SAFER CORNWALL / KERNOW SALWA COMMUNITY SAFETY PARTNERSHIP DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Report into the death of Natalie

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Natalie was born in 1958 in Surrey and was the eldest of four siblings. Natalie was always very much the eldest sister, and she was very good at being in charge. She organised the picnic lunches, took her siblings on buses, looked after them, and made sure they were all home in time for tea. Natalie was often in charge of getting them to school on time.

Natalie was a very happy Brownie and sang in the church choir. Natalie loved to read, and they spent a lot of time at the lending library, a huge Victorian Gothic building that she was immensely fond of. As an adult, Natalie bemoaned the building of a modern library in her hometown beside the original, although she did concede the addition of an art gallery space was an improvement. Natalie always enjoyed art, gardening, cooking, sewing, swimming and history. Natalie particularly loved scented roses and, as an adult, searched for flowers with the same scent as those growing around the gate in her childhood home. Natalie had family holidays in Cornwall and eventually moved down when she was 14. After finishing at her schooling, Natalie went on to study Art and Design. Natalie enjoyed folk music and live music events with friends.

When she was younger, Natalie worked at a bar where she met her husband. Soon after they were married, their first child, Abigail, was born, followed by Hazel three years later. In the 1980s, Natalie her husband, Abigail and Hazel emigrated to South Africa. Natalie loved living there; she loved the landscape, the culture and, of course, the heat! Natalie was not, however, always a well-behaved 'expat'. She would hand out books to the local people at the park, something which was highly illegal, risking arrest. Natalie also bought coffees from the white only coffee shop to share outside with her Indian friends and to the horror of the gardeners and housekeepers did her own garden and washed her own windows!!! In the mid-1980s, after being told she would not be able to have any more children, Natalie and her husband were delighted when her son Owen was born. Owen never slept, and Natalie could often be found walking around the neighbourhood trying to stop him crying while neighbours handed her cups of coffee enroute.

In the early 1990s Natalie and the children moved back to Cornwall, where she not only continued to raise and support not only her own children but also a stream of others. Her door was always open and often used by anyone needing advice, support, or simply a kind ear to listen to, a meal, or a bed for the night. Natalie encouraged all her children to be independent and individual and to work hard.

Natalie's work was a huge part of her life. She was an understanding and supportive boss who encouraged her staff. Natalie worked incredibly hard, setting very high standards for herself and everyone else. Natalie encouraged her staff to learn and grow, supporting many to move on and complete training. Abigail worked alongside Natalie. Working together was an experience Abigail will always treasure.

Natalie loved to talk, and boy, could she talk!! She had such a vast wealth of knowledge on so many subjects. However, despite this, she was also quite reclusive, especially during the summer month when she would become extremely annoyed with 'all those people being here, haven't they got home to go to' and often threatened to go and live on an island over in the Isles of Scilly. She loved spending time with her family and best friend, enjoying garden centre visits, fish and chips on the harbour wall and shopping.

Natalie was born to shop: she would shop for everyone, often turning up delighted with bargains she had bought for you. Natalie loved clothes, especially bright colours and patterns and would wear them all together. She was well known for her flamboyant style and her many, many scarves, which her sisters loved to 'borrow'.

Natalie also loved Christmas, she loved the decorating, the lights, the food and, of course, family time. What she didn't like – and, in fact, loathed with a passion – was wrapping presents. It became a family joke that your gift would often come unwrapped or wrongly labelled, that's if she could find where she had hidden it in the first place. Christmas Eve was often spent in a whirlwind with the girls organising her, hunting down mislaid presents and sometimes wrapping their own from her!!!

When Natalie was 60, she passed her driving test, much to the relief of her very proud children who no longer had to be 'mum's taxi'. She loved her newfound freedom, although she detested parking and never quite worked out how roundabouts actually worked!! Prone to losing things, Natalie would leave her keys in the ignition. On one memorable occasion, she reported the car stolen only to be informed she had parked it across the road at the local shop!!!

Family meant everything to Natalie; she was happiest spending time with them. She adored her grandchildren and would spend hours teaching them to cook and bake, doing crafts, learning flower names and planting in the garden.

Natalie was a kind, caring and generous lady. She would do anything for anyone, and she always had time for people. Her passing has left a gaping hole not only in our hearts, but in the lives of so many people, whom over the years she touched. She will be sorely missed and always remembered by all those who loved her.

Natalie, our daughter, mother, sister and friend ... May you rest in peace.

Pen Portrait provided by Natalie's family

1. Preface

1.1 The Review Process

1.1.1 This report examines agency responses and support given to Natalie,[1] a resident of Cornwall, who was killed by her grandson, Liam[2], in her home.

