SAFER CORNWALL

Kernow Salwa

DOMESTIC HOMICIDE REVIEW DHR16

INTO THE DEATH OF JENNIFER (PSEUDONYM) – 2021

EXECUTIVE SUMMARY

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Report Completed – May 2023

Foreword

In accordance with Home Office guidelines, the pseudonym 'Jennifer' has been used to protect the identity of the victim and her family.

Family Tribute

A tribute from Jennifer's father

To my daughter who was tragically taken. She enjoyed life to the full she loved the band Guns and Roses and heavy rock and she also loved her dogs walking with them across the cliffs, hills, and lanes. Also, she loved fishing. Often she would take photographs of the dolphins swimming beside the boat when she went to sea.

Jennifer would always stand by her word and help anyone. The biggest love of her life were her two children who she adored and loved. My daughter will be loved and missed every day. Rest in Peace sweetheart. Love you always Dad xxx

A tribute from Jennifer' sister

For You, Dear Sister.

This is the hardest thing that I will probably ever write in my lifetime. How much paper do I need to write about my dear sister?

My sister was brutally taken away from us, leaving behind two children, brother, sister, nieces, and nephew, mum (who is now deceased. Mum passed away a year after) and dad.

She had a loving heart, and she was very independent. She had many friends, not just from her school years but through work and people she met whilst on holiday. In her younger years, Jennifer was into Wham and Smash Hits magazine, and I was into Paul Young and Shaken Stephens. As she grew older, her love of music changed. She started to enjoy heavy metal: Guns and Roses, ACDC, Metallica, Black Sabbath, and Aerosmith, to name a few. Jennifer always had it on loud whilst she would be getting ready to go out, and that would annoy Mum lol. Mum would always shout from the bottom of the stairs and ask her to turn it down. Jennifer loved going to the pubs on a Saturday night, especially if they had live music playing. No Picnic and Rhythm Machine were her 'go to', especially if they were playing on Christmas Eve. We would, along with our friends, catch taxis into the town, watch them and have a dance. We would sing along with them, especially after a few drinks inside us. Jennifer loved going to Glastonbury watching the bands live and getting

the full experience. She loved every minute. Me, well, let's just say she needed to take a long shower when she got home. The smell…

Jennifer loved to walk her dogs along the cliff tops, where she would sit on one of the benches and look out to sea. She also loved to go out fishing (not so much on the rainy days). She would often see the dolphins swim up close to the boat or out on the rocks. She would see seals sunbathing in the sunshine.

When my sister fell pregnant, she was overjoyed, to say the least, as she had waited a long time to become a mum. And a great mum was she. Jennifer did everything for her children. They were her pride and joy. As her children grew, they too would go for long walks, be it in the countryside or along the cliff path, down to the local beach. Jennifer enjoyed celebrating her children's birthdays. We, as a family, would go to her house for a BBQ. Jennifer would always make sure that there was pineapple and cheese on sticks for mum as it was tradition in our household. Pimms and lemonade for us 'oldens', as she would call us. Games for the kids to play, and of course, birthday cake. Now it's my turn to carry on my sister's tradition.

I miss my dear sister every day. I miss being able to text her and put the world to rights. I miss her telling me all about Love Island (even though I hate Love Island). I miss our general chats on the phone. It would always be around 9pm. You would be on the wine, and I'd be having a cup of tea. We'd be on the phone for an hour sometimes. God, I miss not being able to text you or speak to you.

Someone once said time heals. How dare they! Time will never heal. My heart will never heal. My family will never heal. Not only have I lost my sister and my mum, my husband has also lost a sister-in-law and our children have lost an auntie in an horrific way. They too have nightmares. I have nightmares. Knowing that I won't see you again breaks us all inside. I wake up crying in my sleep as I see you helpless. If only I'd gone down in the morning to have a cuppa with you, then maybe you might be still here.

We will never forget you. My heart is broken. You were kind, loving, gentle, hardworking, and funny (especially when tipsy). We have planted a rose bush in our garden, which flowers beautifully.

You'll be forever remembered and never forgotten.
Love you, sis xxxxx

A tribute from Jennifer' brother

Jennifer was my eldest sister. She was such a caring, funny and kind person and we always laughed and smiled together. I trusted her with all my problems and she helped me in so many ways over the years. She was my confidante and the person I went to for advice. She supported me throughout my life and always helped to guide me in the right direction. She always knew what to say to me.

