of alcohol whilst taking her prescribed medication advised against this. Discussed the implications of drinking alcohol and particularly the effect it had on the lady by making her angry as she has previously lashed out at her [child]. The lady was in agreement and demonstrated an understanding that using alcohol was a negative coping strategy.*

5.3 Alcohol was a factor in events immediately before Anna's death, with her mum and Child 2 both reporting to police that Anna had been drinking when she returned home after being out with Simon.

5.4 Anna's family spoke to the Chair about Anna's use of alcohol;

- Anna had used alcohol as a coping mechanism from when her father left when she was 14 years old. This correlates with what Anna tells professionals about when she started using alcohol;
- Anna had used alcohol as a response to her brother's death by suicide in 2014;
- Anna didn't know her limit when it came to alcohol and tells professionals that she *didn't know when to stop*;

- Child 2 tells Assia in February 2022, that she believes Anna was using alcohol to self-medicate in the absence of medication for her mental health;
- They recognised how Anna had tried, successfully at times, to stop drinking by using Antabuse and for the duration of her pregnancy but how alcohol was a feature in her relationship with Simon.

5.5 Anna was very aware of how she used alcohol, the negative impact that it had on her behaviours and the consequences.

5.6 The chronology highlights the direct correlation between Anna's alcohol use and negative behaviours/experiences. When seen in the context of the chronology it is also evident that there are specific events that trigger Anna's drinking episodes;

- January 2022 - Anna finds Simon using cocaine at her home. Anna's note implies that he left and the following day Anna goes to his house drunk and is assaulted by him
- 13th February 2022 Anna writes that she is contacted by Simon's best friend who tells her that Simon has been sleeping with his wife. It is early hours on the 14th February that police are called to Anna's home where she has been drinking and is trying to leave the house and is subsequently arrested for the assault on Child 2

5.7 Anna proactively seeks help and support for her alcohol use requesting antabuse from the GP in December 2021 and making self-referrals to the local substance use service in February 2022 and again in April 2022 when she does not receive any contact in response to her earlier referral.

5.8 Anna was receiving ongoing support from the substance use service at the time of her death which is examined further in Section Five.

5.9 Simon's substance misuse is highlighted in Anna's note and the DASH RIC where she refers to his use of cocaine and Valium. This is echoed by Child 2 and Child 1 who spoke to the Chair about Simon's drug use.

b) Mental Health

<u>Overview</u>

5.10 Anna is very aware of her mental health and proactively seeks support throughout the time period covered by the review;

14/07/20	Anna contacts the GP and reports feeling anxious and that her OCD symptoms are starting again. She requested medication and was prescribed Venlafaxine (an anti-depressant)

16/11/20	During her contact with the GP it is noted that Anna has a long history of anxiety and depression and when drunk she does irrational things such as going to the train station to jump on the tracks.
23/04/21	When Anna is booking in with Maternity services it is noted that she is treated for anxiety and depression and is on anti-depressants
28/09/21	Anna contacts the GP on the advice of the midwife to discuss feelings of stress and anxiety
11/11/21	Anna informs Health Visitor that she suffered Obsessive Compulsive Disorder (OCD) and Post Natal Depression following previous birth.
27/01/22	Telephone contact with the GP; Anna wanting to increase medication for low mood to twice a day. Medication increased.
14/02/22	It is recorded by South Wales Police upon attending the incident on the 14th February 2022 that Child 2 had not wanted their mother to leave the house as on a previous occasion she had attempted to lay on the tracks at local train station and also visited the grave of her brother who had passed away 7 years previously. As a result of this incident a warning marker was created for Anna in respect of Self-harm with reference to the fact she had cut herself when she was 20 years old.
16/02/22	Anna contacts GP requesting medication for anxiety. The GP notes that there are *no thoughts of self harm* and refers to the Perinatal Response and Management Service (PRAMS). The referral states that Anna *Has been experiencing periods of low mood, followed by irritability, and lashing out. She has been on Venlafaxine for some time, Her symptoms predate her pregnancy but she has certainly felt that things have become considerably worse since she has had the baby.*
09/03/22	Anna contacts the GP in respect of a headache. GP records state *Anxiety discussed. Sounds in a panic.* A prescription for Diazepam is given.
21/03/22	Records of Perinatal assessment state that Anna *Feels she is not getting better and is struggling to cope generally.* *Admits to feeling manic at times, having lots of energy, with no time to think and cannot rest even when the baby rests and is constantly on the go. Reports to have OCD in relation to cleaning her home.* *Anna feels she has not been an easy person to live with in the past due to jealousy issues and stated that any little thing can cause her to be irritable, frantic and tearful but feels different when it is just her and the baby are together. Feels then she is a different zone feeling happy, as she stated she adores [the baby] and is totally besotted with [them] and thinks of nothing else, but when [the baby] is asleep, her low mood returns.* *Is aware she is reacting badly to things and feels unable to trust anyone, feeling suspicious and anxious, particularly in relation to her partner.* *Reported that she has had issues with her mental health since the age of 14 years but has never been this bad.*
29/03/22	Anna contacts the Single Point of Access and the Perinatal Mental Health Team seeking support for her mental health; *She reported experiencing thoughts to go onto the train track and stated she had done previously. Her brother completed suicide by this means.* *Anna stated "I can't cope", "I am a bad mum", "I am hurting people".* *Noted history of deliberate self-harm, overdoses and has laid on the train track for 40 minutes. History of alcohol misuse; denied daily use, admitted to drinking last night but none today.* *Medication: Venlafaxine 150mg, propanol 3 x 40mg,* *2 weeks ago she was prescribed 2 weeks' worth of Diazepam with nil effect.* *It is recorded that Anna was distressed/ tearful, experiencing feelings of hopelessness and worthless and was actively seeking help.*

	Crisis Team see Anna that afternoon and undertake an assessment.
29/03/2022 – 6/4/2022	Anna receives support from the Community Home Resolution Team (CHRT)
30/03/22	Record of a home visit by CRHT She reports that her moods have been erratic since about 4 weeks after his birth and she is worried how her behaviours are impacting on her partner and her family. As a result of her behaviours she feels guilty and that the children would be better off without her but she denied any current suicidal intent today.
31/3/2022	Anna has an assessment with Assia and it is recorded that she stated that he mental health had gone downhill since the birth of the baby and that it why she was drinking.
31/03/22 and 02/04/22	During her contacts with CRHT Anna is concerned about when her medication review with the Perinatal Consultant Psychiatrist will happen. It is recorded that she *doesn't want to go back to the way she was feeling at the beginning of the week* and wants her medication changed. During the home visit on the 2/4/22 Anna queries whether she has Bipolar disorder and it was explained that only a doctor could give a diagnosis. The symptoms of Emotionally Unstable Personality Disorder were explained and Anna felt that she ticked a lot of the EUPD boxes.
05/04/22	Perinatal mental health nurse contacted Anna to offer an appointment with the Consultant Psychiatrist the following day. It is recorded that Anna expressed *how keen she was for her medication to be changed.* It is also recorded that Anna does not feel that she can trust or rely on anyone.
06/04/22	Perinatal Consultant Psychiatrist appointment *DIAGNOSIS: Emotionally Unstable Personality Disorder with Obsessive Compulsive Disorder Traits.* *She said her mood has been low for the past 4 months and her mood was better two weeks ago for 4 days. She said she is overthinking and that is causing her to have poor sleep. She said she is not eating very well and some days she will eat and some days she will avoid eating. She reported that her relationship broke on 2nd April 2022, and since then she has been thinking about how she is able to manage her baby without [their] father. She has a longstanding history of emotionally unstable personality disorder and alcohol misuse. She works as a cleaner and she has 2 grown up children who are living with her. She said she cleans her home all the time and can't tolerate any small unclean space. She said cleaning is her obsession and has been since early adulthood. There are no thoughts of contamination or history of washing hands or cleaning of clothes. Although she said she does wash clothes a bit more frequently than many other families. The lady states she needs to put her glasses in the same order and keep things in order, any change makes her restless and she needs to put them back in order.* *She said she has been taking Venlafaxine medication for the last three years and it helped in the past but since the baby was born it is not helping. It was explained that it could be because of her recent relationship breakdown but she would like to increase her medication.* *It is agreed to change Anna's medication.* In the summary of the Consultant Psychiatrist appointment it is noted that

	Partner left her last weekend, struggling with the loss of the relationship
07/04/22	At the joint visit Perinatal nurse and Social Worker it is recorded that *She is aware that she has been discharged from HTT and is okay with this, feels that initial crisis point is over and thoughts and feelings of suicidal ideation have started to improve. Discussed appointment with Consultant Psychiatrist yesterday and is happy to change her medication, explained that it could take 4-6 weeks for the medication to have a therapeutic effect. The lady expressed that her main concerns are to do with her partner which she says worsen her anxiety.* *The lady reported that her mental health has always been up and down but became worse when things started to get worse in her relationship.*
24/05/22	Perinatal mental health nurse made contact with Anna as arranged via telephone and recorded the following; *She sounded bright and positive in conversation. No issues with cognition and mood appeared stable, no signs of anxiety evident. The lady reported that her mother had been around to visit her and she was receiving good support from her family and friends. The lady also stated that Social Services had been out to visit her yesterday and there had been no concerns. Her health visitor had also been in touch and is offering support. The lady's mental health was reviewed; she reported "my mental health is fine", and went on to say that she thinks the main reason for her mental health deterioration was down to the relationship with her ex-partner and now that she is not with him anymore and things have calmed down she is doing a lot better. Sleep and appetite are normal, there are no issues with functioning or motivation. The lady stated she is happily going out shopping with her sister and has also attended messy play mother and baby group with flying start last Friday. Booked [child] in to take him to a music group. She denied any thoughts of harm towards herself or others including her children. No suicidal ideation. Described her mood as "getting there" and went on to say she was looking forward to the future and enjoying her time with her baby and being a mum.* *The lady is currently taking prescribed medication: Venlafaxine 150mg morning and 75mg at night. Propranolol 40mg BD. Promethazine 25mg BD. No issues with side effects from medication and feels that it is currently working well for her and is beneficial. She does not wish to make any changes to prescribed medication.* The Edinburgh Post Natal Depression Score is completed with Anna and is recorded as 7/30 compared to 26/30 on referral.
Early June 2022	Before leaving her home on the day of her death Anna is described as distressed and tells Child 2 *I don't want to be here.* The witness at the train station reports that immediately before her death Anna says *I am done, can't live like this anymore.*

5.11 At her appointment with the Perinatal Consultant Psychiatrist in April 2022, Anna is diagnosed with Emotionally Unstable Personality Disorder with Obsessive Compulsive Disorder Traits.

5.12 Emotionally Unstable Personality Disorder, also known as Borderline Personality Disorder, can cause a wide range of symptoms which according to the NHS website[36] can be grouped into four main areas;

- Emotional instability – individuals may experience a range of often intense negative emotions such as rage, panic, severe mood swings or long term feelings of emptiness and loneliness
- Disturbed patterns of thinking or perception which may include upsetting thoughts such as thinking you're a terrible person and feeling you do not exist
- Impulsive behaviour – there are 2 main types of impulses:

  - An impulse to self harm which can led to feeling suicidal and attempting suicide
  - A strong impulse to engage in reckless or irresponsible activities such as binge drinking, drug use

- Intense but unstable relationships with others – a person may feel that other people abandon them or that people get too close and smother them. When individuals fear abandonment, it can lead to feelings of intense anxiety and anger resulting in efforts to prevent being left alone.

5.13 Obsessive Compulsive Disorder is a condition where a person has obsessive thoughts and compulsive behaviours[37]. Anna's behaviours are documented in the notes of her assessment and her children also told the Chair of Anna's obsession with cleaning and how everything in the house had to be colour coded.

5.14 Postnatal depression affects more than 1 in every 10 women within a year of giving birth[38];

- Anna tells her Health Visitor before Child 3's birth that she experienced postnatal depression after Child 2 was born
- An Edinburgh Post Natal Depression Score was undertaken with Anna during her appointment with Perinatal Mental Health Service on the 21/03/2022 which scored 26 (very high)
- Child 2 tells Assia 16th February that Anna had been suffering from depression since having the baby.

5.15 In her note Anna states that she believes that Simon has played with her mental health since their relationship started and by the end of the relationship she was *feeling suicidal and experiencing emotional breakdowns.*

[36] https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/symptoms/
[37] https://www.nhs.uk/mental-health/conditions/obsessive-compulsive-disorder-ocd/overview/
[38] https://www.nhs.uk/mental-health/conditions/post-natal-depression/overview/

5.15 The Panel make the following observations in relation to Anna's presentations and help seeking behaviours for her mental health;

- There appears to be an escalation in Anna's concerns for her mental health between January and early March when she contacts her GP requesting an increase in her medication. The contacts with GP in January and February coincide with a break-up of the relationship with Simon and her being assaulted and following the incident involving Child 2;
- Anna feels that she has reached crisis point at the end of March when she contacts the Crisis and Perinatal Mental Health Teams reporting suicidal thoughts and feelings of helplessness and worthlessness. The Panel note that this presentation is immediately before the relationship between Anna and Simon is reported to have ended;
- The last contact with the Perinatal Mental Health nurse on the 24th May where Anna reports an improvement in her mental health is before the contact by Simon reported by the family at the beginning of June and the two occasions that Anna spent time with him before her death.