1.1.2 The Review Panel expresses its sympathy to the family and friends of Natalie for their loss and thanks them for their contributions and support for this process.

1.1.3 The complexity of the initial police investigation and subsequent criminal justice process meant that Liam was not tried until two years after Natalie's death. Although Liam pleaded not guilty, he was convicted of murdering Natalie and sentenced to life imprisonment (a minimum of 18 years). Liam was sentenced to serve his sentence at a secure hospital until well enough to serve his term in prison.

1.1.4 This report of the DHR (hereafter 'the review') examines agency responses and support given to Natalie before the point of her death. This review considers agencies' contact/involvement with Natalie and Liam in the 4 years prior to her death and will summarise agency involvement before this time. As appropriate, this review additionally considers contact with any other family members, including Abigail (Natalie's daughter and Liam's mother) and Owen (Natalie's son and Liam's uncle). [3]

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

Name	Relationship to victim
Natalie	-
Liam	Grandson / Perpetrator
Abigail	Daughter (Mother of Liam)
Hazel	Daughter (Aunt of Liam)
Owen	Son (Uncle of Liam)

1.1.6 These pseudonyms were selected by the Chair and agreed with the family.

1.1.7 In approaching this case, the review will be mindful that Natalie was killed by her grandson, so this is a case of Adult Family Violence (AFV). AFV is a type of domestic abuse and is included in the statutory definition of domestic abuse, which covers violence and abuse direct by a person to someone with whom they are "personally connected", including family members (see 1.7 below). While there is no single definition of AFV, fatal AFV is generally accepted to involve a homicide between family

[1] Not her real name.

[2] Not his real name.

[3] Not their real names.

members aged 16 years and older.[4] Additionally, it has become apparent that there was abuse directed towards other family members, including by Liam toward his mother (Abigail). This domestic abuse towards his mother, which occurred when Liam was an adult, could also be described as AFV (and specifically a form of Child-to-Parent Abuse (CPA), although there is also no single definition of CPA currently[5]). This review has decided to focus on learning relating to Natalie but will include consideration of the experience of, and response to, other family members in the context of AFV/CPA.

1.1.8 To help better understand Natalie as a person, her family has provided a Pen Portrait, which has been included at the start of this report.

1.2 Contributors to the Review

1.2.1 The Review Panel was comprised of agencies from Cornwall, as Natalie and Liam were living in that area at the time of Natalie's death. Agencies were contacted as soon as possible after the review was established to inform them of the review, invite their participation and request them to secure their records.

1.2.2 The following agencies were contacted but recorded no involvement with Natalie and/or Liam:

- Catch 22
- We Are With You
- CCG - NHS Kernow
- PACT
- CASSPLUS
- Victim Support

- The following agencies and their contributions to this review are:

Agency	Contribution
Catch 22[6]	Summary of Engagement

[4] Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) Case Analysis*. Available at: https://www.standingtogether.org.uk/dhr (Accessed 25th September 2023).

[5] Holt, A (2022) *Child to Parent Abuse. (Academic Insights)*. Available at: https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/08/Academic-Insights-Child-to-Parent-Abuse-Dr-Amanda-Holt.pdf (Accessed 25th September 2023).

[6] At the time, was commissioned to provide 'Through the Gate', a support package working with offenders' subject to probation supervision following a prison sentence.

Cornwall Partnership NHS Foundation Trust (CFT)[7,8] & Royal Cornwall Hospitals NHS Trust (RCHT)[9]	IMR and Chronology
Cornwall Council – Adult Social Care Services	IMR and Chronology
Cornwall Council – Housing Options (for Cornwall Housing Ltd)[10]	IMR and Chronology
Cornwall College[11]	Summary of Engagement
Cornwall Multi-Agency Risk Assessment Conference (MARAC) (Coordinated by Cornwall Council)	IMR and Chronology
Devon & Cornwall Police	IMR and Chronology
First Light – Safer Futures (local domestic abuse service, including Independent Domestic Violence Advisors (IDVAs)[12]	IMR and Chronology
General Practitioner (GP) (facilitated by Cornwall and Isles of Scilly Integrated Care Board, ICB)	IMR and Chronology
His Majesty's Courts and Tribunals Service (HMCTS)	IMR and Chronology
His Majesty's Prison (HMP) Exeter	Short Report
Prison Health Team (provided at the time by the Practice Plus Group, with information shared by the Oxleas NHS Foundation Trust, the provider from December 2022)	Short Report
Probation Service (based on information from the Devon, Dorset and Cornwall Community Rehabilitation Company (DDCCRC), which operated until June 2021)	IMR and Chronology
St Petrocs[13]	Summary of Engagement
StreetLink[14]	Summary of Engagement
South Western Ambulance Service Trust (SWAST)	Summary of Engagement

[7] Provides community and mental health services in Cornwall and the Isles of Scilly. For more information, go to: https://www.cornwallft.nhs.uk/vision-and-values.