In return, I would do what I could for her, like cutting the grass or any other jobs – I wanted to help her whenever I could because of all the things she did for me. Thinking back to our younger years, on a Friday night, we used to enjoy playing darts and having a laugh with her group of friends, where I was readily included – we felt like a big family group, and I cherish those times with Jennifer at the centre of the fun and good times.

A few years ago, Jennifer did some research on our family tree, and I was so interested in what she discovered – I loved listening to her talk about the new information that she had found.

Losing my sister has destroyed me. I miss her so, so much. I cannot believe that she is gone. I cannot understand why he did that to her, it is such a heart-wrenching waste. I want my sister to know how much I love and miss her – and always will.

From her loving brother.

Contents

1 PREFACE

The Safer Cornwall Domestic Homicide Review panel would like to express their sincere condolences to the family members affected by the sad events which have resulted in this review. We hope this Domestic Homicide Review (DHR) helps to answer some important questions relating to the events leading up to Jennifer's (pseudonym) tragic and untimely death.

The review panel also extend their deepest sympathy to Jennifer's children, siblings, nieces, and nephews for the sad passing of Jennifer's mother during the review period. In the short time Jennifer's mum was involved in the DHR, it was clear to see that she was a much-loved and cherished mother and grandmother. Rest in Peace.

The independent chairs and authors of the review would like to express their appreciation for the time, commitment and valuable contributions of Jennifer's family, review panel members and the authors of the individual management reviews from which the foundation of the analysis of this overview report is formed.

Jennifer's family has been sensitively and reliably supported by their Victim Support Homicide Worker throughout this review. The Victim Support Homicide Worker has acted as a trustworthy and dedicated facilitator of communication between the independent chairs and the family, and this level of advocacy is worthy of the review panel's sincere appreciation and praise.

2 SUMMARY OF CIRCUMSTANCES LEADING TO THE REVIEW

2.1 Police received calls from a child reporting that their mother and father were arguing culminating in two separate assaults on Jennifer, the child's mother. Jennifer's husband, Michael (pseudonym) was arrested and interviewed under caution by police. There was insufficient evidence to charge Michael at the time and further work was required to pass the evidential test. As such, Michael was released on bail with conditions not to approach or contact his wife or children and not to attend the family home address for 28 days.

2.2 The following day, police received calls from a neighbour and a child of Jennifer and Michael stating that Michael had entered the property uninvited and inflicted wounds upon both Jennifer and then himself. Both of their children witnessed some of these events but fled to a neighbouring property to protect themselves and seek help.

2.3 Officers attended along with paramedics, but both Jennifer and Michael were pronounced deceased at the scene.

2.4 The information that Jennifer had been killed by her husband resulted in the case being referred to Safer Cornwall[1] as a potential Domestic Homicide Review (DHR). Legislation and statutory guidance[2] specify that when the death of a person over the age of 16 has, or appears to have resulted from violence or abuse and neglect by an intimate partner a review should be carried out to identify lessons to be learnt from the death. Safer Cornwall agreed that the criteria had been met and commissioned this review.

3 THE REVIEW PROCESS

3.1 This summary outlines the process undertaken by the Safer Cornwall Partnership domestic homicide review panel in reviewing the homicide of Jennifer who was a resident in their area.

3.2 The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

[1] Safer Cornwall is a partnership of public, voluntary, community and private organisations who come together to do all that they can to make Cornwall's communities safer.

[2] Section 9 of the Domestic Violence, Crime and Adults Act (2004)

- Jennifer (victim), White British
- Michael (perpetrator, husband), White British
- Child 1 – Child of Jennifer and Michael
- Child 2 - Child of Jennifer and Michael

3.3 Due to this being a homicide/suicide there were no criminal proceedings following this fatal incident. A Coroner's inquest was scheduled in 2023. The Coroner recorded a conclusion of unlawful killing for Jennifer, and a ruling of suicide for Michael.

3.4 The process began with an initial meeting of the Community Safety Partnership when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Jennifer and Michael prior to the point of death were contacted and asked to confirm whether they had involvement with them.

3.5 Three agencies contacted confirmed contact with the victim and/or perpetrator and children involved and were asked to secure their files.

4 CONTRIBUTORS TO THE REVIEW

4.1 Chronologies revealed little involvement with agencies in Cornwall relevant to the Terms of Reference, however, Individual Management Reviews (IMRs) were requested of -

- Integrated Care Board (Representing GPs)
- Mental Health Services (Outlook Southwest)
- Devon and Cornwall Police
- First Light Domestic Abuse Services
- Education Services (Including Together for Families)

4.2 The IMR authors certified that they had no connections or ties of a personal or professional nature with the family. Where a connection with a participating organisation was unavoidable (i.e., they were employed by the organisation in a senior position) assurances were given to apply a fully independent judgement regarding the outcomes of the internal review.