5.16 Anna's family believe that her relationship with Simon had an impact on her mental health and stated that she would become paranoid and her anxiety would increase when she was in the relationship with him.

Analysis

5.17 Although Anna's use of alcohol and her mental health issues have been separated above for clarity purposes, what is notable is that her needs were intertwined in that she drank more and her mental health worsened as she experienced abuse, and that her sense of self-worth and helplessness was heightened and exacerbated by the abuse. All these factors impacted on her behaviours and actions. These vulnerabilities and their interrelationship are explored in further detail below.

5.18 The Learning Legacies study[39] undertook a systemic review of DHRs in cases of domestic abuse suicide. The study found that in 94% of cases, there was a record of victim mental health issues and in almost half of cases, evidence of a history of self-harm. In almost two-thirds of the cases, there was evidence of previous suicidal ideation or attempts and in half of the DHRs there was evidence that the victim had difficulties with drug or alcohol use.

5.19 Safe Lives Safe and Well Report [40] states that there is a link between domestic abuse and mental health problems. Mental health problems are a

[39] Learning Legacies: An Analysis of Domestic Homicide Reviews in Cases of Domestic Abuse Suicide; Dangar, S, Munro, VE, Andrade, LY; Suicide AAFDA and Warwick University April 2023

[40] https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf May 2019

common consequence of experiencing domestic abuse[41] and having mental health problems can render a person more vulnerable to domestic abuse.[42] The report, based on SafeLives Insight data highlights that:

- Victims with mental health needs are more likely to have problems with drug and alcohol use compared to those who do not (14% compared to 4% for alcohol and 10% compared to 2% for drug use);
- People with mental health needs had visited their GP and A&E more times on average compared to those without (5.9 times compared to 3.8 times for GPs and 1.5 compared to 1.2 times for A&E));
- Victims of Domestic Abuse with mental health needs more likely to have visited GP and A&E before accessing support (83% compared to 60% for GPs).

5.20 Research published in the British Medical Journal[43] found that survivors of abuse had double the risk of developing anxiety, and three times the risk of developing depression and illnesses such as schizophrenia and bipolar disease, even after accounting for other factors that can contribute to mental illness.

5.21 Anna was very aware of her mental health and her problematic use of alcohol and the chronology shows how she proactively sought help and support from agencies. Her help seeking behaviours can be seen as correlating to Stage 5 of the Suicide Sequence[44] *Help Seeking*. The study found *that help seeking often occurs when the victim considered things had become more serious, often after an escalation in the abuse, or fears for the safety of children,* which is also reflected in Anna's circumstances.

5.22 Anna recognised how alcohol and Simon's drug use had a negative impact on their relationship. In her note she referenced how there had been periods when, in an attempt to improve the relationship neither of them had used alcohol but how, after a period of abstinence, Simon started drinking and

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[41] Oram, S., Khalifeh, H., & Howard, L.M. (2016). Violence against women and mental health. The Lancet Psychiatry, 4 (2): 159-170. https://DOI.org/10.1016/S2215-0366(16)30261-9

[42] Devries, K.M., Mak, J.Y., Bacchus, L.J., Child, J.C., Falder, G., Petzold, M., & Watts, C.H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. PLoS Med 10(5): e1001439. DOI:10.1371/journal.pmed.1001439

[43] Women who experience domestic abuse are three times as likely to develop mental illness *BMJ* 2019; 365 doi: https://doi.org/10.1136/bmj.l4126 (Published 07 June 2019)

[44] Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide https://eprints.glos.ac.uk/10579/16/10579_Monckton-Smith_%282022%29_Home_Office_Report.pdf

taking cocaine again. The panel notes that the abusive behaviours detailed in her note and the chronology escalate following one or both of their alcohol use. Immediately before Anna's death she had spent time with Simon and had been drinking, both of which were factors known to impact on her mental health and the consequences for her own actions/behaviours.

5.23 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 active at the same time as was the situation at the time of her death. It appears to the Panel that this 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 feeling trapped in the re-emergence of patterns of behaviour.

5.24 It is the Panel's view that Anna's vulnerabilities were significantly exacerbated by and inextricably linked with her experiences of abuse. Together they presented a combination of factors that grew in intensity and complexity and which led to her taking her own life.

6. Experiences of Anna's Family

Overview

6.1 Anna's children and family saw first hand the abusive, coercive and controlling behaviours perpetrated by Simon, they saw the impact the relationship had on Anna and were worried about her. They also recognise that it was Simon's control over her that was the reason she returned to the relationship and, combined with his threats against her family and property, the reason that she met with him in the days before her death.

6.2 Child 1 and Child 2 told the Chair that Anna always tried to *put a smile on her face* and despite what they experienced in the home they were aware that their mum *would never tell us the extent of what was happening.*

6.3 Anna's brother and sister-in-law spoke about how she would only tell them about what was happening when things were bad in the relationship and how she would minimise the abuse and Simon's behaviours. They believe that that this was Anna's attempt to hide the reality of her situation and the embarrassment she felt.

6.4 Family members also told the Chair that they were frightened to say anything to Simon as they worried about consequences for Anna, particularly in respect of the triggering effect it could have on her other vulnerabilities.

Analysis

6.5 A recent article[45] highlights how friends, family, colleagues, and neighbours don't always recognise the signs of abuse, don't know how to help, or fear repercussions or negative consequences if they intervene.

6.6 Whilst there are national resources[46] available for those who are concerned about someone, it is the Panel's view that a more proactive approach is required so that family members and friends understand how they can support someone they are concerned about and where they can access information and support.

7. Children as Victims of Domestic Abuse

Overview

7.1 The Panel considered the experiences of Child 2 in particular in the context of the review. Child 2 spoke to the Chair about:

- The arguments between their mum and Simon, the assaults they had witnessed and the injuries to their mum that Simon had caused, *we had enough of seeing mum getting hit*;
- Witnessing Simon strangling their mum in the kitchen, always calling her names and putting her down and punching doors in the house;
- Simon's drug taking and the photos he sent their mum threatening to kill himself when she tried to end the relationship;
- How they never had time or space just Child 2 and their mum as *he was here all the time*;
- An incident where Simon had come to the house and Child 2's mum had told them to lock the door and hide behind their bedroom door. Child 2 described how Simon got into the house and went to their mum's bedroom where he pushed Anna to the bed. Child 2 described how they had got between Simon and their mum and told him to get out. He went outside but was calling Anna on his mobile. Child 2 explained how they had gone outside and told him to go away and leave their mum alone;
- Simon not liking it when Child 2 got involved as they would *stand up to him.* Child 2 said *I was never scared of him. He never scared me;*
- How Child 2 and Child 1 had tried to keep their mum safe. Child 2 spoke about how, when Anna felt that she couldn't get the help she needed, she would try and leave the house to go to her brother's grave or to the train tracks and Child 1 and Child 2 would try to stop her. It had been similar

[45] Friends, family, colleagues, and neighbours play a vital role in responding to domestic abuse By Blog Editor, IOE Digital, on 23 November 2022 Karen Schucan Bird, Carol Rivas, Martha Tomlinson, Nicola Stokes, Patricia Melgar Alcantud, Maria Vieites Casado

[46] https://www.womensaid.org.uk/information-support/the-survivors-handbook/im-worried-about-someone-else/ and https://safelives.org.uk/reach-in

circumstances that led to the police being called on the 14th February 2022 and Anna being arrested for the assault on Child 2;
- Anna wanting to get *proper help* for her mental health and alcohol use. They told the Chair how they tried to protect their mum; *we tried to keep her safe but we could no longer help her.*

Analysis

7.2 The NSPCC estimates 1 in 5 children in the UK will 'witness' domestic abuse. Domestic abuse is the most common factor identified at the end of assessment for children deemed 'in need' of support from local authority children's social care[47]. Domestic abuse was the most common family characteristic found within Serious Case Reviews, which concerned the most extreme and grievous failures to protect children from harm[48].

7.3 A SafeLives Insights Briefing in 2017[49] reports that "at the time they start school, at least one child in every class will have been living with domestic abuse since they were born and that two in five children (41%) in families where there is domestic abuse have been living with that abuse since they were born." The briefing further reports that:

While older children may be at less physical risk, exposure to abuse has an effect on children of all ages, unrelated to their ability to keep themselves safe. For instance, children over ten were much more likely to try to intervene to stop physical abuse (27% of children over ten, compared to 15% of those under ten). Additionally, Children's Insights data reveals that over half (52%) of children exposed to abuse said they found it difficult to sleep, and almost a third (30%) felt like the abuse was their fault. The same children exhibit higher rates of behavioural problems than their peers, and engage in more risk-taking behaviour, making them vulnerable to other forms of abuse, exploitation and harm.

7.4 When thinking about Child 2's desire to protect and keep their mum safe, it is unsurprising that they do not disclose what is happening at home, either at school or subsequently to the social worker or Assia, and neither do they agree to ongoing support from Assia or the specialist children and young people's support service.

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[47] Characteristics of children in need, Reporting year 2022 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

[48] Dickens et al 2022 Learning for the future: final analysis of serious case reviews, 2017 to 2019, Department for Education.

[49] https://safelives.org.uk/sites/default/files/resources/Insights%20National%20Dataset%20Briefing%202017%20-%20children.pdf

7.5 It is the Panel's view that Child 2 was trying to manage the situation as best they could, attempting to keep services at a distance for fear of the consequences and the impact on Anna.

7.6 The Panel considered how Child 2's increased absences from school from September 2021 could also be linked to their fear of leaving mum at home especially after the birth of the baby in November 2021 and their desire to protect their mum and the baby.

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

7.8 In October 2023, the Domestic Abuse Commissioner for England and Wales published a briefing for professionals in respect of Children and Young People subject to domestic abuse[50] which underlined this as an emerging strategic priority. The reports sets out the Commissioner's vision for;

All babies, children and young people who are subject to domestic abuse should receive an integrated and comprehensive response, rooted in understanding, prevention, effective intervention and long-term support.

7.9 It further details two aims in respect of Children and Young People;

1) Improved identification, response to, and shared understanding of, children subject to domestic abuse.
2) Improved and increased support service provision for children subject to domestic abuse.

7.10 The vision and aims of the Domestic Abuse Commissioner as they relate to children and young people should be adopted by strategic partners across Cwm Taf Morgannwg to improve the identification and responses to children and young people experiencing domestic abuse.

8. Suicide and Self-Harm Prevention

8.1.1 As Anna's death is the first review of a domestic abuse related suicide to be commissioned in Bridgend, the Panel has examined Wales' and Bridgend county-wide responses to suicide and self-harm prevention to identify learning.

a) Wales

[50] Children and Young People subject to Domestic Abuse; Professionals Insight Briefing. Office of the Domestic Abuse Commissioner for England and Wales. October 2023.

- The national suicide rate for Wales as published by the Office for National Statistics has remained between 10.0 and 13.0 per 100,000 population for the last five years with the latest numbers broadly in line with the pre-coronavirus pandemic rates in 2018.
- Over the last decade there were, on average, approximately 330 registered deaths by suicide in Wales.
- Data collected by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)[51] found that during 2008-2018, an average of 74 suicides per year in Wales, were people who had been in contact with mental health services in the 12 months prior to death.

