Executive Summary

Cornwall Community Safety Partnership

Sarah (DHRS 6)

Year of Death September 2021.

Author: Paul Northcott

Date the review report was completed: January 2023

Contents

Preface

Sarah was described by her family and friends as being a lively, bubbly and kind person who was always up for a good time. Sarah lived for her children and was a loving caring mother.

She was extremely hard working, often holding down more than one job to ensure that her family could live a comfortable life. Friends have stated that Sarah was so kindhearted that she would often put others before herself.

Sarah will be missed by all of those that knew her. I would like to begin this report by expressing my sincere sympathies, and that of the Review Panel, to Sarah's family.

I would also like to thank her friends for coming forward and openly discussing Sarah's life and the impact that her death has had on them. Several of them have been profoundly affected by the loss of Sarah.

1.0 Review Process

1.1 This summary outlines the process undertaken by the Safer Cornwall Partnership domestic homicide review panel in reviewing the death of Sarah who was resident in their area.

1.2 The following pseudonyms have been used in this review to protect the identities of the relevant people who were involved;

- Sarah - Deceased female
- Adult B – Deceased females husband.

1.3 The inquest held by HM Coroner recorded her death as suicide by hanging.

1.4 The decision to commission a review was taken by the Chair of the Cornwall Community Safety Partnership on 30th November 2021. All agencies that potentially had contact with Sarah and her family prior to the point of her death were contacted and asked to confirm whether they had involvement with them.

1.5 All of those agencies who were identified as having contact with the family were asked to secure relevant documents, and appropriate professionals were invited to become Panel members. Relevant agencies were then asked to complete chronologies and where appropriate Individual Management Reviews (IMR's) where requested.

2.0 Contributors to the Review

2.1 The contributors to the DHR were;

- Devon and Cornwall Police- Chronology
- NHS Cornwall and Isles of Scilly Integrated Care Board (ICB), also providing chronology and IMT on behalf of general practice, Royal Cornwall Hospitals NHS Trust (RCHT), Cornwall Partnership Foundation Trust (CFT) and Outlook Southwest - Chronology /IMR
- South Western Ambulance Service Foundation Trust (SWASFT) - Chronology
- Adult Social Care - Chronology /Information
- Multi Agency Risk Assessment conference (MARAC) – Chronology/IMR
- First Light and Barnardo's (Safer futures) – Chronology IMR
- Together for Families (this included Education and children Services) – Chronology/ IMR

2.2 Specialist domestic abuse advice and scrutiny was provided by the members from First Light and Barnardo's (Safer futures) who are charities that provides specialist support to those who have been affected by domestic abuse and sexual violence.

2.3 All of the IMR writers were independent. None of the writers' members knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved.

3.0 The Review Panel Members

3.1 The Panel for this review were made up of the following representatives;

- Paul Northcott-Independent Chair
- Information Governance Manager - Cornwall Housing
- Detective Sergeant – Devon and Cornwall Police Criminal Case Review Unit
- Detective Chief Inspector - Devon and Cornwall Police Local Investigation (Cornwall and the Isles of Scilly (CIOS)
- Cornwall Council – Domestic Abuse and Sexual Violence Strategy Manager
- Head of Service Cornwall Council, Children and Families Service
- Adult Social Care (ASC) Statutory Assurance Manager (Initial member from Adult Social Care) but changed as below)
- Adult Safeguarding Service Senior Manager
- Head of Children's Rights and Safeguarding Standards Service
- Cornwall Council MARAC Chair
- NHS Cornwall and Isles of Scilly Integrated Care Board (ICB – Head of Nursing)
- Royal Cornwall Hospitals NHS Trust (RCHT), Cornwall Partnership Foundation Trust (CFT) and Outlook Southwest. Consultant Nurse for Integrated Safeguarding Services for CFT and RCHT
- Children's Service Manager, Barnardo's – Safer Futures
- Nurse for Integrated Safeguarding Services for CFT and RCHT

3.2 The Panel met formally on three occasions. All of the Panel members were independent. None of them knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved.

4.0 Author of the Overview Report.

4.1 The Cornwall Community Safety Partnership appointed Paul Northcott as Independent Chair and author of the overview report in November 2021.

4.2 Paul is a safeguarding consultant specialising in undertaking reviews and currently delivers training in all aspects of safeguarding, including domestic abuse. Paul was a serving police officer and had thirty-one years' experience. During that time he was the head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides.

4.3 Paul retired from the police service in February 2017. Paul has not worked for Cornwall Safer Communities Partnership, nor any of the agencies involved in this review in the period specified in the review.

4.4 Paul has been trained as a DHR Chair, is a member of the DHR network and has attended AAFDA[1] webinars.

[1] Advocacy after fatal domestic Abuse.

5.0 Terms of Reference

5.1 Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Abuse, Crime and Victims Act (2004). The Act, which came into force on the 13th April 2011, states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a. A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;

b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death'.

5.2 The methods for conducting DHR's are prescribed by the Home Office guidelines[2]. These guidelines state;

> *'Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions'*.