Independent Chairs and Authors of the Overview Report and Executive Summary

4.3 The Safer Cornwall Partnership commissioned Martine Cotter, a level-3 accredited DHR Chair, and Jane Wonnacott, an experienced independent reviewer as independent chairs to undertake this Domestic Homicide Review with the responsibility (in consultation with the Review Panel) to conduct the review in accordance with the Terms of Reference and prepare the overview report and its

executive summary.

4.4 Martine Cotter holds an MSc in Neuroscience and Psychology of Mental Health from Kings College London and a Level 7 Post Graduate Diploma in Strategic Leadership. She is a Fellow of the Chartered Institute of Management and a member of the Applied Neuroscience Association. Martine is a member of the DfE National Child Safeguarding Practice Review Panel and a sessional domestic abuse assessor for DV-ACT with over 19 years' experience working in the field of domestic abuse and sexual violence. She has a specialist interest in psychotraumatology and the biopsychosocial effects of adverse childhood experiences (ACE). Martine has previously chaired and published four Domestic Homicide Reviews. She is currently chairing seven active DHRs.

4.5 Jane Wonnacott qualified as a social worker in 1979 and has significant experience in the field of safeguarding at a local and national level. Since 1994 Jane has completed well in excess of 200 Child Safeguarding Reviews, a Safeguarding Adult Review and two Domestic Homicide Reviews (DHRs). She is currently chairing seven active DHRs. Jane is a member of the National Child Safeguarding Practice Review Panel pool of reviewers and in this role has completed national thematic reviews. Jane is the author of 'Mastering Social Work Supervision', and 'Developing and Supporting Effective Staff Supervision' published by Jessica Kingsley Publishers and Pavilion.

4.6 The Independent Chairs are completely independent of the Safer Cornwall Partnership and any associated organisations in Cornwall. They have not had any contact, personally or professionally with Jennifer, Michael or any other persons associated with the Domestic Homicide Review.

The Review Panel Members

4.7 The Review Panel certified that they had no connections or ties of a personal or professional nature with the family. Where a connection with a participating organisation was unavoidable (i.e., they were employed by the organisation in a senior position) assurances were given to apply a fully independent judgement regarding the outcomes of the review. This was honoured and respected throughout the DHR process.

4.8 The first full panel meeting was held on 24th March 2022. This was attended in part by Jennifer's sister. A second panel meeting was called on the 8th September 2022. A full panel meeting was undertaken on 12th January via Microsoft Teams to review the first draft of the overview report. A working group of panel members and local experts was formed to develop measurable recommendations and actions on the 23rd February 2023. A final panel meeting took place on the 27th April 2023 to conclude the recommendations and action plan. The review Panel members were:

- Jane Wonnacott and Martine Cotter - Independent Chairs
- Devon and Cornwall Police
- Cornwall Foundation Trust and Royal Cornwall Hospital Trust
- Cornwall Council |Together for Families |Education Effectiveness
- Firstlight (Specialist Domestic Abuse Service)
- Cornwall Community Safety Partnership
- Integrated Care Board (representing GPs)
- Cornwall Housing Limited
- Adult Social Care - Cornwall Council
- Children, Young People and Family Services
- Safety Partnership DHR Administrator

5 TERMS OF REFERENCE

5.1 Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016) states that the purpose of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice through improved intra and inter-agency working.

5.2 Specific Terms of Reference for this Review:

5.3 In the spirit of epistemic justice, the family of Jennifer was invited to contribute to the development of the Terms of Reference (ToR). The process of drafting a ToR started with them, and their priorities were considered in the following questions:

- What role does technology have in maintaining and enabling controlling and coercive abuse and what mechanisms are in place to ensure agencies stay abreast of technological developments to inform risk assessments?
- What advice is forthcoming for family members who are fearful for an abused relative but are concerned that professional intervention will increase the risk to a fatal level?
- How effective are bail conditions on coercive and controlling abusers and how can safety be increased for isolated or rural locations?
- Were there any barriers at an organisational or practice level that prevented family members from reaching out for help?
- How effective is routine enquiry? How effective is routine enquiry at identifying the full spectrum of domestic abuse?
- Has the professional system done enough to inform family, friends and co-workers of the increased risk associated with separation?
- What was known and understood about Michael's risk towards others and any implications this may have had for the safety of Jennifer and their children?
- Establish whether there is learning from these circumstances which will include considering the way professionals from across the range of services worked together as a collective and review the whole system function.