8.2 Since the publication of Welsh Government's **Talk to Me 2 Strategy**[52] in 2015 the following progress has been made:

- The appointment of a **National Suicide and Self-Harm Programme Lead for Wales** with **Regional Leads** to drive national and local partnership action;
- Publication of "**Responding to issues of self-harm and thoughts of suicide in young people: Guidance for teachers, professionals, volunteers and youth services**";
- Establishment of a **Cross-Government Suicide and Self-Harm Prevention Strategic Group (2022)**. The Group has been established to drive forward cross- Government and multi-agency work to prevent suicide and self-harm in Wales;
- Launch of **Real Time Suspected Suicide Surveillance (RTSSS)** in Wales which was developed in partnership with Public Health Wales, all four police forces in Wales and the NHS Wales Executive. The RTSSS collects data directly from police forces relating to sudden or unexplained deaths that are suspected to have been by suicide. The first RTSSS report was published in January 2024;[53]
- Drafted guidance entitled "**Responding to people bereaved, exposed or affected by suicide"**. The guidance has been informed by insights into the needs and experiences of people living with bereavement by suicide in Wales and aims to ensure services provide a more compassionate response;
- Commissioned a **National Advisory and Liaison Service** for those impacted by deaths that might be a suicide. This service will provide a single point of contact for people across Wales who have been affected by a death by suicide and can be used as a key touch point, and by a wide range of agencies, to signpost people to support;
- The digitisation of the nationally recognised **Help is at Hand** resource[54] for healthcare and other professionals to help people who have been affected by suicide or unexplained deaths;

[51] https://documents.manchester.ac.uk/display.aspx?DocID=55332
[52] https://www.gov.wales/suicide-and-self-harm-prevention-strategy-2015-2020
[53] https://phw.nhs.wales/services-and-teams/real-time-suspected-suicide-surveillance/deaths-by-suspected-suicide-2022-23/
[54] https://sshp.wales/en/help-is-at-hand/

- eLearning for NHS staff and those with a Learning Wales account is accessible via the **Suicide and Self Harm Prevention Training Hub**[55] and work is ongoing to develop an undergraduate curriculum for suicide prevention and an accredited suite of suicide and self-harm prevention training.

8.3 **Welsh Government's Draft Suicide and Self-Harm Prevention Strategy 2024-34**[56] **aims to** reduce the number and rates of suicide deaths in Wales by establishing a pathway to support people who self-harm and improve support for those bereaved by suicide.The draft strategy identifies the following as priority groups;

- Middle-aged men
- People who self-harm or have self-harmed
- People in contact with Mental Health Services
- People in contact with the Criminal Justice System
- People with substance use challenges
- Victims of Domestic Abuse

8.4 The strategy also identifies the following groups as high risk of suicide; pregnant women and new mothers, people who have experienced adverse childhood adversities, victims of rape/sexual assault and those with a history of bereavement especially suicide.

8.5 The Panel note the progress made since the introduction of Welsh Government's Talk to Me 2 Strategy in 2015 and welcomes the intentions set out in the new strategy. It is imperative however that these strategic intentions translate to practical implementation of timely, accessible and effective support to individuals and families seeking help.

b) Local response

8.6 There are 60 confirmed suicides in Cwm Taf Morgannwg every year and the Suicide and Self Harm Prevention Strategic Group is responsible for the implementation of the Cwm Taf Morgannwg Suicide and Self Harm Prevention Plan[57]. This Domestic Homicide Review will be shared with the Cwm Taf Morgannwg Suicide and Self Harm Strategic Group to inform the review of the current prevention plan.

[55] https://sshp.wales/en/
[56] https://www.gov.wales/sites/default/files/consultations/2024-02/consultation-document-draft-suicide-and-self-harm-prevention-strategy.pdf

[57] https://www.cwmtafmorgannwgsafeguardingboard.co.uk/En/Professionals/MentalHealthandWellBeing–Professionals/LifeMattersASuicideandSelfHarmPreventionPlanforCTM20202022.pdf

8.7 An Immediate Response Group (IRG) was convened 11 days after Anna's death. This group identified the key individuals connected to Anna including family members and witnesses to her death and identified any known risks and actions required to mitigate risks. Minutes of this meeting identify *Referral to bereavement services* for all of Anna's family members but there is no individual practitioner or agency noted to complete this action rather it is recorded as an action for *All.*

8.8 When the Chair met with Anna's children and members of her family in early 2023, they reported that they had not been offered any support following her death. With their permission and in liaison with the Regional Suicide and Self Harm Prevention Co-ordinator the Chair made referrals to appropriate postvention support services which family members were able to access immediately.

8.9 If a named practitioner had been allocated to contact the family and provide information on support services this may have enabled those wishing to, to have accessed support earlier.

8.10 The establishment of the National Advisory and Liaison service will offer families access to early postvention support and it is therefore imperative that families and other individuals affected by suicide are provided with this information in a timely and supported manner.

8.11 The Panel also notes that for Anna's family this was the second suicide related death, both of which happened at the same location and welcomes the inclusion of this group within the high risk considerations in the draft strategy.

8.12 The Chair spoke to the Fatality Investigator at British Transport Police to discuss whether any further practical measures could be introduced at the location to prevent future suicides. They explained that the following measures are already in place at the location; signage for Samaritans support, anti-trespass equipment and CCTV but highlighted the limited effectiveness of these in the event that an individual is set upon gaining access to the tracks.

SECTION FIVE – OVERVIEW AND ANALYSIS AGENCY RESPONSES

1. Introduction

1.1 This section provides an overview and analysis of the following agency responses to Anna and Simon not already covered in the report:

- South Wales Police
- Primary Care, Cwm Taf Morgannwg University Health Board
- Mental Health Services, Cwm Taf Morgannwg University Health Board
- Bridgend County Council Children's Services
- Education
- Assia Domestic Abuse Service
- Substance Use Services
- Include, Whole System Approach
- Valleys to Coast Housing

1.2 There are also headings that are included in this section because they have general relevance and observations to make on issues which cut across the overview and analysis of agency contact:

- Multi Agency Responses and Joint Working
- Responding to counter allegations

1.2 This section also outlines, where appropriate, what changes to policy and practice have already been implemented by agencies since Anna's death which are correct at the time of writing.

1.3 There is some repetition in this section and whilst the Author has attempted to minimise this it is necessary in parts to avoid readers having to scroll up and down through the document.

2. South Wales Police

Overview

2.1 Within the scope of the review South Wales Police record 16 separate occurrences involving Anna relating to 14 incidents which can be broken down as follows:

- Eleven incidents relate to Anna and Simon and/or Simon's new partner;
- Requests under the Domestic Violence Disclosure Scheme;
- The domestic incident involving Anna and Child 2 for which Anna was arrested (14/02/2022);
- The incident where Anna forces entry to her property by smashing the glass in her door to gain entry to her home (21/05/2022).

Analysis

2.2 The IMR concludes that in general, South Wales Police policies and procedures were adhered to in relation to the contacts and occurrences involving Anna and identifies the following learning for the Force:

a) Use of warning markers on NICHE

2.3 Warning markers are placed on the police Niche system against someone's details to identify risks to themselves or others including medical conditions, behaviours etc.

2.4 Following the incident involving Anna and Child 2 in February 2022 police add the following warning markers to Anna's Niche record;

- Ailments in respect of her use of alcohol and high blood pressure
- Mental Health – Depression
- Self-Harm – with reference to the fact that she had cut herself 20 years ago
- Violent – relating to the assault on Child 2

2.5 The IMR identifies that during the incident Child 2 tells officers that Anna has previously attempted to lie on the train tracks at the local station but this information isn't included in Anna's warning markers.

2.6 The IMR recommends that officers be reminded that Niche warning markers should be updated to include information about suicide and self-harm.

b) Delays in investigations

2.7 On the 22nd April 2022, Anna is interviewed for the alleged burglary at Simon's property reported by him on the 3rd April. At the time of this interview Anna is also a suspect for causing damage to Simon's new partner's car on the 8th April.

2.8 South Wales Police identify delays in the investigation of this second offence which resulted in links not being made between the two reported offences. In the event that Anna had been linked to the later offence she could have been arrested and/or formally interviewed in relation to this allegation when she attended for the interview on the 22nd April.

2.9 The IMR states that *It is imperative that suspects of offences are recorded as such on Niche so that they are easily identifiable when the same suspects become involved in other cases.*

c) Risk Assessment

2.10 During the incident reported by Anna to South Wales Police on the 13th March 2022, it is recorded that she did not wish to provide details for the purpose of the Domestic Abuse Stalking and Honour Based Violence Risk Indicator Checklist (DASH RIC).

2.11 Following her report on the 11th April 2022, in relation to Simon contacting her and her being distressed and wanting contact to stop there is no record that a PPN was considered.

2.12 The only DASH RICs completed with Anna during the scope of the review are those completed by Assia on 31st March and 3rd May 2022.

2.13 DASH will be replaced by DARA[58] (Domestic Abuse Risk Assessment). The DARA is a risk tool for frontline police practitioners responding to domestic abuse and was developed by the College of Policing in consultation with survivors, frontline police officers, voluntary and charity sector support services, and leading academics. It is intended to improve engagement with victims and produce more accurate assessments of risk. It focuses on making it easier to identify coercive control so that responding officers can make better informed risk assessments and has been identified by the College Professional Committee and the National Police Chiefs' Council (NPCC) as the preferred risk tool for police first responders to domestic abuse.

2.14 It is the Panel's understanding that, as yet, there is no national implementation date for DARA. Standardisation of the Niche system being used by police forces is required and the College of Policing is responsible for the development and dissemination of training to staff and officers to support national implementation.

d) Submission of Public Protection Notices (PPN) for all relevant incidents

2.15 South Wales Police identify that PPNs were submitted in response to all incidents identified as domestic abuse which were risk assessed and shared with relevant agencies. There were two incidents however when a PPN was not submitted:

- 21/05/2022 – Anna forces entry to her home address by smashing the glass pane of her door whilst her eldest child and 5 month old baby were inside. Anna was under the influence of alcohol at the time and submission of a PPN should have been considered to assist in providing a background to Children's Services and Health, especially considering the fact that on 9th May, two of Anna's children had been placed on the child protection register.

[58] https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-2022.pdf

- 22/05/2022 No PPN was submitted following the incident reported by Simon's new partner relating to threats reported to have been made by Anna against her property. The IMR suggests that submission of a PPN would have provided additional information in respect of behaviours and continued events following the children's registration on the Child Protection Register.

e) Domestic Violence Disclosure Scheme

2.16 The Domestic Violence Disclosure Scheme (DVDS) also known as Clare's Law was implemented in all forces across England and Wales in March 2014 and enables police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partners abusive or violent offending.

The scheme has two elements: the *"Right to Ask"* and the *"Right to Know"*[59].

Under the scheme an individual or relevant third party (for example, a family member) can ask the police to check whether a current or ex-partner has a violent or abusive past. This is the *"Right to Ask".* If records show that an individual may be at risk of domestic abuse from a partner or ex-partner, the police will consider disclosing the information.

The *"Right to Know"* enables the police to make a disclosure on their own initiative if they receive information about the violent or abusive behaviour of a person that may impact on the safety of that person's current or ex-partner. This could be information arising from a criminal investigation, through statutory or third sector agency involvement, or from another source of police intelligence.

2.17 The Police create a task for consideration of a Clare's Law disclosure to Anna on the 13th March 2022 and this information is shared with the partnership MARAC coordinator based with Assia. A decision is taken on the 9th May not to disclose because Anna and Simon are no longer in a relationship but it is noted that Police had shared Simon's previous convictions in the Initial Child Protection Conference and this formed part of the rationale. There are three elements of the DVDS that are relevant to Anna; the timeliness of decision making by South Wales Police, the rationale provided for the decision not to disclose and the decision-making process itself.

- <u>Timeliness of decision making</u>

[59] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet#:~:text=The%20Domestic%20Violence%20Disclosure%20Scheme,previous%20abusive%20or%20violent%20offending.

- The rationale to decline the Right to Know application wasn't recorded until 56 days after the incident is assessed (which is also the date of the ICPC). This is significantly longer than the 35 days that forces were expected to have made a decision in respect of DVDS at this point in time and a factor reported by HMICFRS in a previous Police Effectiveness, Efficiency and Legitimacy Report. The statutory guidance, published in April 2023 has now introduced a timeline of 28 days to ensure that victims have quicker access to information.

- The IMR and Additional Information supplied in June 2023 as part of this review by South Wales Police, highlighted that at the time of this incident additional overtime was being used to manage the demand and prioritise the risk, since that time additional resources have been placed into this priority area.

- It also stated further improvements were identified in the annual HMIC Police inspection in August 2022, which led to a complete review and restructuring for all Safeguarding and Public Protection demand. The Domestic Violence Disclosure Scheme is now managed by one centralised department that has control of the demand, decision making and resources across all areas served by South Wales Police.

- In its recent PEEL Inspection published in May 2024[60] HMICFRS reported that:

  Our last inspection identified that the force needed to meet the nationally recommended time limits for making disclosure decisions under the DVDS.

  The force has centralised its management of the scheme within its safeguarding and public protection command. It has refreshed guidance to make sure that all personnel involved in the process understand their responsibilities. A data dashboard now helps supervisors to closely monitor timeliness at every stage of the process and to identify when they need to use members from other teams to minimise delays. We found that inspectors had reviewed the progress and safeguarding risks of each case we audited.

  We found that in most areas, almost all applications awaiting disclosure decisions were within the national 28-day limit. But in Cardiff, 44 disclosure decisions were overdue. The force's disclosure rate within the time limit is 38 percent.

  The multi-agency joint inspection of child protection arrangements in Bridgend in June 2023 found that personnel didn't always fully understand

[60] https://hmicfrs.justiceinspectorates.gov.uk/peel-reports/south-wales-2023-25/

the force's Domestic Violence Disclosure Scheme process. It also found that they didn't progress applications in a timely manner.