In addition to the above Cornwall Community Safety Partnership also agreed that the review should;

- Seek to establish whether the events of late 2021 could have been prevented.
- The time period that will be subject to close scrutiny will be between late 2009 and 2021**.** This time scale was subject to change if information had emerged that prompted a review of any earlier incidents or events that were relevant. Agencies were requested to provide a synopsis of engagement prior to the relevant period.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

[2] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Home Office: Dec 2016

- Conduct and review relevant research and previous DHR's to help ensure that the review process is able to maximise opportunities for learning to help avoid similar homicides occurring in future.

In addition, the following areas will be addressed in the Individual Management Reports and the subsequent Overview Report:

Case Specific Terms of reference

- *Term 1: **Risk /Vulnerability Identification and Management**: Consider how (and if knowledge of) the risk and vulnerability factors surrounding Sarah were fully understood by professionals, and how to maximise opportunities to intervene and signpost to support.*

- *Term 2; Were the appropriate actions taken to identify **risk and vulnerability and were risk assessments** effectively completed and overseen.*

- *Term 3: Multi Agency Risk Assessment Conference (**MARAC):** Timeliness and efficacy of any involvement in MARAC.*

- *Term 4: **Barriers to support**: (a) Determine if there were any barriers Sarah faced in both reporting her concerns and accessing services. This should also be explored against the Equality Act 2010's protected characteristics. (b) Consider whether complex needs regarding alcohol misuse and mental health presented a barrier to accessing support (c)) Were there any barriers experienced by family, friends and colleagues in reporting the abuse. (d) Review any barriers experienced by the victim/family/friends in reporting any abuse or concerns in Cornwall or elsewhere, including whether they knew how to report domestic abuse.*

- *Term 5: **Timeliness of decision making/action planning**: Was information regarding Sarah acted upon in a timely manner.*

- *Term 6: **Domestic Abuse and Safeguarding Policies**: In those services where there was involvement with the victim or their partner were there adequate safeguarding and domestic abuse policies and procedures and were they followed.*

- *Term 7: **Information Sharing and Partnership Working;** Efficacy of information sharing, partnership working and communication between agencies in place to address the level of risk and safeguarding concerns? E.g. Extent to which partners worked together via Multi-Disciplinary Teams (MDT), professionals meetings.*

- *Term 8: **Professional Curiosity and Routine Enquiry**: Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed.*

- *Term 9: **Training:** Consider knowledge, training need and availability for professionals and whether the circumstances of this case require addressing.*

- *Term 10:* ***Equalities and Intersectionality****: Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, her husband and dependent children.*

- *Term 11:* ***Good Practice:*** *Services will identify any best practice and relevant areas where improvements have been made.*

6.0 Summary

6.1 Prior to meeting Adult B, Sarah had been in a previous relationship with another male and together they had a child. This male left Sarah when their child was aged two.

6.2 Sarah met Adult B in 2003, and following their marriage in 2011 the two of them lived in a privately owned house in a small village in Cornwall. The couple had four children, all of which lived with their parents, as did Sarah's eldest child. The two of them were employed and Sarah had worked in a number of jobs.

6.3 In 2018 one of Sarah's children reported that they had been seriously assaulted by Adult B, and this had led to a decline in the couple's relationship. The couple were also struggling financially and as a result of the pressures within the family there was a decline in both Sarah's, and Adult B's mental health. Sarah and her husband had been seeking help by attending marriage counselling to try and overcome the issues in their relationship.

6.4 Sarah had a history of depression and anxiety. In 2011 following an outpatient appointment she had contact with secondary mental health services where she was seen by a consultant psychiatrist. That assessment identified that Sarah 'had a long history of emotional dysregulation and maladaptive coping skills'. At that time she was regularly self-harming and attempting to take her own life. Sarah was also diagnosed with bulimia nervosa, but had declined additional support from eating disorder services. Sarah had not been diagnosed as being clinically depressed.

6.5 In February 2020 Sarah was physically assaulted by her husband at their home address. The police were called but Adult B had left the address prior to their arrival. At that time Sarah said that she would not make a formal complaint. As there was no evidence to corroborate what had happened the police could not pursue an evidenced led prosecution. Later that evening Sarah had also attempted to self-harm and was conveyed to hospital. Following admission Sarah was examined by a psychiatrist and a mental health assessment was completed.

6.6 In April 2021 a further assault was reported to the Police. On this occasion Adult B self-reported to the Police and admitted that he had assaulted Sarah. Adult B had reported the incident after his Barnardo's worker, who was supporting him through a change management programme, had encouraged him to do so. Following the report an initial Police investigation was commenced but Sarah said she would not make a formal complaint about the assault.

6.7 During her contact with agencies Sarah had stated that her husband had been abusive throughout their marriage and that his behaviour had escalated in the months following the reported serious assault that had been made to the Police by one of her children.

6.8 In October 2021 Sarah was found hanging and deceased by one of her children, at her home address.

6.9 The post mortem identified that the cause of Sarah's death was hanging and that she had also taken a 'mixed drug overdose'.