[8] Includes information from Outlook Southwest, originally a stand-alone talking therapies service for anxiety and depression (for more information on talking therapies, go to: https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/), but since April 2020 has been part of CFT.

[9] Provides acute care and specialist health services across three main hospitals in Cornwall. For more information, go to: https://royalcornwallhospitals.nhs.uk.

[10] During the period in question Cornwall Housing Ltd, a company owned by Cornwall Council, fulfilling the statutory homelessness function on behalf of Cornwall Council. In October 2022, the service TUPE'd over to Cornwall Council.

[11] A local education provider. For more information, go to: https://www.cornwall.ac.uk.

[12] Provided advice and support to people experiencing domestic abuse and sexual violence in Cornwall and the Isles of Sicily. For more information, go to: https://www.firstlight.org.uk/our-services/safer-futures/.

[13] A charity supporting people who are at risk of or experiencing homelessness in Cornwall. For more information, go to: https://www.stpetrocs.org.uk.

[14] Enables members of the public to share a concern about someone sleeping rough. After a concern is raised via a website, this is sent to the local authority or outreach service for the area in which the person has been seen. For more information, go to: https://www.streetlink.org.uk.

Witness Care (facilitated via Devon & Cornwall Police)	Short Report

1.2.3 Information was also shared with respect to Liam's contact with Channel / Prevent. These processes are underpinned by the *Counter Terrorism and Security Act 2015* and the Counter Terrorism Case Officer Guide, 2020. In this report, a summary of this contact is provided but, because no counter terrorism concerns were identified and his care was discharged to agencies already working with him, this contact is not analysed specifically. [15]

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

1.2.5 Devon & Cornwall Police disclosed a minor conflict of interest related to the involvement of a senior police officer (D/Supt Beckerleg) with the review who had, concerning an offence committed in September 2020, authored an extension to custody for Liam. The Chair felt, having been declared, this did not preclude D/Supt Beckerleg's involvement.

1.2.6 The IMRs and Short Reports received were largely comprehensive and enabled the Review Panel to analyse the contact with Natalie and/or Liam, and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses were received.

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Job Title	Agency
Practice Manager	GP Practice
Senior Probation Officer	HMP Exeter
Team Manager	First Light
Detective Superintendent, Head of Public Protection	Devon and Cornwall Police
Devon Prisons Regional Service Manager	Oxleas NHS Foundation Trust
Safeguarding Review Lead	Cornwall Partnership NHS Foundation Trust and RCHT

[15] Prevent is a process for safeguarding and supporting vulnerable people to stop them from becoming terrorists or supporting terrorism. Channel is a multi-agency approach to safeguarding, supporting and protecting children, young people and vulnerable adults at risk of radicalisation, extremism or terrorist related activity. These processes are underpinned by the Counter Terrorism and Security Act 2015 and the Counter Terrorism Case Officer Guide, 2020. For more information, go to: https://www.gov.uk/government/publications/channel-and-prevent-multi-agency-panel-pmap-guidance.

Head of Nursing / Lead Designate for Safeguarding	NHS Cornwall and Isles of Scilly integrated care board (ICB)
Operations Manager	We are With You
Senior Information Manager	Street Link
Reviewing Officer	Cornwall Council Housing Options
Domestic Abuse and Sexual Violence Implementation Lead	Cornwall Council and Safer Cornwall Partnership
Forensic Psychiatrist (retired)	Niche Associate
Domestic Abuse and Sexual Violence Coordinator and MARAC Chair	Safer Cornwall
Independent Investigations Senior Manager	South West Regional NHS England Team
Senior Probation Officer	Probation Service
Director of Domestic Abuse Services	First Light
Detective Sergeant, Criminal Case Review Unit	Devon and Cornwall Police
Safeguarding Service Senior Manager	Cornwall Council Adult Social Care
Consultant Nurse for Integrated Safeguarding Services	Royal Cornwall Hospital Trust and Cornwall Foundation Trust

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

1.3.3 The Review Panel met a total of five times. After the first meeting, the Terms of Reference were developed, and the scope of the review was agreed. Thereafter, the decision was made to suspend the review subject to the outcome of the criminal trial. However, subsequently, the trial did not go ahead and was postponed. As a result, following discussions with Devon & Cornwall Police and with the agreement of the Review Panel, the review recommenced prior to the trial. The second and third meetings were held to consider the reports shared by agencies. A fourth review panel meeting was originally planned to take place after the conclusion of the criminal trial. A fifth meeting was held following the completion of the Independent Investigation. Thereafter, the report was circulated to the Review Panel for electronic sign off.