Additional Questions

5.4 Jennifer's children, parents and siblings raised additional specific questions they asked to be incorporated into the review. These were shared at the first meeting with the family and are answered within this overview report.

- Why was Michael's house keys returned to him by police after he was arrested and bailed, with conditions not to return to the property or make contact with Jennifer and his children for 28 days?
- Michael installed a video camera on his front door, linked to an app on his phone which monitored the comings and goings of people entering or leaving the house. This app was not deleted from his phone when he was bailed, enabling him to know when Jennifer was at home. Do the police routinely consider technology when placing conditions on domestic abuse offenders?
- When Michael was arrested for assault, Jennifer was interviewed in her living room by a solo officer. Their two children were left unsupported and unaccompanied in the kitchen for a prolonged period. They were shaken and scared. What is the protocol for supporting children immediately after a witnessed domestic abuse incident, particularly during necessary interviews?

6 SUMMARY CHRONOLOGY LEADING UP TO JENNIFER'S HOMICIDE[3]

Wednesday afternoon - Domestic Abuse Call-Out[4]

6.1 The police were called with reports that Jennifer and Michael had been arguing and that Michael had assaulted Jennifer. The log detailed that the problems had been ongoing for several days and that Jennifer wanted to end the relationship, but Michael did not want to. The log referenced that Jennifer feared that if she left the relationship Michael would kill himself as he had been 'a bit down recently'.

6.2 The police operator immediately dispatched a police unit to the scene. The call handler was able to gain important information about the circumstances leading up to the call, how long Michael's behaviour had been going on for, whether it was out of character, and also if Michael was a firearms holder.

6.3 Police attended the address and as a result, Michael was arrested on suspicion of assaulting Jennifer. He was transported to a police station and detained in custody overnight pending an interview the following day. A Victims Needs Assessment and a Domestic Abuse Stalking and Harassment (DASH) risk assessment were completed by a police constable. The needs assessment was graded as low, and the DASH risk assessment was graded as medium. A Vulnerability identification Screening Tool (ViST) was completed and sent to the Multi-Agency Referral Unit (MARU) to alert them to the children's presence at the scene.

6.4 A police officer took a statement from Jennifer. After a short time, they noticed empty packets of tablets in the bin and interrupted the interview to report their finding. Concerned that Michael may have consumed an overdose of medication, the officer made contact with the custody suite. A check was undertaken, and it was discovered that Michael had not taken the tablets, he had concealed them in a tissue and hidden them behind the sink. The interview resumed, photographs of injuries were taken, and a DASH Risk assessment was completed. The DASH risk status was rated as MEDIUM and consent was obtained from Jennifer to refer her to First Light, a specialist domestic abuse service.

Thursday afternoon

6.5 Michael was interviewed by police officers at the station regarding the alleged assault of Jennifer for which he had been arrested. Michael denied the allegations against him. Michael was interviewed and bailed pending further investigation.

[3] Testimony from statements, in-person interviews and the coroner's bundle.

[4] Records analysed from chronology, IMR, IOPC referral and coroner's bundle.

6.6 The custody record was updated with a gatekeeping decision detailing that further enquiries were required. Michael was released from custody on police bail with conditions not to contact directly or indirectly Jennifer or the children and not to attend the home address for 28 days, save on one occasion with a police officer to collect belongings. As a shotgun holder, arrangements were made to remove his firearm from the house. Michael was bailed to his parent's address, and he was escorted to his car and seen to drive away from the property in the direction of his parents' house.

Thursday – call from FirstLight to Jennifer

6.7 First Light[5] received a referral on Thursday morning from Devon and Cornwall Police via a UNIFI download. This is a robust and automatic IT process that enables the First Light Helpline to contact victims of domestic abuse and offer specialist advice. The referral was graded by the police as medium risk referral. Jennifer was contacted by helpline staff on the same day as receiving the referral. The helpline advisor gave Jennifer the opportunity to speak about the current situation and listened to Jennifer's current concerns, albeit it was a brief conversation because Jennifer was waiting for an update from the police. Jennifer declined to complete another DASH risk assessment on the phone. The helpline advisor gave Jennifer the contact number and helpline opening hours should she wish to continue the conversation at another time.