7.1 Key Issues Arising from the Review

7.1 This part of the report seeks to address the terms of reference and the key lines of enquiry within them.

7.1.1 **Sarah's Mental Health**

7.1.2 Sarah's life experiences would appear to have had a profound impact on her mental wellbeing. Records show that Sarah had been bullied when she was younger, and that there were difficult family dynamics that had left her feeling unloved and unwanted.

7.1.3 Sarah had a long history of 'emotional dysregulation[3] and maladaptive coping skills'[4]. At the age of thirteen Sarah had been regularly self-harming and she was diagnosed as suffering from low self-esteem. Sarah had also been diagnosed with body dysmorphia and she had put all of her "emotional problems" down to this.

7.1.4 Over the years Sarah's mental anxiety had increased as a result of the stresses that were occurring in the family environment, and in particular the "fallout" from the report made against her husband by one of her children. Sarah was also struggling to cope with balancing the demands of her children, her work, finances and illness in the wider family. In order to escape from these demands and the abuse in her relationship her friends stated that Sarah would often drink increasing amounts of alcohol and this in turn led to attempts at self-harm.

7.1.5 From the records held it would appear that professionals made appropriate assessments of Sarah's overall capacity and they formed the opinion that she was able to make informed decisions about her care.

7.1.6 Her GP had established a good working relationship with Sarah. They were thorough in their response to her physical conditions and they understood her emotional and social needs. Sarah's GP continued to maintain contact with her and she was repeatedly encouraged to contact them if she had ongoing concerns. Sarah had

[3] Emotional instability – the psychological term for this is "affective dysregulation" disturbed patterns of thinking or perception – "cognitive distortions" or "perceptual distortions" impulsive behaviour. intense but unstable relationships with others- NHS; Emotional dysregulation.

[4] Maladaptive coping generally increases stress and anxiety, with examples including self-harm, binge eating and substance abuse. The more maladaptive behaviour, the more risk a patient faces in either sustaining or increasing the severity of their disorder.

however found it difficult to contact the practice and talk to someone due to appointment availability and COVID restrictions and this presented a barrier in terms of her seeking support.

7.1.7 There was evidence that her GP had tried to encourage Sarah to see the Community Mental Health Team although she had declined to do this. There was also good evidence of follow up by Sarah's GP about her mental health, when she stated that she was struggling to continue to work due to the abuse that she was suffering in her relationship with Adult B. At that time Sarah's GP had sought assurance from her that she felt safe and was not suicidal.

7.1.8 In February 2020 Sarah was referred for a Mental Health Assessment at a local hospital following an ED admission for self-harming. At that time the Psychiatric Liaison Service (PLS) conducted a mental health assessment. Both in the ED and in the PLS assessments Sarah disclosed that she had been assaulted by her husband.

7.1.9 During that assessment her previous medical history was ascertained and it was decided that the current risk of her harming herself was 'moderate'. This decision was based on her previous history of self-harm and her presentation at that time.

7.1.10 On each of the occasions that Sarah was seen by a Health Professional she was appropriately assessed and support was put into place. On the majority of occasions professionals used her case history and multi-agency information to inform the process. The risks of her taking her own life were considered and the decisions that were made were based on her presentation and capacity to rationalise her behaviour. The risks were balanced against the protective factors in her life, which included her children and her immediate family.

7.1.11 Despite her attempts at taking her own life Sarah did not reach the threshold for detention under the Mental Health Act 1983[5]. These decisions would appear to have been proportionate and in line with agency policies and practice.

7.1.12 The true impact of COVID on Sarah's mental health has been difficult to determine. It would appear that she felt isolated and that she struggled during the pandemic to mentally cope with the demands of her life. During that period she had to rely on her husband for help. Sarah's inability to socialise during that period would also appear to have increased her mental anxiety and this had led to her drinking more alcohol.

7.1.13 Friends have stated that her drinking had increased over the twelve months prior to her death, although this would not have been readily apparent to agencies from the information that was disclosed to them. Sarah's use of alcohol was however not seen as significant enough to warrant referral by any agency to drug and alcohol services and never fully explored by agencies. This was a missed opportunity for intervention and to reduce the risks associated with her self-harming behaviour.

[5] Mental Health Act 1 983

7.1.14 Whilst professionals were aware that there had been several attempts by Sarah to self-harm there was no indication that she would take her own life at the time of assessments.

7.1.15 There would appear to be no single factor that led to Sarah's decision to take her life but there was a culmination of several issues which contributed to the decline in her mental health and her actions on the day in question.

7.2 **Domestic Abuse**

7.2.1 There was evidence of an early disclosure of domestic abuse in 2011 when Sarah told a consultant psychiatrist that she had been in a 'very abusive relationship' following the birth of her first child (and prior to her relationship with Adult B). Further disclosures were also recorded in GP notes (2016) when Sarah had stated that her relationship with Adult B 'was stressful'.

7.2.2 Whilst friends had initially believed that Sarah and Adult B had a good relationship her later disclosures highlighted that there was a continuing pattern of abuse throughout their time together. This could often be linked to his alcohol consumption and the apparent use of illegal substances.