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

1.4 Involvement of the Victim's Family, Friends, Work Colleagues, Neighbours and Wider Community

1.4.1 The Review Panel sought to involve the family, friends, work colleagues, neighbours and the wider community.

Name[16]	Relationship to Victim	Means of Involvement
Abigail	Daughter (Mother of Liam)	Abigail
Hazel	Daughter (Aunt of Liam)	Hazel

1.4.2 The notification and the involvement of the family with the review was affected by the criminal justice process, but they were notified and provided with information on specialist advocacy support. After the criminal justice process concluded, the Chair was able to engage directly with the family, who were being supported by the Victim Support Homicide Service (VSHS)[17] caseworker.

1.4.3 The Chair met with Abigail and Hazel, along with a VSHS caseworker, to discuss the review. Thereafter, Abigail and Hazel were kept updated, including being provided with opportunities to comment on the Terms of Reference. Having confirmed that they felt the Terms of Reference covered everything that they wanted considered, Abigail and Hazel subsequently decided not to be involved directly, stating that they were confident that their concerns had been addressed. However, Abigail and Hazel provided a Pen Portrait, which is included at the start of this report. Abigail and Hazel also asked the Chair to provide updates and so were kept informed of the review's progress.

1.4.4 Consideration was given to approaching Natalie's friends, work colleagues, neighbours and the wider community. However, during the review, it was not possible to establish contact with these wider networks.

1.5 Involvement of the Perpetrator and their Friends, Work Colleagues, Neighbours and Wider Community

1.5.1 Given the parallel Independent Investigation (see 1.12 below), it was agreed a joint letter would be sent from the Chair, Safer Cornwall / Kernow Salwa CSP and NHS England, notifying Liam of the decision to commission a review and an Independent Investigation. It was agreed that NHS England would take the lead on the involvement of the perpetrator, with letters being sent to Liam via the Responsible Clinician at the secure hospital where he was serving his sentence. No response was received from Liam.

1.5.2 Consideration was given to approaching Liam's friends, work colleagues, neighbours and wider community. However, in the absence of his engagement, it was not possible to identify potential participants.

1.6 Parallel Reviews

1.6.1 *Criminal trial:* After Natalie was killed, there was not enough initially sufficient evidence to charge Liam. Subsequently, following a complex investigation, Liam was charged in. After Liam was charged, the progress of the criminal justice process also affected the

[16] Not their real name

[17] The Victim Support Homicide Service supports bereaved families to navigate and know what to expect from the criminal justice system and providing someone independent to talk to. For more information, go to: https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service.

timeframe for the DHR, with Liam's trial postponed for 7 months. The Senior Investigation Officer (SIO) was invited to the first meeting of the Review Panel to share information about the criminal investigation and address issues concerning disclosure. Subsequently, until the conclusion of the criminal justice process, there was ongoing liaison. The trial was held and after having pled not guilty, Liam was convicted of murder and sentenced to life (a minimum of 18 years). Liam was sentenced to serve his sentence at a secure hospital until well enough to serve his term in prison.

1.6.2 *The Coroner's Inquest*: The death of Natalie was referred to the HM Coroner, and an inquest was opened, adjourned and – after at a Pre-Inquest Review (PIR) Hearing, which the chair attended – a decision was made it that would not be resumed.

Other parallel reviews

1.6.3 *Serious Further Offence Reviews*[18]: The Probation Service commissioned a Serious Further Offence Review. As the statutory guidance refers to the Chair having "*access to all relevant documentation*" (p. 21), the Chair made a request to access the Serious Further Offence Review. The Probation Service refused this request, giving the rationale that a Serious Further Offence Review served a specific purpose and that the IMR requested as part of the DHR was the most appropriate route for disclosure. Consequently, a DHR recommendation was made to address this issue.

1.6.4 *Independent Investigation:* NHS England commissioned an Independent Investigation into the mental health care and treatment of Liam (sometimes referred to as a mental health homicide review),[19] with this delivered by Niche Consult.[20] Throughout the review, there was ongoing liaison with the Independent Investigation. This enabled coordination around contact with the family and Liam, representation from NHS England and Niche Consult on the Review Panel, and findings from the Independent Investigation being integrated into the analysis.