6.8 Jennifer called family members and told them about Michael's arrest for domestic abuse and her decision to separate. She disclosed how bad the relationship had been and spoke about planning her life moving forward as a single parent.

Thursday – Call from the Multi-Agency Referral Unit (MARU) to Jennifer

6.9 An attempt to contact Jennifer by phone was made by the MARU Team as a result of receiving a ViST[6] from the police. Jennifer did not answer the call. A decision was made to try again on Monday morning. This was in line with standard practice.

6.10 The MARU provides a multi-disciplinary response to concerns about the welfare or safety of a child or young person in line with statutory guidance from the Safeguarding Children Partnership for Cornwall and the Isles of Scilly.

Friday morning

[5] First Light supports victims of sexual violence living in the Plymouth and Cornwall area and domestic abuse for those living in Cornwall

[6] Vulnerability identification Screening Tool - https://www.devon.gov.uk/support-schools-settings/safeguarding/guidance-policy-and-tools-2/safeguarding-one-minute-guides/no-42-devon-and-cornwall-police-vist-cara-operation-encompass/

6.11 Michael arranged for his adult child from his previous relationship to visit the house and collect some fishing equipment. They arranged to meet nearby the property as Michael said he was keen not to break his bail conditions.

Friday Morning – Michael's call to his GP[7]

6.12 Michael called his GP surgery seeking help for ongoing stress, anxiety, and depression which he stated he had been experiencing over the last 10 years. Michael had not previously shared or sought medical help regarding his mental health and had never been on any medication for this. Michael reported a recent breakdown in his marriage as well as chronic health issues. He claimed these issues had contributed to a recent decline in his mental health. Michael clarified that he had no current plans of taking his own life and was more focused on sorting things out with regards to getting help for his mental health.

6.13 At this point, Michael brought up the fact that he had been in police custody the night before. He explained that this was as a result of an argument with his wife. He mentioned that there was no physical altercation and he had been released on bail. The GP asked Michael about his alcohol use to which Michael replied that he had cut down significantly since his diagnosis of rheumatoid arthritis. Michael admitted using cannabis at night-time which helped with sleep and leg spasms. The GP discussed Michael's diagnosis of rheumatoid arthritis and his treatment. Michael thought his medication had caused a decline in his mood over the years. Michael was asked if he had ever mentioned this side effect on his mood or mental health to a GP or the rheumatology team. He replied that he had not. Michael was asked if he had any expectations from the GP consultation prior to making the phone call regarding how he could be helped. His reply was that he just needed help with his mental health. He mentioned issues with anger like shouting and swearing at himself when stressed. He was clear there had been no episodes of violence. He felt all the issues with his mental health had gone on for longer than his diagnosis of rheumatoid arthritis and it was time he addressed them.

6.14 The GP acknowledged Michael's need for help and support with his mental health. He was informed to tell the rheumatology team (on his next scheduled review) of the effect his medication was having on his mental health. The GP signposted Michael to Outlook Southwest[8] and was given the telephone number to self-refer along with the contact details for Samaritans UK. The GP offered and arranged to have a telephone review appointment with Michael in 2 weeks' time.

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[7] Taken from GP statement contained in the Coroner's Bundle and the GP IMR

[8] Outlook Southwest and Improving access to psychological therapies (IAPT) service help people recover from common mental health problems such as: anxiety, stress, depression, trauma, as well as other conditions like OCD. https://www.cornwallft.nhs.uk/outlook-south-west/

Friday morning – Michael's call to Outlook Southwest

6.15 Michael self-referred to Outlook Southwest by phone. He reported problems with relationship issues, and feeling very depressed and anxious, stressed out and having suicidal thoughts, but with no intention to carry them out. He classed himself as separated and said that he had plans to take his own life. When asked if he was going to act on these plans, Michael responded, 'no'.

6.16 Michael was given an appointment with a clinician to discuss accessing therapy for 11 days' time at 9am.

6.17 Michael called his adult child from a previous relationship to say he would be late for their prearranged meet-up and rescheduled to meet nearby the property instead. He then forced entry into the rear door of the property and attacked Jennifer causing fatal injuries. Michael pulled the knife on himself, causing fatal injuries to his stomach and neck. Both Jennifer and Michael died at the scene.

6.18 Police arrived closely followed by Jennifer's brother and Michael's adult child from a previous relationship, who had each been en route to the house at the time of the attack.

6.19 Following CPR attempts, Jennifer was declared 'life extinct'.

7 KEY ISSUES ARISING FROM THE REVIEW

FINDING ONE

The DASH risk assessment, on its own, did not adequately record the context of what was happening in Jennifer's life.