The force has made encouraging progress but needs to demonstrate sustainable improvement in promptly informing applicants of the information it needs to make decisions about their safety.

- The Panel note the progress that HMIC has identified in respect of steps taken by South Wales Police to improve the timeliness of decision making in respect of DVDS but remain concerned regarding the findings referenced in respect of the understanding of personnel and timeliness of applications in Bridgend.

- <u>Rationale for decision making</u>

- Ex-partners have been included in the DVDS scheme since 2015 but the Panel acknowledge that the DVDS guidance (2016) did not specifically refer to the person to be notified as being an ex-partner or previous partner of the perpetrator. The 2023 guidance does now specify at paragraph 75 that this includes *current or former intimate partners and family members*. Regardless of the fact that this wasn't specified in the guidance it was accepted practice and this in itself should not have been the basis of the decision not to approve disclosure to Anna. It is the Panel's view that this highlights a lack of understanding by decision makers at the time and furthermore the absence of monitoring of DVDS decisions. This is further highlighted in the fact that two other Domestic Homicide Reviews in the South Wales Police area have identified where decisions relating to DVDS have been made on the basis that that relationships are said to have ended.

- The South Wales Police rationale to decline the Clare's Law disclosure does however note that Police had shared the ex-partners previous convictions in the recent ICPC. It is also recognised that Anna's handwritten notes that she was made aware of Simon's previous history of domestic abuse during the ICPC on the 9th May. Despite the relationship with Simon being over at this time the Panel considered how having this information may have validated Anna's experiences of abuse from Simon knowing that she wasn't the first or only victim.

- <u>Decision making process</u>

- There is no evidence that the disclosure application was brought to any multi-agency fora by South Wales Police or discussed with key agencies to inform their decision. It is recognised in the IMR that this information was shared with the Assia MARAC coordinator and Social Services. Paragraph 86 of the statutory guidance states that the multi-agency panel used to inform disclosure or plan next steps for safeguarding should

ideally consist of *no less than three, and consist of the police, probation service and a representative from a domestic abuse service.*

- Since Anna's death the Home Office has published improvements to the DVDS Guidance (April 2023) specifically for 'Right to know' disclosures for previous partners. Assia has also confirmed to the panel that an IDVA is now present for all consideration of Clare's Law applications in Bridgend.

3. Cwm Taf Morgannwg University Health Board Primary Care

Overview

3.1 Anna was known to universal services which includes health visiting, maternity services and General Practitioner and as can be seen from the chronology she has a significant amount of contact with all agencies.

Analysis

a) Issues and learning

3.2 Cwm Taf University Health Board IMR identifies the following issues and learning in respect of Primary Care;

- All contact between Anna and the GP practice detailed in the chronology was via telephone due to the changes to practice introduced as a result of the Covid 19 pandemic. The IMR acknowledged the challenges that both patients and practitioners experienced due to this.

- It is noted that Primary Care were working to Welsh Government COVID guidelines during the time they had contact with Anna which did affect how some services were delivered for part of the scope of the review.

- When treatment was commenced for anxiety in July 2020 a plan was made to review treatment three weeks. The practice confirmed that the onus would have been on Anna to make an appointment if she thought this was needed.

- The record of contact in November 2020 refers to how alcohol exacerbates Anna's behaviours and includes details of Anna going to the railway station to jump on the track. The IMR identifies that this information may not have seemed significant to the GP in the absence of the family history of Anna's brother taking his own life in this way.

- Following this contact the Practice proactively attempted to contact Anna on three occasions and whilst two of these were unsuccessful, contact was made at the beginning of January.

- The IMR author identifies the potential that a referral to Primary Care Mental Health could have been made as a result of Anna's contact with her GP practice in March 2021 when she reports that she is still experiencing *low days*. A referral at this stage may have provided support to Anna whilst she was awaiting allocation of a WCADA support worker. The referral to the PCMH team is subsequently made a month later following Anna reporting that she is pregnant and her medication for anxiety being reduced.

- It is unclear from Primary Care and Maternity notes whether information regarding Anna's mental health and alcohol use was shared with maternity services. The regular safeguarding meetings that were held between GPs, health visitors and maternity services were suspended at the time of Anna's pregnancy due to Covid. The IMR identifies how this would have affected communication and information sharing between health services.

- Midwifery records identify a history of mental health but there is little exploration of this with Anna considering the level of input from Primary Care. As part of audited standards it would have been expected for mum's emotional health to have been considered at each ante natal contact. There is only one documented enquiry recorded within the records.

- The targeted ante natal contact at 36 weeks was good practice. However, the recordings of the visit lack analysis around parental mental health. Having known the mental health concerns identified at the ante natal visit it would have been expected for health visiting to have had wider discussions with primary care and midwifery about support and a treatment plan for Anna.

- It is also unclear what the intended visiting pattern of the health visitor was in light of the mental health concerns and the effects of the challenging pregnancy.

- Maternity records between September and November 2021 indicate that Anna was seen almost daily at the maternity unit highlighting concerns around the pregnancy.

- During the primary birth visit on the 29th November the Health Visitor asks the Routine Enquiry questions in respect of domestic abuse. Anna discloses abuse with two ex-partners one of which is Simon. This is the only record of Routine Enquiry in Anna's notes. There is no record of a DASH RIC being completed by the Health Visitor or rationale as to why one wasn't completed.

- There is no evidence of the Edinburgh Post Natal Depression Score (EPDS) being completed in any of the health visiting or midwifery records despite Anna telling the health visitor that she had previously experienced

post-natal depression. The EPDS is a more accurate tool that the emotional health questions in assessing emotional health and completing this with Anna may have resulted in an earlier referral to PRAMS. When the EPDS is completed by PRAMS at a later date Anna score 26 which is a high-level score.

- When Anna requests Antabuse from the GP on 8th December 2021 following an incident of being drunk there is no record that the GP had any discussions with any practitioners or that there were any safeguarding considerations in light of the fact that there was a newborn child in the family.

- The IMR considers whether, at this point, other measures could have been considered by the GP as the current level of support for Anna did not appear to be working. In light of Anna's previous needs relating to alcohol use there is no record that support from WCADA is discussed or that a referral is offered to Anna.

b) Case Recordings

3.3 The IMR also identified the following learning in respect of case recordings;

- The IMR author was unable to locate community midwife post-natal notes. It was explained to the panel how health visitors and midwives in CTMUHB are using a combination of both paper and computer records and this practice has been highlighted as a risk in the service's Risk Register;
- There was no narrative in the records as to who was present during appointments or any rationale provided as to why emotional health/routine enquiry were not asked;
- The monitoring of maternal mental health is part of the midwifery standards of care but Anna's records capture limited information regarding her mental health;
- Health visiting contacts are not recorded in line with agreed standards. There were a number of clinic contacts that if recorded in depth would have provided an opportunity to reflect on Anna's mental health.

3.4 The Panel note the following in respect of record keeping and exchange of information:

- Despite being identified within the maternity booking process and discussed on two occasions it appears that Anna's mental health and physical symptoms became lost in the wider picture.

- The panel note that there is no reference in the GP records of Anna being the subject of a MARAC meeting on the 9th March (as a perpetrator) or the fact that the children are placed on the child protection register in May. The CTMUHB representative on the Panel

explained that MARAC information is shared with GP Practices however it is the decision of individual practices as to whether they include this information on their IT system. It was explained that some practices have invested resources so that staff input this information on to the system whereas other GP practices do not want the MARAC information. In light of this discussion Panel members are not confident that victims, including those identified as high-risk are being flagged consistently on GP IT systems within CTMUHB.

- The CTMUHB representative explained to the Panel that the Health Visitor had only become aware of Anna's death when she attended to undertake a home visit at Anna's home. This section will highlight other examples of services not being made aware of Anna's death and the Panel feel that there is learning for services in relation to how and with whom information about a death is shared in order that contact can be sensitive and appropriate.

c) IRIS

3.5 Identification and Referral to Improve Safety (IRIS)[61] is a social enterprise established *to promote and improve healthcare response to domestic violence and abuse.* IRIS improves the General Practice response to domestic violence and abuse and essentially improves the safety, quality of life and wellbeing of survivors. IRIS has been operating in CTMUHB since the latter part of 2015 and was extended to incorporate Bridgend practices from February 2021. 13 of the 15 GP practices in Bridgend are IRIS practices.

3.6 A report prepared for the CTMUHB Safeguarding Board in 2022 found that *the patient engagement rate for IRIS referrals is approximately **88-90%** as compared to community-based services engagement rate of 30-35%. This evidences the unique and trusted relationship between patient and IRIS trained GPs and clinicians, who are able to recognise symptoms that present as a result of past and ongoing domestic abuse and signpost patients for specialist DVA support via the practice's allocated Advocate Educator.*

3.7 Anna's GP practice has been an IRIS practice since March 2021 but the Panel notes that despite Anna's statements during her telephone contact with the GP on the 16th February 2022 there is no referral made to IRIS.

3.8 When making enquiries in respect of Anna's practice the IRIS Advocate Educator shared the following with the Chair;

The practice is probably one of the best in Bridgend in terms of engagement. Referrals have been received from most of the clinicians in the practice and they are second highest in respect of referrals. Whenever I have asked for extra support for a patient (referrals to mental health services or letters of support) they have always replied and actioned things immediately.

[61] https://irisi.org/who-we-are/

4. Cwm Taf Morgannwg University Health Board Mental Health Services

Overview

4.1 Due to Anna's involvement with Mental Health services immediately before her death an internal CTMUHB investigation was carried out by the Quality Improvement Nurse for Bridgend Mental Health Services in 2022. The Chair requested a copy of the investigation report but at the time of writing this review she has not yet been provided with a copy.

Analysis

4.2 The IMR included the following learning and main findings:

- Safe sleeping, particularly whilst taking medication that could have a sedative effect was not routinely discussed with Anna by the Perinatal Mental Health Service (PNMHS) during their contacts. Although there were no concerns with regards to safe sleeping, it is advised this advice should be provided to those individuals who co-sleep or take prescribed medication with a sedative effect.

- The PNMHS showed care and compassion when supporting Anna and offered her appropriate support within agreed time frames as per protocols, despite the service being stretched with low staff and high referrals at the time.

- The PNMHS showed they had systems in place such as RAG (red amber green) ratings that allowed review of the case and for the case to be expedited when required.

- Some errors were identified in dates recorded by Home Treatment Team on entries and a prescription.

- There could have been improved pathways and engagement with Local Primary Mental Health services to provide a seamless transfer of care/ sharing of information for patients. A smooth transfer between services would have continued good support for Anna and maintained her trust and confidence in services.

- Evidence of good joint working across PNMHS, the Home Treatment Team and Social Services which provided a supportive environment for Anna and ensured that services providing support were involved and informed of the plan of care. Concerns were also discussed between the appropriate teams.

- PNMHS provided a detailed report for the Initial Child Protection which was discussed with Anna prior to its submission. PNMHS attended the

ICPC and provided a further update to the core group meeting on the 17th May as a PNMHS representative could not attend.

- Documentation could be improved in the Single Point of Access, Home Treatment Team and PNMHS. There were occasions when risk assessments were not completed in full, more in-depth rationale for decisions made/medication prescribed could have been provided and more details could have been documented during some discussions i.e. full discussions when incidents of domestic abuse were disclosed.

4.3 The Panel identified the following additional learning points in relation to mental health service practice in Anna's case:

- The PNMHS assessment was shared with Anna's GP, health visitor and social worker ensuring that practitioners working with Anna had sight of all relevant information from the PNMHS.

- No DASH RIC was completed by the PNMHS practitioner following Anna's disclosures in respect of domestic abuse during the telephone contact on the 5th April 2022. It is noted that the practitioner discussed the possibility of a further assessment with Assia and later shared this information with Anna's social worker. However the Panel considered that Anna had disclosed information relating to her relationship with Simon including matters of a sexual nature, potential indicators of coercive and controlling behaviours and physical abuse to the PNMHS practitioner and it would have been good practice to have completed a DASH RIC at this time to better understand Anna's risk of abuse as she felt comfortable and safe to talk about the nature of her relationship with the PNMHS practitioner .

- PNMHS were unaware of the PPNs shared by South Wales Police with the multi-agency safeguarding hub (MASH) in Bridgend. The PPN coordinator at the MASH triages all PPNs and sends out the information to all relevant teams within Health. It was identified by the Panel that the MASH coordinator who is employed by Bridgend CBC cannot access FACE, the system used by PNMHS. This means that the coordinator cannot check FACE to see whether the subject of the PPN is known to PNMHS and neither can they share the PPN with FACE.