1.7 Chair of the DHR and Author of the Overview Report

1.7.1 The Chair and Author of the Review is James Rowlands Chair, an Associate of Standing Together. James is a qualified Social Worker and IDVA and has worked in a variety of frontline and strategic roles in the domestic abuse sector since 2004. James has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 19 previous DHRs.

1.7.2 *Independence*: James has no connection with Cornwall or any of the agencies involved in this case.

[18] A Serious Further Offence Review is undertaken when violent and sexual offences are committed by people who are under probation supervision or have very recently been under probation supervision at the time of the offence. For more information, go to: https://www.justiceinspectorates.gov.uk/hmiprobation/about-hmi-probation/about-our-work/serious-further-offence-reviews/.

[19] Sometimes referred to as mental health homicide reviews, independent investigations are commissioned into homicides that are committed by patients being treated for mental illness. For more information, go to: https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports/.

[20] For more information, go to: https://www.nicheconsult.co.uk.

1.8 Terms of Reference for the Review

1.8.1 At the first meeting, the Review Panel shared information about agency contacts with the individuals involved, and as a result, established the period to be reviewed. This timeframe was chosen because from the first point at which concerns about Liam's behaviour were reported. However, agencies were also asked to summarise any relevant contact they had had with Natalie and/or Liam outside of the review period, as well as any contact with Abigail (Natalie's daughter and Liam's mother) and Owen (Natalie's son and Liam's uncle) if there were concerns related to Natalie.

1.8.2 *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in the statutory guidance and identified and considered the following case-specific issues:

- Analyse the communication, procedures, and discussions, which took place within and between agencies.
- Analyse the co-operation between different agencies involved with Natalie / Liam [and wider family].
- Analyse the opportunity for agencies to identify and assess domestic abuse risk, specifically in the context of AFV.
- Analyse agency responses to any identification of domestic abuse issues, specifically in the context of AFV.
- Analyse organisations' access to specialist domestic abuse agencies, including expertise relating to AFV.
- Analyse the policies, procedures, and training available to the agencies involved in domestic abuse issues.
- Analyse any evidence of help-seeking, as well as considering what might have helped or hindered access to help and support, including:
    - (a) The impact of and service response to Liam's mental health needs
    - (b) The impact of and service response for family members in relation to Liam's mental health needs, including as (informal) carers
    - (c) The impact of the Covid-19 pandemic.

2. Summary of Chronology

2.1.1 In the period covered by this review, Natalie had contact with a range of health providers relating to her own physical and mental health needs, including her GP practice and also RCHT. Natalie also had contact with CFT in relation to support for Liam, as well as her son (Owen). While this contact was appropriate, opportunities to identify and explore potential concerns around domestic abuse – specifically AFV – where often not identified, nor was Natalie's potential carer status known to the GP practice or addressed by CFT or other agencies.

2.1.2 Mental health providers also had contact with Natalie, both in the community, and when he was in prison. This included CFT, as well as the Prison Health Team when Liam was in custody on two occasions. Throughout this contact, a significant challenge was assessing Liam's needs (be that mental health, or in relation to his presumed Autistic Spectrum Disorder (ASD), given both his presentation (including non-engagement) and his changing circumstances (including homeless, as well as time in prison). In relation to this contact, as detailed in a parallel Independent Investigation, while there was an appropriate response in many respects (including, for example, assessment both after arrest and in prison, as well as medication management), there were challenges too (in terms of understanding of Liam's diagnosis, liaison between teams over time around assessment and medication) but also more broadly (in particular, around risk to others).

2.1.3 Natalie, as well as other members of her family (including her daughter, Abigail, and later her son, Owen), also had contact about Liam with different parts of the criminal justice system. Devon & Cornwall Police had contact throughout the period covered by this review, spanning four years. While there was often a good response to individual incidents (including, for example, risk assessment and taking positive action, as well as engaging with other agencies), there was also learning too. This included a tendency to focus on an individual member of the family in specific incidents rather than making the wider connection over time about concerns of AFV and the inconsistent completion of Vulnerability identification Screening Tools (ViSTs)[21] to document safeguarding concerns. There has also been learning about how information was shared with Victim Support or the First Light IDVA service at the time, although since then systems have changed.

2.1.4 Other criminal justice agencies that had contact include HMP Exeter, when Liam was detained: first on remand and then conviction, before being released on licence, and then, after a few days on release, for 2 months after being recalled. Key learning has included taking up opportunities with Liam to more fully explore his family relationships, his intentions on release, and opportunities to share information about his mental health. The DDCCRC (now the Probation Service) also had contact with Liam, around incidents involving Natalie and Abigail (for a pre-sentence report) and then later after his release from prison. While this contact often included active attempts to engage

[21] A ViST form is submitted whenever a police officer identifies a person (adult or child) with a vulnerability.

with Liam, and liaison with other agencies, there was significant learning around the consistency of recording practice, risk assessment, and enforcement.