CONCLUSION ONE

7.1 There are many factors that can impact on the effectiveness of the DASH risk assessment as a tool for predicting future harm, from the timing of its completion to the levels of distress being experienced, comprehension and interpretation of answers, subjectivity, and training/competency. The effectiveness of DASH has been doubted[9] when completed by police officers with studies concluding that too much focus is placed on the immediate domestic violence incident, rather than situating the individual incident in the context of coercive and controlling behaviour. Patterns of behaviour in Michael and Jennifer's relationship were not specifically sought, nor did the DASH risk assessment identify the scale of coercive control or account for

[9] https://academic.oup.com/bjc/article/59/5/1013/5518314

possible minimisation[10] on Jennifer's part. As a tool, it is missing specific questions around advancing technology which provides offenders with greater powers of monitoring, and 'love bombing' - a step within the 8-steps to domestic homicide and an indicator of future separation resistance[11]. It is currently used as a method to assign a risk level and dictate resource allocation – a practice that is strictly forbidden by NICE for suicide and self-harm risk[12]. This should cause practitioners to question why risk assessment tools and scales to predict future suicide or repetition of self-harm are not acceptable, yet entirely acceptable, and even wholly relied upon for predicting future domestic abuse harm and recidivism.

FINDING TWO

There is insufficient understanding of coercive and controlling abuse in order to manage risk and keep victims safe.

CONCLUSION TWO

7.2 The way that coercive and controlling abuse was risk assessed was the wrong way around – professionals were reassured and less concerned due to a lack of a history of known or reported domestic abuse, a lack of warning markers and the removal of Michael from the property[13]. This is a potentially dangerous way of responding to this typology of abuse. The tactics used by coercive and controlling abusers can terrorise victims into compliance. They often become trapped in a life of fear, isolation, threats, intimidation, and psychological abuse. Many victims find survival strategies to protect themselves and their children. Jennifer's children indicated that they all 'treaded carefully' around Michael. Jennifer adjusted her personality and her way of life to accommodate Michael's 'rules'. Rather than be reassured by a first report to professional agencies, the reverse should have happened. Professionals should have been immediately alerted to a possible change in circumstances that escalated Michael's behaviours to the point of them being exposed externally for the first time. When cases of coercive control are identified, a 'one chance rule' is a safer approach[14].[15] As Jennifer's homicide tragically demonstrates, there may be only one chance for the victim to disclose and one chance for professionals to save a life. Given that homicide risk is increased 9-fold following separation from a controlling abuser, a robust safety plan is paramount, and if risk levels are applied, it should automatically acquire a high-risk status and a MARAC referral. Jennifer should have been assertively warned of the dangers so that she could make informed decisions about her safety and that of her children. Overall, there is a need for an immediate

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[10] https://academic.oup.com/policing/article-abstract/10/4/341/2742980

[11] https://www.womensaid.ie/assets/files/pdf/jane_monckton_smith_powerpoint_2018_compatibility_mode.pdf

[12] Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

[13] Information provided by Reviewing Officers and the children's school

[14] https://www.saverauk.co.uk/information-and-advice/resources/1-chance-rule/

[15] https://m.facebook.com/watch/?v=2306592176149473

review of the professional response to coercive and controlling abuse to improve practitioner confidence, knowledge, skills and quality of response.

FINDING THREE

Practical responses to limiting the power of abusers in situations of coercive control need to be developed and used in order to ensure that families are as safe as possible.

CONCLUSION THREE

7.3 Technology is advancing on a daily basis. Over 7 million apps exist across iOS and Android platforms[16] with a further 90,000 new releases every month[17]. It is impossible to stay ahead of the download phenomena, however, some technological advancements, in the hands of coercive and controlling abusers, can be used to further isolate, monitor or incite fear remotely, and if these devices or electronic apps are discovered, Police either need the powers to confiscate, uninstall or block usage to protect victims, or victims need expert advice on how to protect themselves from cyber control. Jennifer was monitored remotely via a doorbell camera. It is not known if other tracking devices were installed on her electronic devices, however, the doorbell camera was an effective device that enabled Michael to know when Jennifer was at home on the day of the homicide. Removing or blocking his access to the app may not have deterred him, but it should still have been considered and acted upon. Similarly, Michael's house keys were returned to him even though he had bail restrictions prohibiting him from attending the house for 28 days. This issue has been raised by the coroner under a Regulation 28 Preventing Future Deaths Report to Rt Hon Chris Philp MP Minister of State for Crime, Policing and Fire. The coroner outlined an obvious disconnect in the guidance issued by the College of Policing and the laws provided to police under s19 PACE in relation to the power to confiscate house keys. The coroner has asked for clarification for officers. Jennifer's children have explicitly requested that powers are afforded to Police that enable them to remove house keys for the duration of the bail conditions/DVPO and until such time as all parties are confident a robust safety plan is in place. Even though Michael bypassed the door security to attack Jennifer on the day of the homicide, other perpetrators may not be so successful and having their keys confiscated or extra safety measure put in place, could save lives.