- Anna's self-reported positive outcomes from her engagement with PNMHS. Anna's Edinburgh Post Natal Depression score on referral to the service was 26/30. On discharge this was noted as 7/30 indicating a reported improvement in both mood and mental health.

- Anna's family were sent a letter of condolence from the PNMHS following her death which also included details of the 111 helpline should they need to speak to anyone about their own mental health and well-being.

- Anna's diagnosis of Emotionally Unstable Personality Disorder, as detailed in Section Four paragraph 5.12 is shared with the Health Visitor but there is no record of this information being shared with the GP. Details of Anna's diagnosis is not included in Children's Services Care and Support Assessment or referenced in the notes of the ICPC or the subsequent Core Group meeting. The PNMHS representative explained how Emotionally Unstable Behaviours can present in different ways including individuals having difficulties communicating issues, not knowing what will help and sometimes being perceived as manipulative.

- The Panel considered how, if practitioners working with Anna had been aware of her diagnosis in April 2022, they may have better understood her behaviours particularly after the ending of the relationship with Simon.

4.4 The IMR highlights the following practice improvements that have been implemented since Anna's death:

- Introduction of a perinatal specific care plan, risk assessment and initial assessment;
- Roll out of violence against women, domestic abuse and sexual violence training across Mental Health services;
- Safe sleeping information be discussed and provided to all new mothers under Perinatal Mental Health Services and is audited monthly by the Team leader;
- A clear referral pathway to Local Primary Mental Health services for patients in the care of PNMHS implemented;
- PNMHS now attend MARAC meetings in Bridgend;
- Perinatal mental health duty line available 24/7 to provide information, advice and support to families and professionals;
- Appointment of a domestic abuse liaison worker within CTMUHB funded until 2026.

5. Bridgend County Borough Council

Overview

5.1 Anna had contact with a number of services provided by the local authority. An analysis is provided below for each of the services.

a) Children's Services

5.2 Bridgend CBC Children's Services IMR highlights social work practice in this case that is in line with the Wales Safeguarding Procedures[62] and Social Services and Wellbeing (Wales) Act 2014[63] including:

- Statutory timescales were adhered to in respect of the initial strategy discussion, completion of the Care and Support assessment and subsequent Initial Child Protection Conference and Core Groups;
- The Care and Support Assessment[64] identified strengths and positive support networks that Anna had around her;
- Home visits were undertaken by the Social Worker and the children were seen during these visits;
- Social worker made referrals on behalf of Anna for support including Assia and requested a referral to PRAMS;
- Social worker shares information with some agencies working with Anna e.g. Health Visitor, PRAMS;
- Anna was involved in meetings including the ICPC and Core Groups.

5.3 It is noted in the IMR that the social worker who completed the assessment spent a considerable amount of time with Anna, completing more visits that statutorily required. The Panel member representing Children's Services felt that there was a sense in the social worker's records that they really wanted to identify Anna's needs and support her to get the help that she was seeking. This is evident in the documented contact with PRAMS, the Health Visitor and Barod.

5.4 The Chair spoke with the social worker who completed the assessment and they reflected on their contact with Anna. Whilst acknowledging that their involvement was relatively short (approximately 10 weeks) they felt that they had built a positive relationship and that Anna communicated well with them; speaking about her use of alcohol and starting to disclose some of the abusive and controlling behaviours perpetrated by Simon. The social worker spoke about Anna's worries about social services involvement and how they had tried to provide reassurances. Anna's family also spoke to the Chair about the relationship Anna built with this social worker, how she trusted them and felt they listened and understood her needs and the help that she wanted.

5.5 Family members also spoke to the Chair about how Anna's relationship with the new social worker, allocated when the children were registered on the Child Protection Register, was very different. They spoke about how Anna did

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

[63] https://www.gov.wales/sites/default/files/publications/2019-05/social-services-and-well-being-wales-act-2014-the-essentials.pdf

[64] Local Authorities have duties under the Social Services and Well-Being (Wales) Act 2014 to assess and meet the needs of children and adults for care and support and to assess and meet the needs of carers for support including adult and child carers https://www.gov.wales/sites/default/files/publications/2019-05/social-services-and-well-being-wales-act-2014-the-essentials.pdf

not feel listened to and how this impacted on her interactions with social services. The initial social worker reflected on this during their discussion with the Chair. They spoke about families involved with Children's Services being expected to engage with social workers and in Anna's case she had built a rapport and developed a relationship where she felt able to start talking about her relationship, her alcohol use and mental health. When the 'system' mandated a change of social worker Anna was expected to invest time and energy again in developing a relationship which her family say she felt unable to do.

5.6 The IMR identifies the following learning for Children's Services practice;

The Child Protection Plan was weak in that it:

- Focused solely on Anna's mental health and alcohol use to the exclusion of the domestic abuse she reported in her relationship with Simon;
- Doesn't record the children's needs or identify support provision for Child 2;
- Wasn't SMART or meaningful in the actions identified.

5.7 The Panel note that Anna's relationship with Simon and the abusive and controlling behaviours she discloses to the Health Visitor, PRAMS and Social Worker during the assessment period are not explored in the ICPC or subsequent core groups, effectively minimising her experiences and focusing instead on her mental health and use of alcohol.

5.8 Similarly, there is no evidence of the breakdown of her relationship with Simon and the potential emotional impact of this being explored by the social worker or at these meetings which may have provided a better understanding of the dynamics of the relationship. The Panel notes that Anna's diagnosis of Unstable Emotionally Behaviours is made prior to the ICPC but it does not factor as a discussion in any of the statutory meetings.

5.9 The IMR identified that there was no evidence of direct work undertaken by the social workers with Child 2 for the duration of Children's Services contact and neither is there a record of their views and wishes being recorded or considered. Child 2 was 16 years old at the time of the assessment, had been assaulted by their mum and was no longer attending school. Agencies were aware of Anna's mental health and her use of alcohol as factors that had led to the assault on Child 2 and the Panel is concerned that there is no record of Child 2's experiences or wishes being explored during the assessment or subsequent child protection proceedings.

5.10 It is noted in the record of the ICPC that the Education Engagement Coordinator states that *[Child 2] does appear to be struggling with [their] emotions and confidence and requires support around this and additionally with progressing [their] education* but this does not result in any direct support being actioned for Child 2.

5.11 The Team Manager who signed off the Care and Support assessment identifies that Child 2 takes on the role of a young carer particularly when Anna's mental health and decision making are impacted. The Panel notes that there is no evidence of Child 2's role as a young carer being explored further with Anna or Child 2 or that an offer of support is made.

5.12 The IMR highlights that the social worker spoke with Simon on a number of occasions as part of the Care and Support assessment but there is no evidence of discussions with him in respect of his behaviours as reported by Anna and how these may impact on Child 3 and Child 2. Whilst his views are sought for the purpose of the assessment these are not included in the assessment record nor is there any reference to actions/accountability expected of him as part of the Child Protection Plan. There is no evidence of interventions to challenge Simon about his behaviours or to ask him to take responsibility for his actions and the impact of them on Anna and the children.

5.13 Whilst the Care and Support assessment and subsequent meetings include information from a number of agencies supporting Anna and her family, the Panel has identified two notable omissions; Child 2's school and Include.

5.14 Whilst the panel acknowledge that Child 2 had been de-registered from school in January 2021, there is no evidence that school were invited to contribute information at any point in Children's Service's involvement. The Panel feel that school could have provided information that could have contributed further to an understanding of Anna and the childrens' family life.

5.15 Despite being aware of Anna's referral to Include at the strategy discussion on the 14th February 2021 and an email from her Include worker on the 8th March, information from Include is not requested for the assessment nor were they invited to ICPC or the subsequent Core Groups.

5.16 By not including information from Education and Include the Panel feels that there were opportunities missed to include all relevant information in the decision-making processes resulting in Include not having sight of all relevant information whilst working with Anna.

5.17 The Panel wishes to highlight the language used in both the Care and Support assessment and IMR which refers to Anna as being *dishonest* in relation to her contact with agencies, in particular Assia. This could be interpreted as victim blaming and does not reflect a level of understanding of barriers facing victims particularly in the context of Anna's fear of consequences should services become involved if she was to disclose the extent of the abuse that she was experiencing.

5.18 The IMR highlights the following occasions where professionals did not use their professional curiosity to explore or challenge statements made by Anna:

- During the core group meeting on 23rd May, Anna is recorded as saying *I feel like a new woman. I haven't cried for about two weeks. I feel happy. I*

am moving on. The IMR author highlights that there is no evidence that this statement was explored further with Anna for example; why had she been crying, how had she managed during this period, what impact did she think this may have had on the children, what had changed two weeks ago and what was different for her now? It is the author's view that there was an overreliance on Anna's account which was accepted on face value without any questioning or challenge which could have provided a better understanding of her emotions and coping mechanisms at the ending of her relationship.

- Anna is not challenged by either social worker in respect of her behaviours as reported to the police by Simon including her alleged harassment and burglary of his flat which occur whilst Children's Services involvement is ongoing. The chronology evidences that the relevant PPNs were shared with Children's Services however there is no record that these incidents were discussed with Anna or flagged at the ICPC.

- The panel note again that there is no attempt by the social worker to complete the DASH with Anna when she makes disclosures about her relationship with Simon during the joint social worker/PRAMS visit on 7th April. Instead, a re-referral is made to Assia and a second DASH is not completed with Anna until the beginning of May. It is the Panel's view that Anna felt comfortable and safe speaking about the abuse she had experienced during this interaction and completion of the DASH at this time, during a face to face meeting with practitioners that she trusted may have provided a further insight into the nature of the abuse and coercive and controlling relationship.

b) Early Help Services

Analysis

5.19 The Early Help model operating in Bridgend consists of three locality teams comprising a Team Manager, Education Welfare Officer, family support worker, family engagement worker, youth worker, school counsellor, Health and Well-being practitioner, Inclusion worker and a Police Community Support Officer. The Early Help model is based on consent; both in terms of contact and engagement with the service.

5.20 The Panel notes the following observations in relation to the Early Help service:

- Anna pro-actively sought help from the Early Help service, contacting them in relation to Child 2 having left school and presenting low in mood. The records indicate a referral to the Youth Emotional Health Team but despite numerous enquiries as part of this DHR there is no record of a referral being received by the Youth Emotional Health team from Early Help and consequentially Child 2 didn't receive any support;

- Anna's contact for support is 3 weeks prior to the incident when she is arrested for assaulting Child 2;
- Whilst understanding that the service is based on consent there is no evidence that a pattern of referrals/incidents was identified or that checks were made to ascertain whether the family were open to children's services.

c) Education Services

Analysis

5.21 The Headteacher of the Comprehensive school attended by Child 2 describes them as a *determined and strong-willed young [person]*.

5.22 Child 2's attendance in Year 10 (2020-21) was 61% and the head teacher described the beginning of a pattern of internal truanting and school refusing which continued into Year 11 when Child 2's attendance reduced to 48%.

5.23 The headteacher described Child 2's attendance record as a concern before Covid and explained how Child 2's year group in particular were impacted by Covid and the introduction of online learning. After pupils returned to school, the headteacher describes Child 2's refusal to attend becoming more persistent and for longer periods of time resulting in the measures outlined in the chronology being introduced.

5.24 The Panel note that it is not only Child 2's attendance that is concerning school but also their behaviour in school deteriorated including being described as having a *poor attitude towards staff, confrontational, rude and swearing at staff.*

5.25 The Panel further note the meetings that took place with both Anna and Child 2 present and measures introduced to support Child 2's attendance including daily check ins and regular meetings with the Student Support Officer and reduced and bespoke timetable. These arrangements were reviewed and adapted in line with Child 2's and Anna's agreement.

5.26 The Panel wish to acknowledge the lengths that the school went to in encouraging Child 2 to attend school including the Assistant Headteacher going to the home in an attempt to support Child 2 to attend their examination in November 2021.

5.27 The Chair asked the Headteacher to reflect on what opportunities there had been to ask Child 2 about their home life and identify other support needs. The Headteacher explained that:

- Child 2 visited the pastoral office every day, appeared to be comfortable in that environment and had good relationships with the pastoral team.

- Counselling was offered but Child 2 had been reluctant to engage. The Headteacher commented how Child 2 took time to establish new relationships and was reluctant to engage with people that they didn't know.

5.28 Child 2's refusal to attend school begins very shortly after Child 3's birth in November 2021 and the Panel considered how, from Child 2's perspective the following factors could have been significant in their reluctance/refusal to attend school at this time:

- There was a newborn baby in the house;
- Anna and Simon were still in a relationship and Child 2 was aware of and experiencing the abusive nature of this relationship;
- Concerns for Anna being at home with the baby and Simon being there;
- Anna's episodes of drinking after Child 3's birth and the negative impact this had on her behaviours;
- Child 2 wanting to protect their mum and the baby;
- Child 2 being a young carer both in respect of their mum and the baby;
- The pattern of Child 2's home life – we see from the police incidents how reports were made in the early hours of the morning and considerations how these were impacting on Child 2's ability to sleep and concentrate during the day.