2.1.5 Other criminal justice agencies with contact included HMCTS (for Liam, when he was subject to prosecution for assault on Natalie and Abigail and breaches of a Restraining Order (RO), as well as other offences not related to Natalie and Abigail) and Witness Care.

2.1.6 Domestic abuse services – specifically First Light's IDVA service – also had contact spanning the review period. This contact, triggered by referrals from Devon & Cornwall Police and the MARAC respectively, led to engagement with Natalie. This engagement was positive, including evidence of risk assessment and safety planning and liaison with other agencies. However, there was learning nonetheless, including considering AFV and the risk to wider family members, recognising Natalie as a carer, and ultimately a premature case closure without ensuring all Natalie's needs had been addressed.

2.1.7 The local authority also had contact in this case. Cornwall Housing Ltd. (now brought back in house, so it is provided directly by the council) had contact with Natalie relating to concerns about his housing. Most notably, in the months leading up to Natalie's death, Cornwall Housing Ltd. had contact with Liam and professionals after he made a housing application, although he was later found not to be in priority need. There has been significant learning about this contact, including about the response to Liam himself (because of, for example, delays or no response to his calls), and limited pro-active engagement with professionals and other agencies.

2.1.8 More broadly in terms of housing, there has been learning about the consistency by which housing needs were identified and addressed by agencies, although there were examples of attempts to address Liam's needs, including referrals to agencies like StreetLink and St Petrocs) and Through the Gate received referrals for Liam when he left prison. Since this time, there have been changes in street outreach commissioning in Cornwall, including the development of a Rough Sleeper Service.

2.1.9 The other local authority department with contact in this case was Adult Social Care Services, which had indirect contact with Natalie in so far as there was safeguarding involvement with Owen, including after Liam's release from prison in the year that she was killed. While responding to Owen, and there was an awareness of contact with other family members (i.e. Natalie and Abigail), there is no evidence that transferable risks were explored, including in the context of AFV.

2.1.10 Liam was also the subject of multi-agency arrangements. In terms of the MARAC, there were two referrals in the year that Natalie was killed, triggered by concerns for her. While it was positive that Natalie and Liam were discussed at the MARAC, there has been learning about the extent to which risks were identified (including to other family members in the context of AFV), as well as needs addressed (including Natalie being a carer). There has also been specific learning about referral routes into the MARAC to respond to escalation (because Devon & Cornwall Police could have potentially referred earlier if there was clarity locally around 'potential escalation') and ensuring there is a pathway to share information between the MARAC and GP practices. During

the period covered by the review, there were also referrals to Prevent/Channel for Liam and, while not explored specifically, these were considered and found to be proportionate and appropriate.

3. Conclusions and Lessons to be Learnt

3.1 Conclusions

3.1.1 Natalie's death was a tragedy, and the Review Panel extends its sympathy to her family and those who knew her. The Review Panel also recognises the heavy burden of fatal violence in a family, given Natalie's family have also had to come to terms with Liam's actions and his conviction.

3.1.2 The Review Panel has sought to try and understand Natalie's lived experiences and consider the issues she faced to try and understand the circumstances that led up to her killing by Liam and identify relevant learning.

3.1.3 Broader learning has also been identified during this review concerning how Liam's potential risk and needs were managed, the recognition of Natalie's needs (including as a carer), and how agencies work together. It is vital that agencies and local partnerships consider this learning to develop and improve local responses.

3.2 Key Themes and Learning Identified

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

3.2.2 The specific learning for individual agencies has been described in detail and is reflected in the recommendations. The learning has included issues relating to policy and procedure, as well as the response of staff in specific circumstances, both internally and concerning multi-agency working. This learning has encompassed individual agencies (including health providers, criminal justice agencies, as well as domestic abuse services and others like local authority housing), as well as the local MARAC.

3.2.3 In terms of overarching learning:

3.2.4 A first theme has related to AFV. It is vital that professionals and agencies understand AFV and – supported by policy and systems – are able to identify and respond to it. Critically, this recognition includes considering the impact of violence and abuse across family network. Although Natalie, as the grandmother of Liam, has been the focus of this review, and her experiences of AFV were not consistently identified and responded to, so too Liam's mother (Abigail) and uncle (Owen) were also affected, and their needs not always addressed either.

