SAFER CORNWALL
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Introduction: The Safer Cornwall Partnership undertook a Domestic Homicide Review (DHR) into the death of a woman aged 32, who for the purposes of the review was known as Dolly. Dolly was killed by her partner, known as Adult B for the purpose of the report. The purpose of the review was to establish lessons to be learned from the domestic homicide, regarding the way in which local professionals and organisations work individually and together to safeguard victims.

Dolly lived in Cornwall with her partner Adult B. Dolly had three children; 2 sons and a daughter, who were not resident with the couple at the time of Dolly's death. The couple had known each other since school and had been in a relationship since 2008. Dolly and Adult B had a complex relationship. They both experienced difficulties with their mental health, drug and alcohol use and homelessness. Dolly experienced significant trauma as a child and, as an adult, faced the loss of her children through intervention by the Police and Social Care.

Reviewing domestic homicides are a way to improve our local coordinated community response. Looking at the death of a person aged 16+ as a result of DVA, reviews aim to:
- understand what happened;
- identify where agency responses could be improved;
- learn lessons including how agencies work together;
- identify how to improve responses;
-and to prevent something similar happening to others in the future.

Learning Arising from the Review.

Recognition of domestic abuse where other vulnerabilities are present. The levels of knowledge and understanding of domestic abuse across services were variable. It was evident that the level of vulnerability, including drug and alcohol use and mental health, often masked the domestic abuse and led services to not engage in routine enquiry or to question safety. The need for better awareness of domestic abuse, particularly coercion and control, and how this can be compounded with other complexities is a key learning point within this review.

Support for those with multiple vulnerabilities. The complex needs of homeless and transient people and those with multiple vulnerabilities are not always well understood or responded to. They may pose particular risks to themselves or others and identifying these is key to be being able to respond effectively. The review highlighted the need for robust and routine liaison between agencies in order to triangulate information and prioritise response. It also highlighted the need for accurate and timely recording of interventions and decisions. In particular, the need to ensure multi-disciplinary discussions and to properly record those discussions in sufficient detail. A key learning point was the need to provide persistent and assertive outreach support for individuals who are at risk and who have multiple vulnerabilities.

Need for better understanding of the impact of trauma and its effect on future behaviour, relationships, health and wellbeing. The agencies involved tended to focus on their own specific role and not take into account wider factors or determinants in relation the issues that Dolly and Adult B experienced now, or in the past. Each vulnerability was dealt with in isolation rather than the combined impact of them all. This meant that no comprehensive holistic picture emerged. The significant emotional distress during Dolly's childhood, which included physical and sexual abuse, and the impact of these Adverse Childhood Experiences on her psychological health and wellbeing does not appear to have informed the thinking of those professionals working with her.

It is unclear whether the impact of the removal of her children was considered at the time and whether support was offered to Dolly by services. The review highlighted the need to have a better understanding of the impact of, and an offer of support available, for those with multiple vulnerabilities who have a child/children removed.

Domestic Homicide Review process in CIoS. This review highlighted the need for better and more consistent family support throughout the DHR process within Cornwall. There is a need to ensure families are integral to the review process, and involved at the earliest stage, remaining essential stakeholders throughout the review. This DHR has also highlighted the need for organisations to be better equipped to respond to requests for IMRs and to more fully understand the need to prioritise their completion, to do so in a meaningful way and to seek and accept support in their completion when needed.