5.29 The Panel can understand why Child 2 may have been reluctant to share any of this information even with staff members they trusted for fear of consequences for their mum and baby brother, instead they tried to manage the situation at home to the best of their ability by ensuring that they were there with their mum to protect her. This was an extremely complex and worrying situation for a young person to cope with and manage.

5.30 It is three weeks after Child 2's de-registration that the police are called and Anna is arrested for the assault on Child 2.

5.31 Operation Encompass[65] operates in the South Wales Police area and involves police sharing timely information with schools in respect of all police attended domestic abuse incidents to enable schools to identify and support children. Police confirm that an Operation Encompass notification was shared with Bridgend CBC Education services following the incident on the 14th February but that it was already noted that Child 2 had left school. There is no record that school were aware of the incident between Anna and Child 2 on the 14th February 2022 as she had de-registered by this point.

5.32 The Headteacher confirmed that the school receives Operation Encompass notifications which are placed on the My Concern system. Pastoral staff are then made aware and can carry out a welfare check with the child as appropriate. The Headteacher explained that the current Operation

[65] https://www.operationencompass.org/about-us

Encompass process only includes being notified of the name of the pupil. There are no details of the police attended incident which can make it challenging for staff to establish what has happened, whether the child was present or whether they are even aware of the incident, information which would be helpful in determining the best approach to check in with the child and identify support options.

5.33 The Panel identified that Operation Encompass is operating differently not only within the South Wales Police area but across England and Wales and that with the obligation on Police Forces following the passing of the Victims and Prisoners Act 2024 there is a pressing need to ensure a consistency of approach in respect of information sharing between police and education settings to ensure that children are safeguarded and supported. Additional training is required to raise awareness for Police resources to appropriately share information through Operation Encompass reports systems, as there are numerous variables which alter the information capable of being shared.

5.34 As detailed elsewhere in the report school information was missing from key processes and multi-agency discussions including Daily Discussion, MARAC and child protection processes. Whilst there are actions noted in respect of Education for the Daily Discussion meeting in February and MARAC in March 2022 these actions relate to making enquiries as to whether Child 2 could leave school and to sharing the minutes from the meetings with the school if this was relevant. There is also an action for the school to consider making a referral to children's services should there be concerns about Child 2 leaving school. This Review has received no information as to whether these actions were completed or any outcomes.

d) Elective Home Education

Analysis

5.35 Local Authorities in Wales have a statutory obligation to maintain a register of all Elective Home Educated pupils who have de-registered. Guidance published in October 2023[66] provides statutory guidance for local authorities on arrangements for identifying children of compulsory school age who are resident in their area, who are not on any maintained school roll, not in education other than at school (EOTAS), not on any independent school roll, being educated at home by parents and also those not known to the local authority as receiving a suitable education.

5.36 At the time of Child 2's deregistration from school the requirements for EHE were:

[66] https://www.gov.wales/sites/default/files/publications/2023-10/elective-home-education-guidance-oct-2023.pdf

- Parents to notify school in writing of their intention to take full responsibility for educating their child and requesting removal from the school register;
- School to notify Local Authority of this deregistration;
- When notified, the Elective Home Education Officer places child's details on the Elective Home Education database and maintains contact/undertakes an annual visit in line with the Welsh Government guidance document

5.37 From the relevant sections in the chronology the Panel note that:

- At time of home visit 4/3/2022 there is no indication that the Education Engagement Officer is aware of the incident 14/2:
- An update from the Education and Engagement service is included in the Care and Support assessment and the coordinator attends both the ICPC and Core Group meeting;
- There is no evidence that the suitability of EHE was considered in the child protection process in the context of the nature of the incident which lead to the assessment (i.e. Child 2's educational needs to be met by Anna who had assaulted her).

5.38 The Panel considered what learning could be taken from this case in relation to Elective Home Education. Paragraph 2.34 of the Welsh Government Guidance states that: *It is imperative that the parental decision to home educate is a positive choice and not considered as an option when children have disengaged from education prior to becoming home educated as there will be difficulties trying to engage with children who have already disengaged. The expectation in these instances would be that Local Authorities put in support for these children.*

5.39 The Panel considered what checks/balances are still needed in respect of Elective Home Education. This case highlights a situation where neither school nor Anna were convinced that home education was the solution for Child 2 and yet because the 'process' had been followed this became the position. It appears that Anna really wanted Child 2 to continue in education and was initially supportive of the steps taken by school, however, it is the Panel's view that in light of everything that Anna was trying to manage in her life this became the only remaining option, despite her not being certain it was the right one.

5.40 The school could have considered a safeguarding referral if they had concerns about the decision to home educate but their omission from subsequent safeguarding processes meant that they were unaware of the changing circumstances and there is no evidence that a review of the decision to educate at home was considered at any point during child protection proceedings.

6. Assia Domestic Abuse Service

Overview

6.1 Assia is the gateway for all domestic abuse services in Bridgend. The team provides community-based services for victims of domestic abuse aged over 16 years including the Independent Domestic Violence Advisers (IDVA).

6.2 Assia asked the Panel to consider the following context when scrutinising their contact with Anna and Child 2;

- Assia had taken over the provision of domestic abuse services in Bridgend on the 1st May 2021. The Service Manager came into post as of the 1st July 2021 and a full service restructure was completed by March 2022.

- At the time of contact with Child 2 and Anna the team consisted of:

  - One full time IDVA
  - One part time IDVA who was on a return to work plan after long term absence
  - Four part time support workers
  - One part/time support worker who had recently returned from maternity leave
  - Two agency workers
  - MARAC co-ordinator
  - Team Leader
  - Manager

- Assia had already identified that additional staff were required and recruitment was ongoing for a male IDVA, two full time IDVAs and a Business Support Officer.

- Between 01/03/2022 and June 2022 Assia received 640 referrals. Five staff members were carrying a total of 231 cases, averaging 39 cases per worker (SafeLives recommend a caseload of between 20-25 cases).

- The period between the social workers referral on the 14th April, Anna's self-referral on 3rd May and her death in June 2022 included the two Easter Bank Holidays, May Day, Whitsun and the Jubilee Bank Holiday. Assia stated that bank holidays create a backlog of referrals for the service.

Analysis

6.3 The Assia IMR identified the following key points:

- Initial contact with Child 2 was made on the same day as the referral. The follow up call requested by Child 2 was a day later than agreed and there is no record as to why there was this delay/change to this follow up call.

- Safety planning was undertaken with Child 2 including the offer of ongoing support from Assia and/or the specialist Children and Young People's service which Child 2 did not want.

- On receiving the referral for Anna from the social worker on the 21st March it was placed on the call list for the assessment team. Assia aims to make contact with self-referrals within three working days. Contact with Anna is first attempted on the 31st March and the service accepts that this falls outside its target of 3 working days. The service has identified a number of potential reasons for this delay including staff returning to work from long term absence and maternity leave and re-allocation of staff to assist with the assessment team.

- Detailed case notes of discussion with Anna on 31st March note that a DASH RIC was completed which was assessed as medium risk (8) and Anna stated that there was no domestic abuse in the relationship.

- Good evidence of the social worker being updated as to the outcome of the referral and assessment with Anna.

- Assia aim to make three attempts at contact over 5 days a period and also use text, voicemail and mail as methods to contact individuals if it is safe to do so.

- Following the re-referral on the 14th April there were two attempts to make contact recorded on the 14th and 22nd April, the second after follow up contact by the social worker. A further follow up call was made to Assia by the social worker on the 27th April. Assia identify that Easter bank holidays were the 15th and 18th of April and this creates a backlog of referrals requiring initial contact and assessment. This was also the school Easter holidays and there was the equivalent of one full time IDVA on leave for the duration of the two week holiday period.

- Anna contacts Assia on the 3rd May and safety planning and a further risk assessment is completed which identifies risk factors of non-fatal strangulation, coercive and controlling behaviours, assault, separation and young child in the household. Anna's risk is assessed as medium (10) and actions were agreed with Anna for a referral to community support, one-to one Freedom Programme and a target hardening referral to Valleys to Coast Housing – all of which are recorded as completed.

- Assia acknowledge that Anna was on the waiting list for over 4 weeks at the time of her death and there is no evidence of any contact during this period.

6.4 The following learning is also identified by Assia:

- PPNs (other than high risk) not being shared with Assia and therefore as a service they were unaware of ongoing incidents between Anna and Simon. Having information relating to these incidents may have escalated the assessment of risk on both occasions.

- A gap identified in the provision of support to those aged 16 and 17 years experiencing domestic abuse. Whilst the service can and does support individuals aged 16 and 17 years there is an absence of a specialist worker. The Panel identifies learning from this review as an opportunity to address this gap and strengthen the provision of services to young people in line with the provisions of the Domestic Abuse Act 2021.

6.5 Since Anna's death Assia confirm that:

- Since October 2022, a full time IDVA has been in post to manage the waiting list contacting individuals every 2-3 weeks whilst they are waiting for their support to start;
- Case management toolkit reviewed in March 2023 with training provided to staff in respect of its implementation;
- Staff have completed training in respect of Non-fatal Strangulation and a refresher DASH RIC session;
- Team Leader completed the Safe Lives Managers in November 2022;
- Assia received Safe Lives Leading Lights Accreditation in June 2024.

6.6 The Panel recognise how Anna can be seen attempting to manage her own situation during her contact with Assia on the 31st March. By this point Children's Services are undertaking an assessment and the Panel recognises how Anna may have been fearful of disclosing the nature of her relationship with Simon for fear of the consequences for her and her children resulting in her denying abuse, blaming herself and minimising experiences.

7. Substance Use Services

Overview

7.1 There are three episodes within the scope of the review when Anna sought support from substance use services for her alcohol use: January 2021 when the GP refers Anna to WCADA, February 2022 when Anna self refers to WCADA and April 2022 when Anna self refers to DASPA (Drug and Alcohol Single Point of Access) and the referral was sent to BAROD.

Analysis

a) Wales Centre for Dependency and Addiction (WCADA)

7.2 Contact 1 (January – April 2021) and Contact 2 (February – March 2022) were with WCADA, the service provider for substance use services in Bridgend County Borough until 1st April 2022 when the service was transferred to Barod.

7.3 During the first contact period an assessment was undertaken with Anna within 10 days of the referral from her GP being accepted by the service. The Chair has seen a copy of this assessment which records that Anna answered 'yes' to the following questions:

Do you use alcohol to excess?
Are you having thoughts relating to suicide and self harm?
Are you experiencing a high degree of stress/guilt or low self-esteem?

7.4 Anna's risk is assessed as low and a peer support group is identified as the most appropriate intervention. There is no evidence recorded in the file that Anna was able to attend a group session before her case was closed in April 2021 after Anna had informed WCADA that she was *pregnant, abstinent and had good family support.*

7.5 When Anna self-refers to WCADA on 28th February 2022 there is no evidence that she was contacted before the service changed to Barod on the 1st April 2022, despite her referral being accepted on the 10th March. When the Chair requested a copy of WCADA's Referral and Assessment Policy to consider whether the response to Anna following her self-referral in February in 2022 was in line with policy, she was informed that there wasn't a policy that could be shared. WCADA did however confirm to the Chair that expected practice would be to offer an intervention (which would have included an assessment) within 20 days of receiving the referral.

7.6 Whilst the Panel recognise that Anna's referral was received and accepted by WCADA in the final weeks of their service provision in Bridgend there is no documented reason as to why Anna wasn't contacted or offered an assessment before services transferred to Barod. It was left to Anna to re-refer herself via DASPA in April.

7.7 Furthermore, the Panel was informed by Barod that Anna's details were not included in client details shared with them on taking over the commissioned service on 1st April 2022 and they were therefore unaware of Anna's attempts to access support until they received the self-referral via DASPA on 13th April 2022.

7.8 The DASPA coordinates all referrals for substance use support in Cwm Taff Morgannwg University Health Board area. On receipt of Anna's referral it was sent to Barod Low Intensity team and to the Community Drug and Alcohol Team.

b) Barod

7.9 Barod started delivering services in Bridgend from the 1st April 2022 and provide Tier 1 and Tier 2 services that provide harm reduction and a person-centred approach to support people around their or someone else's substance use.

7.10 Barod's policy requires the service to allocate referrals with 48 hours of their receipt and for first contact to be attempted within 24 hours of allocation.In Anna's case the allocation was made four working days after receipt of the referral with contact attempted two working days later. In their IMR Barod acknowledge that staff and processes were still in transition for several weeks before and after the contract commencement date which may have accounted for the delay in allocation and initial contact.