7.2.3 In this case there was clear evidence of coercive and controlling behaviour. One member of her family stated that Adult B would control what his wife ate, drank and wore. They stated that he "controlled every part of her lifestyle". Despite Sarah being seemingly independent her husband would also control the family finances.

7.2.4 Adult B had economically and financially exploited Sarah by ensuring that she was reliant upon him for all her needs as he had control of the family finances. This limited her ability to leave the relationship and to live independently. The impact of this type of abuse on an individual's mental and physical health can be substantial and in Sarah's case had led to a barrier to independent living, depression and increased risk of self-harm

7.2.5 There was also evidence of Adult B gaslighting[6], with Sarah stating that despite her trying to assert control in their relationship, and instigate boundaries, Adult B would often react badly to this and blame her for how he was feeling. Such behaviour had on several occasions caused Sarah to question her own behaviour and to minimise the abuse that she had suffered.

7.2.6 Adult B's behaviour had become increasingly volatile after a serious assault report had been made about him by Sarah's eldest child. In February 2020 there was a reported incident of physical assault on Sarah by Adult B. This had been witnessed by one of Sarah's children. Police attended the scene but were unable to fully ascertain what had happened due to the limited disclosures that were made by those who were present. The Police ensured that Sarah and her children were safe before commencing a search for Adult B, who had run off.

[6] Gaslighting is an extremely effective form of emotional abuse that causes a victim to question their own feelings, instincts, and sanity, which gives the abusive partner a lot of power (and we know that abuse is about power and control). Once an abusive partner has broken down the victim's ability to trust their own perceptions, the victim is more likely to stay in the abusive relationship (Tracey, N; 2021)

7.2.7 In accordance with the force's policy the officers submitted appropriate referrals for all of the children and a DASH[7] risk assessment (medium) was completed. At that time, and despite repeated efforts by the Police, Sarah declined to provide details for the risk assessment.

7.2.8 Whilst in hospital Sarah disclosed that her husband was controlling and that he had become both abusive and violent. On this occasion there was evidence of professional curiosity and an exploration of her being a victim of domestic abuse. Due to the information that Sarah disclosed adult and child safeguarding referrals were made but there was no indication that the health staff who had spoken to her had considered a MARAC referral.

7.2.9 Following this incident referrals were made to Safer Futures by the Police and appropriate risk assessments were completed. Full safety advice was also given to Sarah and a MARAC referral was made. IDVA contact was also initiated to provide help and support.

7.2.10 Later that same month Safer Futures contacted Sarah and a DASH risk assessment was completed. At that time appropriate safety plans were implemented and signposting advice was given to Sarah. During the assessment Sarah had disclosed that the level of physical violence had increased in the past six months and she stated that she was not afraid of Adult B.

7.2.11 In April 2021 a further assault was reported to the Police. Officers attempted to obtain a complaint from Sarah but she declined to report the matter, which is not an unusual reaction for victims of abuse[8]. On that occasion Sarah attributed her husband's behaviour to alcohol and stress, and stated that she felt sorry for him. She also felt a prosecution would not be appropriate and friends state that she didn't see him as a "serious threat".

7.2.12 Whilst completing the DASH (medium) for the incident reported in April 2021 Sarah disclosed a further assault that had taken place some months previously. Sarah declined to support a complaint. The Police acted in accordance with their policy and procedures and didn't pursue the matter as this was in line with Sarah's wishes and there was insufficient evidence for a victimless prosecution. Following this incident Sarah was re-referred to the SUsie Programme[9] and a referral was also made to WAVES[10] and Adult Social Care. The referral to Adult Social Care was not pursued as it was assessed as not reaching the threshold for intervention. This decision was in line with policy and practice.

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[7] The Dash risk assessment is used by frontline professionals to identify and assess risks when a potential victim discloses domestic abuse, 'honour'- based violence or stalking. The questions in the DASH risk checklist are based on extensive research about domestic abuse.

[8] On average victim's experience fifty incidents of abuse before getting effective help (Safe Lives ;2018). This can be due to isolation, fear of further abuse, dependency on their partner, fear of losing their children (Gurm et al 2020).

[9] Domestic Abuse and Sexual Violence Adult Recovery Programme

[10] WAVES Counselling Project is a confidential counselling and outreach service for victims of abuse, domestic abuse or family violence.

7.2.13 In terms of the response to abuse by Health services Sarah had presented to her GP with unexplained injuries and on some of those occasions, there was little evidence of appropriate enquiry. There were also opportunities where Sarah could have been encouraged to contact domestic abuse services in February 2020, April 2020 and August 2020.The report writer has noted that routine enquiry[11] was not in practice until late 2020 in RCHT and CFT and it was and remains the practice within Cornwall for GP's to only conduct an appropriate enquiry if they observe any possible indicators, which include physical trauma, and mental distress.