The Inquest into Jennifer's death highlighted practicality issues with removing house keys due to multiple sets potentially being accessible via spares and family members. Therefore, even if house keys are removed, an assessment of the victim's sense of security and risk from technology, surveillance software and general property security

[16] https://www.businessofapps.com/data/app-statistics/

[17] https://www.statista.com/statistics/1020956/android-app-releases-worldwide/

should still be undertaken. In this case, a referral to the Sanctuary scheme18 would have been helpful. Unfortunately, this was not considered due to the scheme being reserved for high-risk cases.

FINDING FOUR

Families and friends who are concerned that someone may be being abused are not always aware of how to best respond and where to go to for help and advice.

CONCLUSION FOUR

Jennifer had no idea of the danger she was in when she decided to leave Michael. She believed she was in control and could manage the situation. Friends, neighbours, and some family members were aware of Jennifer's intentions to separate from Michael, but professional support was not discussed. The abusive behaviour and escalation of intimidation and threats were triggered further by Jennifer telling Michael she was going to leave him. This resulted in Michael becoming more erratic, unpredictable, and desperate. Jennifer's family said that they wish she never told him she was going to leave him, which is only after learning of the risks associated with separation. This is not the only DHR in Cornwall where the reviewers have been told by family and friends that they were unaware of the risks, meaning that there is a significant and alarming gap in knowledge within the general public that needs to be addressed as a matter of priority. It is not enough to train professionals to understand the risks and assume that victims and their family will always seek professional help. They may need encouragement, through education of the risks, to feel empowered to ask for help. Clear and concise public health messaging may prevent well-intentioned but ill-informed advice for victims to leave abusive relationships without considering a safe exit.

FINDING FIVE

Recognition of and response to domestic abuse in GP surgeries is an area for practice development.

CONCLUSION FIVE

7.4 Michael was not asked specifically about domestic abuse, even though he expressed distress over a marriage/relationship breakdown during a call to Outlook Southwest and disclosed that he had been arrested and bailed during a GP referral. He was not asked about domestic abuse or aggression in relation to his disclosure that his chronic health issues were impacting his mental health, even though he mentioned to his GP that his pain negatively impacted his mood. It is not always easy to ask

[18] Sanctuary schemes for households at risk of domestic violence: guide for agencies - GOV.UK (www.gov.uk)

explicitly about domestic abuse, but it is necessary to assess an individual's coping potential and to enquire about the impact of their distress on others. Appropriate exploration must be a priority and further training is required to ensure practitioners feel confident to ask and engage in challenging conversations routinely. It is acknowledged that for some agencies, it will be relevant to routinely ask every individual (e.g., midwifery, mental health), however, for others, professional exploration should be appropriate to the presenting clinical issue and its association to domestic abuse (for example, unexplained chronic pain and toxic stress).

FINDING SIX

The methods and systems for flagging existing firearms holders is not adequate.

CONCLUSION SIX

7.1 At the time of this report, a new Digital Firearms Marker system has been implemented to will help make firearms licensing safer. The marker will be deployed on 6 Feb 2023 for practices using EMIS Web (EMIS) systems. All GP records use a coding system called 'standardised nomenclature of medicine, which is known as SNOMED. This means that there is a short code for every type of problem that a GP helps people with. SNOMED includes codes for people who have a firearms licence.

7.2 There is a now new safeguard in place. The GP system can now flag when a person has both a firearms licence, and a new condition that may affect their suitability to have the licence. GPs add the appropriate SNOMED code to a patient's record when they receive notification of a firearms certificate application or when a certificate is granted. This will now create a Digital Firearms Marker on a patient's record. If a potentially relevant condition of concern is added to their medical record during the application process or after a certificate has been issued, an alert will pop up. The alert will help enable GPs to determine if the police need to be made aware of the new condition. This is currently available in two of the three main GP systems and will soon be released in a third.