7.11 The following observations are made in respect of Barod's practice

- Anna's assessment on the 5th May is completed over the phone;
- Whilst Anna was offered an in-person appointment on the 19th May it is recorded in the case notes that this appointment took place over the telephone;
- There is a delay in case notes being recorded on the case management system in particular the assessment undertaken on the 5th May not being recorded until the 17th May;
- Good practice recognised in respect of the Low Intensity Worker contacting the social worker on the 19th May to share relevant information and goals agreed with Anna.

7.12 It is noted by the Panel that Barod were not invited to the Initial Child Protection Conference on the 9th May despite their involvement being recorded in the Care and Support Assessment completed on the 18th April but did subsequently attend the Core Group meeting on the 17th May.

7.13 The review has also identified the following practice points;

- Telephone/Online contact – All of Anna's contacts with Barod were conducted on the telephone due to what are referred to in the IMR *as ongoing Covid related restrictions*. The Panel note that Anna was offered two face to face appointments (19th May and 16th June) but that the 19th May appointment was subsequently carried out over the telephone. Whilst it appears from the case notes that Anna engaged well with the low intensity worker the IMR considers whether this method of communication created any barriers to Anna's engagement. The IMR highlights that all appointments are now offered face to face with telephone appointments by exception only.

- Information Sharing - Public Protection Notifications (PPNs) are not shared at the Joint Allocation Meeting. Individual agencies including

Dyfodol (another substance use service) and Children's Services receive the PPNs from South Wales Police but this is not practice for all services involved with the Joint Allocation Meeting. The Panel heard how sharing PPNs with Barod would provide a greater understanding of incidents involving individuals discussed at Joint Allocation Meetings and are integral to informing decision in respect of risk.

- Service transition following re-commissioning – Barod report that they were not provided with client files on transition only a list of names and contact details (which did not include Anna's). This has highlighted learning in respect of commissioning processes, the continuation of services and meeting client needs during service transition.

7.14 Barod confirm that since Anna's death:

- All staff have completed mandatory Mental Health First Aid and Suicide and Self Harm Prevention training;
- All frontline staff have completed the DASH RIC training;.
- Barod now attend every MARAC meeting in their service delivery areas

7.15 In 2023 the Cwm Taf Morgannwg Substance Misuse Commissioning team and the VAWDASV Regional Adviser identified the need for improved substance misuse support within VAWDASV services and applied to the Area Planning Board for funding. Barod secured the tender to provide this support for all specialist services in the region through three case workers who work across the CTMUHB footprint to support individuals in relation to their substance use and their experiences of domestic abuse. The objectives of the service are:

- To provide advice and guidance on substance use issues to staff at specialist domestic abuse, sexual violence and violence against women services;
- To engage with perpetrators of domestic abuse where substance use has been identified as a contributing factor;
- To provide a Tier 2 substance use intervention to individuals who are experiencing both domestic abuse and substance use issues;
- To refer perpetrators and victims of domestic abuse to other tiers of substance use services as indicated by an assessment of their substance use needs.

8. Include

Overview

8.1 Include provides a range of services across South Wales supporting vulnerable and disadvantaged groups and aims to reduce reoffending and support multiple needs.

8.2 Services include a contract commissioned by South Wales Police and Crime Commissioner and His Majesty's Prison and Probation Service to deliver the *Whole System Approach (WSA),* a diversionary service from the criminal justice system. The WSA service is delivered by Include, in partnership with others as part of the Future 4 Consortium led by G4S.

Analysis

8.3 Include provided the following analysis in their IMR:

- The WSA Diversion scheme was a suitable disposal for Anna, as she was identified as an individual who would benefit more from support than a caution or conviction.

- Key Performance Indicators require contact to be attempted with all new referrals within 72 hours. Contact was attempted with Anna on the same day that her referral was received and contact was made with her two days later.

- There were 22 case notes on Anna's file which included two face to face contacts, three telephone contacts and six attempted contacts. Anna contacted her case worker three times, once to cancel an appointment and a further two contacts one by phone and one by text.

- During the initial contact with WSA, Anna refers to *an argument with her partner* prior to the incident that led to her arrest and that they had also had an *argument at his when she was drunk and he had pushed her out of his house*. The WSA case worker asks about domestic abuse in the relationship which Anna denied.

- It is recorded that Anna speaks about her post-natal depression and how she has been to see her GP and has been referred to PRAMS. She also recognises that she may need some support around her use of alcohol and agreed to support from WSA.

8.4 Include note that the case notes recorded for this contact were of a good standard and thorough, providing an appropriate level of detail of potential concerns and safeguarding issues to be passed on to Anna's allocated worker.

8.5 Following the allocation of a case worker, the Include representative on the Panel explained that a risk assessment would be completed for each client prior to an initial meeting. The risk assessment uses information on the referral and from the Police Niche system. The IMR states that;

The risk assessment serves the purpose of assessing risk to staff but also importantly is a safeguarding document making the support staff aware of any risks that may be identified that the client could be facing (current or historic)

for example Domestic Abuse, self-harm, suicide. The risk assessment is not usually completed with the client but can include risks disclosed by the client.

8.6 The risk assessment in this case was completed on the 8th March. There was reference in the risk assessment to a Public Protection Notification on Niche in relation to *concern for safety* but the worker could not access this document, so no further detail was included.

8.7 The IMR concludes that the risk assessment was completed adequately however it was felt that more detail could have been provided and concerns explored in more depth. The risk assessment was rated as *red* from a safeguarding perspective due to the assault on Child 2, a baby in the household and social services involvement. This is in line with WSA expected practice. A red risk assessment triggers contact with social services and the WSA case worker emailed the social worker that day to inform them of WSA involvement and ensuring that they had the information relating to the assault on Child 2. The email also highlights that the WSA worker is aware of the MARAC scheduled on the following day (9th March).

8.8 It is noted by the Panel that whilst the social worker is aware of WSA involvement they are not asked to contribute to the Care and Support assessment nor are they invited to the Initial Child Protection Conference or the subsequent Core Group meeting. Similarly, whilst the referral to WSA is noted at the Daily Discussion on the 18th February 2022 a representative is not invited to the MARAC on 9th March.

8.9 These omissions highlight missed opportunities for WSA to have been part of the multi-agency information sharing and safeguarding arrangements for Anna and her children.

8.10 During the course of Anna's support two home visits are completed by the WSA worker. The Panel notes the different approaches between providers to contact with service users i.e. face to face and telephone. In Anna's case the former was the most effective.

8.11 During these home visits Anna wanted to focus on debt management and her use of alcohol and there is evidence of person-centred support being provided by the case worker in relation to debt management.The case worker is aware of other agencies providing support to Anna including WCADA and PRAMS but there is no evidence of contact being made with services to inform of WSA support. The IMR identifies the importance of making contact with partner agencies known to be working with an individual and it is recommended that supervisors use case reviews to ensure that contact has been made with all relevant agencies for the purpose of information sharing.

8.12 The panel note that there is no evidence that the WSA case worker was aware of any of the incidents reported to the police involving Anna after the initial referral. The Include panel representative explained that it would not be routine practice for case workers to proactively check Niche when a client had

accepted support and would not therefore necessarily be aware of any subsequent police contact. It was also highlighted that Include do not receive copies of PPNs following incidents of domestic abuse.

8.13 The panel considered how the notification function on Niche could be used as an effective mechanism to share information with WSA in relation to individuals who were being supported by the service. The South Wales Police representative suggested that WSA could request these notifications which would be flagged to case workers whenever new information was entered on to the system.

8.14 Whilst Anna was an open case to WSA, the fact that there is no evidence of the case worker being invited to the ICPC or Core Group or being aware of the incidents reports to the police result in them operating in an information vacuum, unaware of the deterioration in Anna's mental health, the ongoing involvement of social services and the incidents reported to South Wales Police. It is the Panel's view that this is particularly relevant when considering the timing of Anna's communications with her case worker on the 18th and 31st May. At this point there had been no contact between Anna and WSA since 12th April and as detailed in the chronology there had been increased intensity of service contact with her during this time particularly in relation to her mental health and the safeguarding of the children.

8.15 The IMR acknowledges the delay in responding to Anna's contacts in May 2022 and explains that this is somewhat attributable to the case worker being part time, on annual leave and the Bank Holidays around this period of time, however, this is recognised as an area for practice improvement within the service.

8.16 One of the aspects discussed at the Panel was the fact that the WSA case worker was unaware of Anna's death until the request to provide information for the DHR. The case worker had continued in their attempts to contact her for months after she had died including writing to her address.

8.17 The Panel noted how the allocated social worker had contacted Assia and Barod to inform them of Anna's death but this information wasn't shared with WSA despite their involvement being known to Children's Services. The Panel considered how the notifications detailed in paragraph 8.13 above could also be used in respect of the death of individuals.

8.18 Whilst the record of initial contact was felt to be thorough the IMR identified that subsequent case recordings could have been more detailed and highlighted the opportunity to remind case worker about the importance of detailed, accurate and timely case recordings.

8.19 Include confirm the following changes to practice since Anna's death

- A DASH RIC is now completed with any individual who discloses domestic abuse or where there are concerns that there may be domestic abuse in a

relationship. On occasions where an individual does not wish to provide information to complete the DASH RIC it is expected that the case worker will call the police Domestic Abuse Unit to share their concerns and seek advice.

- Single Points of Contact are in place for MARACs in all the areas where a service is offered ensuring that Include are partners in the information sharing processes to safeguard victims and children. Minutes of the MARAC are then shared with the case worker.

9. Valleys to Coast Housing (V2C)

Overview

9.1 Valleys to Coast (V2C) is a not-for-profit organisation who provide and manage approximately 6000 homes across Bridgend.

9.2 The only records relating to Anna for the scope of the review relate to an allegation in May 2022 that she was harassing another V2C tenant (Simon's new partner). This allegation was followed up by the V2C Housing Officer through liaising with South Wales Police. Valleys to Coast also confirmed to the Panel that Anna reported that she had lost the key to her front door and garage in May 2022 and requested two lock changes.

Analysis

9.3 Anna had been a tenant of V2C for over 20 years. The V2C representative on the Panel explained that Anna was compliant with her tenancy; her rent was paid by Universal Credit, she reported repairs and allowed all statutory compliance tests to be completed. The Panel representative stated that from a housing perspective there was *no reason for concern.*

9.4 The Panel noted that V2C weren't aware of any of the incidents reported to police during the scope of this review nor were they aware of the involvement of Children's Services.

9.5 There is no record of V2C attending the Daily Discussion on the 18th February or the MARAC on the 9th March. When asked by the Chair what was expected practice for MARAC the V2C representative stated that the MARAC representative was expected to:

- Check V2C systems for contact with any party listed on the MARAC list;
- If victim or alleged perpetrator known to V2C, records including rent account, file notes and repair history to be reviewed;
- Notify the relevant Housing Officer that case is being discussed.

9.6 There is nothing on Anna's V2C file to evidence that she was identified as a tenant either for the daily discussion or the MARAC. As a consequence, no information was shared by V2C with either meeting. Furthermore, as there

was no V2C representative present at either meeting, information relating to the incident involving Ca and Anna was not known to V2C. Furthermore there is no evidence that V2C were contacted in respect of the Care and Support assessment undertaken by Children's Services or for the Initial Child Protection Conference or subsequent meetings.

9.7 In respect of the lock changes requested by Anna in May 2022 the V2C representative explained that Housing Officers were not notified as a matter of course in relation to repairs requested at properties. V2C has no record of the target hardening referral made by Assia Domestic Abuse Service on the 3rd May 2022.

9.8 The Panel note that the Housing Officer met with the Neighbourhood Policing Team to discuss the complaint made by Simon's new partner but there was no further action taken in respect of Anna and the Housing Officer closed the complaint. There is no record of the Housing Officer speaking to the complainant or Anna. The Valleys to Coast Panel representative explained that good practice would have been to have contacted Anna and discussed the complaint with a view that a conversation may have enabled Anna to share information relating to the wider issues in her life at that time.

9.9 It was also noted by the V2C representative that the week after the Housing Officer met with the Neighbourhood Policing Team there were two Bank Holidays (Whitsun and Jubilee) and an appointment with Anna is not likely to have happened until the following week by which time she had died.

9.10 It was of interest to the Panel that there is an Information Sharing Protocol between South Wales Police and V2C in respect of Anti-Social Behaviour related crime but a similar arrangement does not exist in respect of domestic abuse related incidents. This indicates an area where changes could be made in sharing information with Registered Social Landlords whose tenants are reporting/experiencing domestic abuse.

9.11 The V2C representative informed the Panel that the following actions had been taken since Anna's death;

- V2C representatives attend all Daily Discussion and MARAC meetings.
- A new Domestic Abuse Policy and internal VC2 MARAC guidance has been introduced.