7.2.14 There were opportunities where the GP's could have adopted a 'think family' [12] approach. On these occasions even if Sarah or Adult B hadn't consented to signposting and support the information could have led to a referral to the Multi Agency Referral Unit (MARU) for the children. The author of the General Practice IMR has confirmed that whilst there is an increased knowledge in the GP Practice about DA services but this work has not been fully embedded across the County and needs to continue (**Recommendation 1/2**).

7.2.15 There was evidence that Sarah's GP had conducted an appropriate enquiry in February 2020, following a reported assault by Adult B.

7.2.16 The psychiatric assessment that was conducted in February 2020 not only looked at Sarah' mental health but also demonstrated that professionals were being professional curious about domestic abuse. The assessment concluded that Sarah was ''vulnerable and at risk from her partner and domestic violence'. Sarah also reported that whilst her husband had never been violent to their children, they had witnessed violence on many occasions. Health services offered support and signposting for Sarah but she declined that help at that time.

7.2.17 There is work currently ongoing to support staff in Trust services to increase staff confidence to ask all patients RE questions. Following previous DHR's (e.g. DHR 7,10,12 and S4) Cornwall Foundation Trust has continued to try and embed RE into frontline practice and this continues to be a work in progress.

7.2.18 This case has also prompted further discussions with the clinical lead for muscular skeletal services to improve the use of RE in outpatient services. This has led to the view that the documentation used by therapist departments would benefit from the inclusion of the RE questions in their assessments as staff within those departments tend to spend more time with patients **(Recommendation 3).**

7.2.19 In March 2020 Children's Services made a referral to First Light asking them for support for Sarah. This referral had led to further contacts from an IDVA and/or a support worker from the SUsie Programme. During that contact Sarah disclosed that physical violence had been escalating in the last six months. Sarah stated that she had furniture thrown at her, her ribs broken and that Adult B had strangled her to the point of passing

[11] NICE guidelines do not recommend the use of routine enquiries about domestic abuse in all general practice contacts. They recommend that health professionals in most areas ask about domestic abuse if they observe any possible indicators, which include physical trauma, and mental distress.

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out. Professionals recognised that this was a high-risk case and that it should be transferred to a MARAC IDVA. Full safety advice was also given during these contacts which was in line with their agencies policy and practice.

7.2.20 In terms of specialist domestic abuse support there was evidence of an immediate response by First Light and the ongoing use of their helpline. The First Light IMR writer identified that the helpline gave Sarah the opportunity to speak about her current situation and the specialist staff listened to her in a respectful, non-judgemental, and supportive manner. The service also kept Sarah informed of the support that was available to her and the referrals that were going to be made in her case.

7.2.21 There was evidence of good communication between the Social Worker for the family and the IDVA, with relevant and appropriate information being shared when reviewing the case. There were twenty-eight attempted contacts with, or messages left, for Sarah by the SUsie and Change 4 U workers to engage with them between July and October 2021. Both workers communicated clearly with each other to ensure that Sarah received support from the most appropriate service at the right time Unfortunately, on many occasions, Sarah felt that she was unable to engage with professionals and found it hard to attend appointments.

7.2.22 Following the referral by the Police to Children's Social Care in February 2021 and the subsequent assault on Sarah during that assessment period, the TFF IMR writer identified that there did not appear to have been enough professional curiosity by their staff when considering Sarah's vulnerability. The comments made by Sarah and the past history appeared to have been dealt with in isolation rather than adopting a holistic approach and staff should have listened to the voice of the victim. At that time no safety plan was implemented, and the case progressed to closure without an in-depth exploration of potential ongoing risks. The IMR writer also identified that the TFF social worker would appear to have taken Sarah, and her husband's word, that the abuse had stopped. At this point it is accepted by the TFF IMR writer that staff should have contacted Sarah's IDVA and gained a full understanding of the risks that had been identified. Such action should have been taken in accordance with the organisations current policy and practice. The IMR writer was unable to ascertain why this hadn't happened but identified that the current approach to trauma informed practice needs to recognise such risks **(Recommendation 4)**.

7.2.23 Sarah's case was discussed at MARAC in March 2020 following a referral by an IDVA six days earlier. Those at the meeting were appraised of the facts and it was established that Sarah had been in an abusive relationship for sixteen years and that coercive and controlling behaviour had been evident in the relationship for the past three years. The case was closed in April 2020.

7.2.24 On reviewing the MARAC process, the IMR writer identified that Sarah's suicidal thoughts had been mentioned in the meeting, however this was not reflected in any action or identified as a risk factor. This information should have been reviewed to mitigate the further risk of self-harm, as well as suicide. The Chair had also asked the Police if they could refer the case back into the next MARAC once further information

had been gathered. Unfortunately, the case was never referred back into MARAC. The case should not have been closed without addressing this issue.

7.2.25 Since this case the Panel and IMR writers have provided assurance that there have been significant changes to the MARAC system in Cornwall and this has led to improved action management and effective communication across all agencies. The IMR writers identified that further awareness of the links between suicide, child sexual abuse and domestic abuse could be delivered through the existing training programmes (**Recommendation 5**).