3.2.5 A second theme has been the recognition and response to Natalie's experience as a carer. Natalie was often trying her best to support Liam and it would have been apparent to agencies that she had significant role in Liam's life. Yet, no specific action was taken about Natalie being a carer, although at times this was identified by agencies.

3.2.6 A third theme has been the focus on Liam's mental health, which meant that recognising his patterns of behaviour or considering the efficacy of interventions were rarely viewed through a domestic abuse lens. There has also been wider learning about mental health responses to Liam too, with this captured as part of a parallel Independent Investigation.

3.2.7 A fourth theme, as a result of Liam's ASD, has been the response to neurodiversity generally. This learning includes the extent to which concerns about potential ASD were understood and addressed, but also how to manage issues like non-engagement (which was a barrier to the diagnosis of Liam) and also to ensure that specific concerns were addressed (for example, when raised by family, or in the context of Liam's potential risk).

3.2.8 While there has been significant learning in this case, it is evident too that there was good practice from professionals and agencies. That included around risk identification (for example, re-referral by Devon & Cornwall Police to the MARAC, as well as the Probation Service's recommendations for a RO and later recall decision), some aspects of multi-agency liaison (for example, between mental health agencies as Liam moved between the community and prison, albeit this was not consistent), and also other systems (for example, although not explored extensively here, this includes safeguarding for Owen, as well as Prevent/Channel).

3.2.9 A review is an opportunity for agencies to consider their response to domestic abuse, individually and in partnership. Reflecting this, both single and DHR recommendations have been made to address the learning identified. Taken together, the Review Panel hopes that the work of individual agencies and the Safer Cornwall / Kernow Salwa CSP will be underpinned by a recognition that the response to domestic abuse is a shared responsibility as it is everybody's business to make the future safer for others.

4. Recommendations

4.1 Single Agency Recommendations

4.1.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section 5 following the analysis of contact by each agency.

4.1.2 These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to the Safer Cornwall / Kernow Salwa CSP.

General Practitioner (GP) (facilitated by Cornwall and Isles of Scilly ICB)

Single Agency Recommendation 1: The ICB and Cornwall Council present a business case to the ICB to request sustained funding to continue the primary care domestic abuse and sexual violence service by the end of April 2022 (note this has already been written).

Single Agency Recommendation 2: The ICB informs Safer Cornwall about the outcome of the business case by September 2023 and an update of the plans how the ICB intends to continue to support improvements in general practice.

Single Agency Recommendation 3: The ICB provides assurance to Safer Cornwall that there is sustained improvement in the recognition of less obvious signs of abuse outside intimate partner relationships by the end of April 2024.

Single Agency Recommendation 4: The ICB provides Safer Cornwall with assurance that the Domestic Abuse Act 2021 is referenced in the contracts with providers, including GPs. This should be provided by April 2025 or an update of why this has not taken place (change due to what is appropriate to reference in a report about an agency that was not on the panel and date due to contracting cycle).

Single Agency Recommendation 5: The ICB develops and circulates a domestic abuse policy template for use in general practice by the end of March 2025.

Single Agency Recommendation 6: The specific learning from this IMR in relation to signs of domestic abuse and abuse outside of partner and spousal relationships will be disseminated to all general practices in Cornwall one month after the final draft of the report is completed.

CFT/ RCHT

Single Agency Recommendation 1: Ongoing MARAC audit to be established - documentation and flags.

Single Agency Recommendation 2: Develop a guidance checklist for safeguarding meetings and conferences for the safeguarding team on who to invite to safeguarding meetings and conferences.

Single Agency Recommendation 3: CMHT Team managers will not case hold.

HMP Exeter

Single Agency Recommendation 1: Can be a propensity for statements made by mentally unwell prisoners to be attributed to their mental health as opposed to possible triggers to inform risk assessments.

Single Agency Recommendation 2: Prison staff in an offender management role to explore more fully any statements made by prisoners which relate to the circumstances and context of a prisoner's offence, especially when this involves known victims.

Single Agency Recommendation 3: For any diagnosis made by prison mental health team to be shared with prison offender management unit.

Probation Service

Single Agency Recommendation 1: To ensure that practitioners' workloads do not exceed 110% on the Workload Measurement Tool.

Single Agency Recommendation 2: To continue to prioritise recruitment of staff where there are vacancies in the PDU.

Single Agency Recommendation 3: To prioritise training and continuous professional development for all staff.

Single Agency Recommendation 4: To ensure that cases are allocated to the appropriate grade of staff based on risk and complexity.

First Light

Single Agency Recommendation 1: To produce clear guidance of information required when making a referral to the service.