7.3 In addition, new guidance[19] produced by the government requires police, and general practice to work together to make sure that it is safe for people to have and keep firearms. However, a recent incident in another part of the Southwest, identified that it is not possible for the police to notify GPs of all retrospective applications, therefore people who already have a licence may not be identified with a warning marker. Therefore, even if this system was functioning at the time, it is not guaranteed to have alerted the GP to Michael's firearm status. This is an important consideration given that Michael called the GP and Outlook Southwest disclosing suicide ideation. Subsequently, five Regulation 28 Preventing Future Death Reports

[19] Firearms licensing - GOV.UK (www.gov.uk)

were sent by the senior coroner to government departments calling for a root and branch reform of the 1968 firearms legislation and Home Office policy, including the need for a firearms reminder on all medical records within a unified records system. It will be important for Cornwall agencies to stay abreast of the response to the preventing future death reports and changes deriving from these calls to action.

FINDING SEVEN

This review, alongside other DHRs in the county, acknowledge a gap in accountability for DHR recommendations and actions, and how community safety initiatives and changes from DHRs are shared and reported to families and the general public.

CONCLUSION SEVEN

7.4 Many families ask how they will know if the recommendations will be implemented and how they will be evaluated. The independent reviewers are not in a position to provide an update on progress after the completion of the DHR, therefore the onus is placed on the Community Safety Partnership to engage with families regarding the implementation of learning. This, however, is often locally led as there is no definitive framework in place to share the outcomes of statutory reviews with the public to increase community confidence after a domestic homicide. Subsequently, a general despondency towards retrospective and reflective reviews can happen, rather than them being regarded as a positive impetus for change. As a public service, it could be argued that DHRs are carried out in the interest of the citizens of Cornwall and the Isles of Scilly on behalf of the local authority, therefore, the citizens should be afforded the opportunity to oversee the progress of DHR outcomes.

8 RECOMMENDATIONS

RECOMMENDATION ONE – SAFER CORNWALL

Safer Cornwall should co-ordinate work across all agencies to ensure effective risk assessment at the first point of contact in situations of domestic abuse.

RECOMMENDATION TWO – SAFER CORNWALL

Explore the feasibility of a commissioned comparative study between 'service as normal' (Recommendation 1 above) and a 24/7 specialist IDVA risk assessment service.

RECOMMENDATION THREE – SAFER CORNWALL

Information sharing practices between Devon and Cornwall Police and First Light should be monitored and evaluated regularly to ensure that it is effective.

RECOMMENDATION FOUR – ALL AGENCIES

All statutory and commissioned agencies in Cornwall and the Isles of Scilly need to evidence that their agency has a robust and accessible policy or practice guidance that addresses how their organisation will explore and identify coercive and controlling abuse at the first point of contact, followed by a plan on how they will assess, manage, escalate, and record coercive and controlling domestic abuse for adults and children under their care.

RECOMMENDATION FIVE - DEVON AND CORNWALL POLICE

Devon and Cornwall Police should stay abreast of the response from Rt Hon Chris Philp MP Minister of State for Crime, Policing and Fire in relation to the removal of house keys for the duration of imposed bail conditions and adjust practice accordingly to any formalised changes to national guidance or policy.

RECOMMENDATION SIX – CORNWALL COUNCIL

There should be an expectation that the sanctuary scheme is always offered in situations of coercive control. This should always include practical remedies to help families feel safe including consideration of the way in which technology may be allowing abusers to continue to exert control remotely.

RECOMMENDATION SEVEN – PUBLIC HEALTH AND FIRSTLIGHT

Public Health, together with First Light, should produce a marketing strategy that reaches the communities in which people live to raise awareness of the patterns and risks associated with coercive and controlling abuse and the importance of gaining free specialist safety planning advice prior to, and after separation *This should not rely on technology or websites as these methods are often controlled and monitored.

RECOMMENDATION EIGHT – INTEGRATED CARE BOARD

The integrated care board (ICB) supported by Cornwall Council should work together to improve the domestic abuse response within general practice.

RECOMMENDATION NINE - ALL AGENCIES

In the absence of a robust system for flagging existing firearms holders, professional agencies in Cornwall need to establish an interim way of identifying firearms holders.

RECOMMENDATION TEN – SAFER CORNWALL

The Safer Cornwall Partnership should develop a strategy to reassure the public of accountability following statutory reviews. This should include the transparent sharing of outcomes on a consistent basis.