7.2.26 In terms of additional support Sarah was also referred to the SUsie Programme by her IDVA and they were able to provide additional phone support. Sarah was also given the details for the Change 4 U programme[13] (Change 4 U Partner Support) and it was after this that Adult B made a self-referral.

7.2.27 Professionals felt that the level and variety of support that was offered appeared to have made a difference with Sarah reporting that Adult B was engaging well with his support programme and that there had been some positive changes in his behaviour. Despite this positive interaction friends and family felt that there was an element of disguised compliance[14] in terms of both Sarah and Adult B minimising the extent of the abuse that was continuing in their relationship.

7.2.28 The impact of the COVID lockdown increased Sarah's risk of further abuse. The initial referral came into Safer Futures/First Light during the pandemic and the first lockdown and this affected the support and contact that the service was able to offer. At that time Safer Futures moved all staff members to home working and support was offered to clients remotely. This practice therefore prevented the usual face-to-face visit with an IDVA. First Light reviewed its processes and practice during this period and moved very quickly to a hybrid service during the other national lockdowns, offering predominantly telephone support but also face to face support when a Covid assessment was completed.

7.2.29 Although the couple had split up during the lockdown period Adult B had returned to the family home in November 2020 so that he could assist with childcare. The family were experiencing additional strain at that time as a result of COVID and Sarah was struggling to cope with family life. Protective factors such as contact with family and friends was unavailable to her and her ability to provide financial support through work for her children was also severely curtailed. Sarah had disclosed to Safer Futures that she was reliant upon Adult B for financial support at that time. The IMR writer for First Light has reflected that National guidance would be beneficial for professionals and families regarding child contact during any future lockdown scenario. This would ensure that vulnerable individuals are allowed appropriate access and support to minimise risks **(Recommendation 6).**

[13] Change 4 U is a domestic abuse programme which provides single-sex group support to men and women who display abusive behaviour within their relationships.

[14] The NSPCC defines this concept through parental behaviours, suggesting that parents may appear cooperative when working with professionals to reduce concerns and professional involvement (NSPCC, 2019).

7.2.30 The impact on children in domestic abuse households can be considerable in terms of their physical and emotional development[15]. Sarah's family and friends have described how the abuse had impacted on the children. Family members described the children as unhappy and increasingly withdrawn. Some of them had started to mimic concerning behavioural traits which could be attributable to the abuse that they had witnessed and this included being abusive to others.

7.2.31 Some of Sarah's friends had described how the level of control by Adult B in the relationship had led to one of her children being ostracised and excluded from the family unit. This child had since stated that they had witnessed the abuse and would attempt to intervene. They would often be left to deal with the other "screaming children" and comfort their mother. Sarah would say "what would I do without you saving me".

7.2.32 In this case professionals had recognised the impact that the abuse was having on the children within the family, and Sarah had been engaging with TFF.

7.2.33 Discussions took place with the children about the impact of the abuse and they were referred for Clear[16] and HUGS therapy. The referrals relating to domestic violence were triaged rapidly by Children's Social Care and there was clear evidence of multi-agency working between, health, education, the police and social care regarding the impact of Adult B's behaviour on the whole family. When decisions were made to remove the children from plans these were made in consultation with other agencies and the risks in terms of Adult B acknowledged and addressed. Sarah's sisters however believe that whilst risks were acknowledged in terms of Sarah's eldest child there was little emphasis on the trauma experienced by the other children and the impact of Adult B's behaviour on them.

7.2.34 There was evidence of effective referrals being made by the Police and SWASFT Paramedics to TFF. The referrals had resulted in a S17 Child in Need Assessment. At the time of the assessment Adult B had moved out of the home address and in May 2020 the case was closed to Children and Family Services. A further Child Protection assessment was completed in April 2020 and again the case was closed as it was reported that the couple had permanently separated. This action was proportionate and in line with the agencies policy on the information known at that time, although it did fail to take into account that Adult B was constantly visiting the home address. TFF should therefore ensure that its staff are aware of the impact of separation in terms of increased risks to children particularly in relationships where coercion and control is evident. Such considerations should be evident in child protection assessments. (**Recommendation 7**).

7.2.35 Although TFF had provided help and support to Sarah there were numerous comments made by friends and family that she was concerned that the issues experienced at home could have resulted in her children being taken away from her. This would appear

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[16] Clear are a Cornwall based charity dedicated to the care and support for people of all ages and all genders impacted by abuse and other emotional trauma. Their mission is to help children, young people and adults harmed by abuse and emotional trauma and to prevent abuse from occurring.

to have been a barrier in terms of Sarah feeling able to be open with agencies and feeling able to freely talk about her mental health, drinking and the abuse that she was suffering.

7.2.36 Police had followed policy and submitted the relevant notifications to the schools where the children were attending. In this case CARA /ViST's were submitted and there is an established process in place where these forms are automatically downloaded and shared with Education, Social Care and Health which should be seen as good practice.