10. Multi Agency Responses to Domestic Abuse

a) Daily Discussions and Multi Agency Risk Assessment Conference (MARAC)

Overview

10.1 SafeLives define a MARAC as[67]

a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with other fora to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety.

10.2 The Daily Discussion is a mechanism operating in Bridgend by which all incidents of domestic abuse which have been assessed as high risk in the last 24 hours are discussed daily at a multi-agency meeting to ensure that all immediate safeguarding and safety planning is in place. The Daily Discussion determines whether a case will be escalated to MARAC.

10.3 Child 2 was discussed at the Daily Discussion meeting on the 18th February 2022 following the assault by Anna and it was agreed by agencies present to escalate the case to MARAC which took place on the 9th March 2022.

Analysis

10.4 The Panel make the following observations in relation to the Daily Discussion meeting:

- Children's Services were not present;
- The report provided by Health states that there is no relevant information in respect of Child 2 or Anna. The Panel note that there is no reference to recent appointments that Anna has had with her GP indicative of her needs and vulnerabilities including her reporting an episode of drinking and requesting antabuse (8/12/21), reporting low moods (21/1/22) and requesting medication for anxiety resulting in a referral to PRAMS (16/2/22);

[67] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

- Bridgend County Borough Council Housing Services are represented but there is no other housing provider in attendance and there did not appear to be any mechanism to identify who the housing provider was for Child 2 and Anna in order to include this information in this or subsequent meetings;
- It is known at this point that Anna has been referred to the Whole System Approach but WSA are not invited to the Daily Discussion nor are they identified as a relevant party for the purpose of the subsequent MARAC;
- Education report that Child 2 left school in January but provide no further details;
- The IDVA service provided a comprehensive report of their contact with Child 2 highlighting how they feel their mum is depressed but is not getting any help. The report also highlights how the IDVA feels that Child 2 is minimising Anna's alcohol use and the reasons that they are no longer in school.

10.5 Actions from the Daily Discussion are listed as:

- Children's Services to provide an update at MARAC;
- Community Drug and Alcohol Team to write to Anna in relation to her use of alcohol;
- Health to share information with the GP and Health Visitor;
- Education to share minutes of the Daily Discussion with Child 2's school if relevant and to consider a safeguarding referral.

10.6 In respect of the MARAC meeting on the 9th March, minutes of which were shared with the Chair by South Wales Police it is noted that:

- There were three Housing providers present but no representative from V2C (and no apologies noted).
- WSA were not invited to the MARAC despite it being known at the Daily Discussion that Anna had been referred.

10.7 When discussing the existing Daily Discussion and MARAC arrangements in Bridgend, Panel members unanimously expressed concern about increased demand and the capacity of agencies to respond. The Chair requested data to evidence this from the MARAC Coordinator, Bridgend CBC but at the time of writing this report the data has not been made available to her. The sustainability and effectiveness of existing arrangements are a concern for the Panel and recommendations are made in Section 7 to address this.

10.8 Some Panel members also raised concerns about the *Information Only* arrangement operating within South Wales Police MARAC. This arrangement was described to the Panel as a list of High-Risk victims recently discussed at MARAC but where there had been a further incident. These cases are listed as *Information Only* and agencies asked during the MARAC whether they had further information to share. The concern raised was in relation to these cases not being prioritised by agencies as they do not form part of the main MARAC

list to be discussed and therefore research not being carried out by agencies in respect of these cases. Panel members felt that this practice was potentially unsafe in that victims identified as high risk and where further incidents had happened were not being fully considered at MARAC.

10.9 Panel members informed the Chair that this matter had been escalated to the MARAC Quality Assurance Group.

10.10 Due to the high-risk nature and duty of care failures should agencies not undertake research checks on the MARAC cases shared for information purposes, the DHR chair raised this serious concern with South Wales Police. The Panel noted that once South Wales Police were informed, all agencies were contacted and reminded of their duty of care to undertake the required checks and share information. It was acknowledged that this requirement is clearly stated in the MARAC minutes and on the information being shared.

10.11 In November 2023, MANTA,[68] a multi-agency platform designed by frontline MARAC practitioners to support engagement, delivery and accountability was introduced in two areas within South Wales Police as a pilot. Initial learning from the pilot areas is highlighting how the MANTA system is allowing MARAC referrals to be seen by all agencies enabling real time immediate allocation of resources for risk assessment and engagement with victims. It was also highlighted to the Panel how this is presenting challenges to agencies in respect of the immediacy and volume of work being generated.

10.12 One of the main findings included in the HMICFRS PEEL Inspection Report of South Wales Police published in May 2024[69] is that;

The force needs to evaluate its multi-agency risk assessment conference arrangements.

Our inspection found that meetings were chaired by experienced detective inspectors, who identified risks and agreed appropriate safeguarding actions with partner agencies. MARAC meetings occur either weekly or fortnightly.

In the year ending 31 March 2023, the force discussed 5,172 cases at MARAC meetings. This was above the 2,150 cases recommended by SafeLives based on the size of the local population. This situation hasn't changed notably since our last inspection. We found that in some areas of the force, such as Cardiff, discussions about referral criteria took place with a smaller group of partner agencies. These discussions decide whether a referral to a MARAC meeting is likely to result in more effective safety planning. This should help to reduce any unnecessary referrals.

[68] https://www.mantasystem.co.uk

[69] https://hmicfrs.justiceinspectorates.gov.uk/peel-reports/south-wales-2023-25/

The number of repeat domestic abuse related crimes recorded by South Wales Police continues to increase. In the year ending 31 March 2023, the force recorded 9,582 repeat domestic abuse related crimes, which equated to 7.2 repeat domestic abuse crimes per 1,000 population. This compares to the 5,960 repeat domestic abuse related crimes the force recorded in the year ending 31 March 2022 (which equated to 4.5 crimes per 1,000 population).

The force needs to evaluate whether its various methods of managing the volume of high-risk domestic abuse and its risk of harm are equally effective at preventing repeated domestic abuse incidents.

10.13 When these findings are combined with the concerns raised by the DHR Panel in respect of effectiveness and sustainability it would suggest an evaluation of the existing MARAC and Daily Discussion arrangements are required.

b) Responding to counter allegations

Overview

10.14 When looking at the chronology the Panel considered how policing and partner agencies are assessing who is the victim and who is the person causing harm within an abusive relationship.

10.15 This consideration has also been highlighted as learning in another DHR currently ongoing in South Wales where the following recommendation is made;

Establish a task and finish group to provide guidance on the management of cross allegations in domestic abuse cases.

Analysis

10.16 Currently, there are no resources/approaches being applied by agencies in Bridgend to inform professional judgements in respect of who may be the victim and who is causing harm within a relationship and thus enabling services to identify the most vulnerable person and appropriate pathways for support.

10.17 The chronology highlights how South Wales Police respond and deal with incidents in isolation and in line with Home Office Crime Recording Rules[70] .In

[70] Home Office Recording Rules require police to record a crime where;

a) *The circumstances of the victim report amount to a crime defined by law; and*
b) *There is no credible evidence to the contrary immediately available.*

A belief by the victim that a crime has occurred is usually sufficient to justify its recording as a crime. https://www.gov.uk/government/publications/counting-rules-for-recorded-crime

line with these rules, Simon was recorded as a victim of crime in respect of the burglary and harassment he reported and his new partner a victim of criminal damage and threats to cause damage.

10.18 Anna is not recorded as a victim of crime in any of the incidents detailed in the chronology relating to Simon but is considered a victim of a domestic incident following her report in March 2022. She is assessed as medium risk but not a *repeat victim*. In assessing the incident in March, South Wales Police identify Simon as a *serial perpetrator* with a warning marker for domestic abuse against a previous partner and a task is created to consider Clare's Law disclosure for Anna (examined further in Section 5).

10.19 When Police attend an incident at the home of Simon's new partner on the 15th April 2022 she is reported as saying that Simon was in a *mood* and that he had been responsible for the shouting and swearing that had resulted in a neighbour calling the police. Simon had left the property by the time that police arrived and it is recorded that there had *not been any domestic incident and no offences were disclosed.* It is noted however that the female's uncle and nephew attended and were going to stay with the female.In response to this incident a PPN is submitted which identified the female as a victim in a domestic incident and again identified Simon as a *serial perpetrator.* When assessing the PPN a task was been created to consider a Clare's Law disclosure to the new partner due to Simon's antecedence.

10.20 Where an individual is identified as a serial perpetrator of domestic abuse and patterns of behaviour have been identified the Panel feel that there would be merit in establishing systems to share information with specialist domestic abuse services.

10.21 Whilst Simon is reported to the police by Anna for incidents on the 13th March and 11th April, neither circumstances are considered to have met the threshold to be reported as a crime. Whilst Simon's is noted to be Anna's partner/ex-partner and his warning marker of *serial perpetrator* recorded on the incident there is no crime for which he is a suspect requiring police action. In relation to the incident on the 11th April, Anna does not wish to make a statement and does not want officers to speak with Simon. Similarly for the incident involving his new partner that police attended on the 15th April. There are indicators of Simon's behaviours recorded on the occurrence log and police offer the new partner a referral to the IDVA service and complete a PPN which would suggest they suspect that there has been a domestic abuse incident but there are no offences disclosed.

10.22 It is the Panel's view that both Anna and Simon's new partner were frightened of making a complaint against Simon resulting in his behaviours going unchallenged and effectively allowing him to continue the pattern of behaviours that he had perpetrated previously.

10.23 South Wales Police is a pilot force for CARA[71] (Cautioning and Relationship Abuse); an early intervention for low risk, first time offenders of domestic abuse who receive a conditional caution. Attending CARA requires individuals to participate in two workshops which are designed to raise awareness of domestic abuse and motivate to address behaviours and make changes through referrals to behaviours change programmes.

10.24 The Drive Project[72] is also delivered across the South Wales Police area. A community-based intervention for perpetrators whose victims are assessed as high risk of significant harm this intervention aims to address offending and motivate engagement in activities that will result in sustained behavioural change.

10.25 In addition to those detailed above the following domestic abuse perpetrator interventions are offered across Cwm Taf Morgannwg; Driving Change, an intervention for medium risk perpetrators and CLEAR, an early intervention model developed by Respect in partnership with Welsh Women's Aid as part of the Change that Lasts model.

10.26 The Panel acknowledges the scope of domestic abuse perpetrator programmes available in the region but note concerns about the sustainability of these offers in light of reliance on grant funding.

10.27 Welsh Government's Violence against Women, Domestic Abuse and Sexual Violence Blueprint High Level Action Plan[73] identifies the following actions in respect of the perpetration of violence against women, domestic abuse and sexual violence;

- Consolidate and enhance existing evidence bases and needs analyses on perpetration of Violence Against Women, Domestic Abuse and Sexual Violence in Wales.
- Develop a Wales-wide whole system approach for tackling perpetration of Violence Against Women, Domestic Abuse and Sexual Violence that encompasses early intervention and prevention through to the criminal justice response.
- Establish clarity on the responsibilities to prevent and tackle perpetration of Violence Against Women, Domestic Abuse and Sexual Violence of all relevant authorities under the Violence Against Women, Domestic Abuse and Sexual Violence Act and other non-devolved public services.
- Strengthen accountability mechanisms to ensure public services are meeting their responsibilities to tackle and prevent perpetration of Violence Against Women, Domestic Abuse and Sexual Violence.

[71] www.projectcara.org.uk
[72] www.drivepartnership.org.uk
[73] https://www.gov.wales/violence-against-women-domestic-abuse-and-sexual-violence-blueprint-high-level-action-plan-html#119925

10.28 The Tackling Perpetration workstream, established to deliver these actions has undertaken a survey to map perpetrator interventions across Wales and will provide an analysis of current provision with a view to supporting a better understanding of existing interventions and gaps in provision. This report is expected in Autumn 2024 and is intended to be used by regions to determine priorities relating to the perpetration of violence against women, domestic abuse and sexual violence.

SECTION SIX - CONCLUDING REMARKS

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.

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.

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.

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.

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.

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 Child 2's behaviours particularly in relation to their concern of leaving their mum at home with Simon which resulted in them not feeling able to attend school. Child 2's fear of agency involvement and possible consequences for their mum, themself and their younger sibling may also have contributed to them attempting to manage the situation in their 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.

Child 2's account of experiencing abuse within the family home and the steps they took to protect their 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.

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.

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

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.

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.

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.

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 SEVEN - 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[74] (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
- Establish links between mental health services and the Domestic Abuse liaison role within the Health Board

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

- 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[75], 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

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

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
- 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[76] 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

Welsh Government

- 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

Royal College of General Practitioners (Wales)

- 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

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

Home Office

- Develop statutory guidance to support implementation of Operation Encompass
- NPCC and Home Office to ensure consistency of DVDS application forms across all Police Forces
- Undertake a national review of MARAC effectiveness and sustainability
- Provide a statutory framework for MARAC including statutory guidance