Single Agency Recommendation 2: First Light to review the online referral form and potentially include mandatory fields for professionals.

Single Agency Recommendation 3: All assessments to consider wider family members, especially when inter-familiar abuse is identified, including reviewing assessment forms and providing training for staff (in house and additional training around AFV).

Cornwall Council – Adult Social Care Services

Single Agency Recommendation 1: All safeguarding interventions consider wide family members, when inter-familiar abuse is identified.

Single Agency Recommendation 2: When assessing needs around "Maintaining Family Relationships", in accordance with either section 9 or 11 of the Care Act, Adult Social Care professionals should explore transferable risks to other family members

Cornwall Council – Housing Options

Single Agency Recommendation 1: Set service standards for call-backs:

- Agree timescales by which a customer should receive a telephone call-back.

- Agree an escalation procedure with the Contact Centre to follow if a customer makes repeat calls without response.
- Create guidance for placement officers a policy for contacting clients to make accommodation offers, to include making contact with partner agencies (where consent is held).
-

Single Agency Recommendation 2: Enhance prison and offender working:

- Embed specialist working in the housing options service dealing with ex-offenders.
- All ex-offenders released from prison in the last 12 months and under supervision from probation will be allocated to a specialist worker, in accordance with the prisoner pathway.
- Create closer communication channels with Probation and offender services including a named point of contact, through Homeless Prevention Taskforce.
- Ensure referrals are all received through the agreed pathway, in conjunction with Probation, the Prison.
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Single Agency Recommendation 3: Agree standards of casework supervision, including frequency of supervision meetings and their content which includes 'challenging' cases. To include:

- Monitoring to ensure that these standards are being met.
- Creating guidance for caseworkers on dealing with customers that present difficulties to caseworker by aggressive behaviour, including unreasonable customer behaviour guidance.
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Single Agency Recommendation 4: Provide guidance and check expectations of casework officers on dealing with cases allocated to them that present as an emergency and deliver further training to staff on homelessness duties including:

- Ending the s189B relief duty.
- Making enquiries to comply with s184 duty.
- Investigating priority need and making the s188 interim accommodation decision.
- S177 homeless due to risk of violence.

4.2 DHR Recommendations

4.2.1 The Review Panel has made the following recommendations during this review in response to learning identified. These are described in section 5 as part of the analysis.

4.2.2 The Safer Cornwall / Kernow Salwa CSP is responsible for overseeing then development and monitoring of an action plan.

DHR Recommendation 1: As part of the revised statutory guidance, the Home Office to clarify expectations around the release of underlying documentation during a review, including single agency reviews.

DHR Recommendation 2: The Safer Cornwall / Kernow Salwa CSP to work with local partners to review the findings from this and other local DHRs involving killings by an

(adult) child or a family member to identify cross-cutting themes and issues and develop a thematic response

DHR Recommendation 3: The Safer Cornwall / Kernow Salwa CSP to work with local partners to review the findings and develop a thematic response to violence and abuse by a child or a family member. This should include:

- Developing evidence of the local need.
- Ensuring professionals and agencies are able to recognise, identify, assess, and respond.
- Establishing robust referral pathways to specialist support.
- Completing a training needs assessment to identify the skills and training required by professionals to enable this response.
- Identifying the actions that agencies can take individually and collectively.

DHR Recommendation 4: CFT to ensure that the Independent Investigation recommendations are implemented and presented to the trust quality assurance committee to enable the ICB oversight required by NHS England. CFT will then provide updates as required to Safer Cornwall / Kernow Salwa CSP so that these can be discharged.

DHR Recommendation 5: The Safer Cornwall / Kernow Salwa CSP to review the existing MARAC Operating Protocol and introduce – in line with SafeLives guidance – a referral route for potential for escalation based on the frequency of abuse.

DHR Recommendation 6: Using the learning from this case, the Safer Cornwall / Kernow Salwa CSP to audit the effectiveness of MARAC action planning, with a particular focus on AFV and complex cases.

DHR Recommendation 7: The ICB and Cornwall Council to develop a business case to the ICB to agree sustained funding to continue the General Practice Domestic Abuse Support Service after July 2025.

DHR Recommendation 8: The Safer Cornwall / Kernow Salwa CSP to work with local partners to review the findings from this DHR and evaluate the response to neurodiversity locally.

DHR Recommendation 9: The Safer Cornwall / Kernow Salwa CSP to work with Cornwall Council – Housing Options to remind the public bodies listed in Homelessness (Review Procedures etc) Regulations 2018 of their legal obligation to refer people that are homeless. Circulate guidance for partners on this topic, including the procedure to use when making a referral to the housing options service in Cornwall.