7.2.37 In this case the family lived in a small rural village with no close neighbours. The true impact of this isolation could not be fully identified by the review but was a likely barrier to reporting the abuse and seeking support. The DASV strategy in the county highlights the impact that social and geographical isolation can have on individuals and the impact on the provision of effective services. The Safer Cornwall's Domestic Abuse and Sexual Violence Strategy 2023-2028 recognises this issue and aims to improve access to services and increase the number of people and families seeking support. A multi-agency response is being taken to provide responsive, flexible services which respond as early as possible to victims' needs.

7.3 Operational Practice, Policy and Procedure

7.3.1 Although there were opportunities to improve information sharing in this case there were also examples of good multi agency interaction and practice across all agencies.

7.3.2 Cornwall have implemented further changes in practice to improve information sharing opportunities relating to domestic abuse. Safer Futures has identified and arranged to co-locate with multiple agencies in the County. This has improved the opportunities for effective multi-agency working and has led to the creation of effective joint action/support plans. First Light have also seen improvements in information sharing at MARAC meetings and this has been assisted by the use of a case management system (HALO).

7.3.3 First Light is currently running the Primary Care DASV identification and referral pathway pilot. This pilot has seen the appointment of three named workers who are a direct point of contact for each GP surgery. The pilot is currently in its second year and is delivering improved outcomes but at present it only has funding to deliver the project until 2023 (**Recommendation 8**).

7.3.4 Since this case access to mental health support has been increased in Cornwall through the development of a network of mental health practitioners who are attached to GP surgeries. At present this arrangement is independent from secondary mental health services and relies on GP funding arrangements. The initiative has therefore not been fully rolled out across the County. The work that is currently being implemented in relation to a Community Mental Health Framework will ensure that there is a consistent approach across the County.

7.3.5 On reviewing this particular case the IMR writer from RCHT identified additional learning in relation to the use of body maps to record injuries. A decision has been made that the

maps should be completed on an admission to ED and recorded on the triage sheet alongside the RE questions (**Recommendation 9/10**).

7.3.6 As a direct result of the learning from this review Safer Futures have committed to producing clear practice guidance around a more direct approach to including and involving families and wider support networks in support processes. This guidance would include a threshold for appropriate consent in line with GDPR and confidentiality policy as well as clear and defined measures for what information is shared (**Recommendation 11/12/13**).

7.4 **Training**

7.4.1 Representatives of the agencies involved in this review have confirmed that training and awareness in relation to domestic abuse continues to be delivered to all staff in order to promote greater knowledge and understanding.

8.0 Conclusions

8.1 Sarah had a long history of mental anxiety. At the time that she took her own life she had a history of self-harming and she was suffering from depression.

8.2 Over the years there is evidence within records indicating that Sarah's distress had increased and that it was impacted upon by the stresses within her own family environment. From the disclosures that were made it would appear that Adult B had been abusive throughout their marriage and their relationship had deteriorated further following an reported serious assault that had been made against him by one of her children. There was clear evidence in agency records that the abuse had increased after this time and her husband had been coercive and controlling.

8.3 There were occasions where professionals had not shown professional curiosity and there were opportunities missed where appropriate enquiries could have been made by Health professionals. However on those occasions where the abuse was reported professionals adhered to policy and appropriate help and support was offered to Sarah.

8.4 There were a number of occasions where services were unable to engage Sarah or and Sarah felt unable to make formal complaints against her husband. Despite this agencies continued to encourage Sarah to seek out support for both herself and her children. Sarah was signposted to a number of agencies and support was provided by specialist domestic abuse workers, including IDVA's. Sarah was also referred to a number of therapeutic and counselling services. It would appear that much of the abuse had remained hidden and only came to light after Sarah had taken her own life.

8.5 There were barriers identified that prevented Sarah from freely talking to professionals and reporting. The main barriers were the shame that she felt (as a result of the coercion and control that was being inflicted by Adult B) about the abuse that was occurring in her relationship, and the belief that she could lose her children.

8.6 From the records held it would appear that professionals had made appropriate decisions about Sarah's capacity and that she was able to make informed decisions about her care and support. Records indicate that her GP had attempted to maintain contact and Sarah had been repeatedly encouraged to speak to them if she had ongoing concerns. There was also evidence that her GP had tried to encourage Sarah to see the Community Mental Health Team although she had declined to do this on some occasions.

8.7 When Sarah had presented in crisis to Health professionals they had made appropriate assessments and she was encouraged to consent to referrals to other areas of specialist support. Where possible referrals were made for additional help and support.

8.8 The level of information sharing across agencies was variable. Whilst opportunities were missed there were also many occasions where agencies had submitted the relevant referrals to each other and discussed Sarah's case.

8.9 The impact of Covid was apparent in this case, in terms of the strain that it put on the family and Sarah, and this had resulted in her maintaining contact with her husband through necessity. Agencies had offered help and support through this time but this was limited in view of the restrictions that were in place, and they had failed to identify the significance of Adult B's return in terms of the risk to Sarah.

8.10 There have been a number of improvements in practice within Cornwall following the learning from this case and previous DHR's and this was evident in the Panel discussions and the IMR's. These improvements have included increased partnership working between specialist domestic abuse services and those working in primary care. The MARAC process has also been reviewed and practices strengthened to ensure that the needs of victims are met. All of these improvements are welcomed but agencies accept that more work is required to continue to strengthen the current approach to domestic abuse and the prevention of self-harm.

9.0 Learning and Recommendations

9.1 The learning opportunities identified in this case that have resulted in recommendations are listed below;

The learning opportunities identified in this case that have resulted in the recommendations are listed below;

Learning point 1: Whilst there have been improvements in the use of appropriate enquiry, trauma informed practice and the Think Family Approach within general practice there is a continuing need for ongoing training for GP's. This training will assist in identifying victims of abuse at an early stage and enable effective signposting and referrals. At the time of writing the Current DASV service is a pilot service and is only funded until March 2024.

Recommendation 1*:* Training for GP's should continue to be provided by the DASV primary care service (to increase understanding of indicators of possible domestic abuse

and the need for appropriate enquiry and the links between self-harm and domestic abuse).

Recommendation 2: GP attendance at the DA training and the use of appropriate inquiry should be monitored and audited by the ICB within twelve months of the publication of the report.

Learning point 2: The review highlighted that there was a need to amend documentation within 'therapy' departments (RCHT) to improve the current approach to RE and deliver more effective outcomes for people experiencing domestic abuse.

Recommendation 3: The RCHT to amend the 'therapies' documentation with a view to include Routine Enquiry prompts. *A RCHT/CFT recommendation from DHR 17 'to review the roll out of RE across all Trusts services' has commenced and will provide the necessary evaluation of this recommendation*.

Learning point 3: Despite there being indicators of abuse professionals working for TFF had not worked effectively with other agencies to identify ongoing risks and to obtain a holistic view of what was happening in the family unit.

Recommendation 4: TFF, ASC, Firstlight, Police and NHS Cornwall & Isles of Scilly ICB to ensure that their current trauma informed working practices include the relevance of the history of abuse in the family and that policy and practice is amended to ensure that practitioners are prompted to ask the right question about what the experience of DA might mean in terms of future risks.

Learning point 4: The review identified that additional work is required to raise awareness across all agencies through existing training programmes about the links between DA and suicide.

Recommendation 5: Safer Futures to amend their current training programmes to ensure that they raise awareness of the links between suicide and Domestic Abuse and the links between child sexual abuse and domestic abuse. The attendance and the evaluation of the outcomes of this training to be reported back to the Domestic Abuse Local Partnership Board.

Learning point 5: The impact of COVID lockdowns on the ability for professionals to deliver DA services was apparent in this case. This was particularly relevant in terms of access to children who may be impacted by DA.

Recommendation 6: Cornwall Safer Partnership to write to the Home Office to ensure that the Government provides clear and concise guidance around services delivering contact (face to face) which could be used by professionals in the event of a further lockdown.

Learning point 6: TFF closed the children's case without sufficient consideration of the impact of separation in terms of increased risks to children particularly as coercion and control was evident in the relationship. Such considerations need to be clearly evidenced

in child protection assessments and where appropriate advice obtained from the Children's Independent Domestic Abuse Advisor located within the MARU and from the nine new Family Domestic Abuse Advisors (appointed early 2023) who are positioned throughout the county. These individuals have been specifically commissioned to strengthen the consideration of domestic abuse and its impact on children. These individuals also have the responsibility of working with agencies to support families experiencing domestic abuse in the home.

Recommendation 7: Together for Families will ensure that child protection assessments include appropriate consideration of the risks associated with parental separation where DA is evident in the relationship, including seeking specialist advice/guidance from the Children's Independent Domestic Abuse Adviser located in the MARU or from a Family Domestic Abuse Advisor.

Learning point 7: First Light is currently running the Primary Care DASV identification and referral pathway pilot. The pilot is currently in its second year and is delivering improved outcomes to victims and survivors of DA but at present it only has funding to deliver the project until 2023.

Recommendation 8: The ICB to review the current capacity of DASV primary care service and how these feature in long term ICS plans.

Learning point 8: The use of body mapping regarding domestic abuse injuries was found to be inconsistent and staff found that they were difficult to access.

Recommendation 9: The RCHT to review the current system of accessing body maps in ED and implement a process that ensures staff have access the documentation.

Recommendation 10: RCHT to Review and address the current level of knowledge amongst staff regards the appropriate use of body maps.

Learning point 9**:** As a result of this review Change 4U and the wider integrated Service Safer Futures have identified the importance of strengthening their existing approaches to engaging with and supporting families and the wider networks of those impacted by domestic abuse.

Recommendation 11: Change 4U and the wider integrated service Safer Futures to identify opportunities for increasing targeted engagement with both victims and abusers - those whose lives are impacted by domestic abuse.

Recommendation 12: Change 4U and the wider integrated Service Safer Futures to raise public awareness around all forms of domestic abuse and sexual violence and how families can provide support and get help. This should be achieved through training, attending events within the community, organising drop-in groups.

Recommendation 13: Change 4U and the wider integrated service Safer Futures to devise an effective support package to families, friends, and colleagues of someone whose lives are being impacted by Domestic Abuse.