SAFER CORNWALL

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REVIEW DHRS1

INTO THE DEATH OF ADULT A - MARCH 2017

EXECUTIVE SUMMARY

Report Author and Independent Chair

Martine Cotter MCIM

Report Completed – September 2018

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. The unexpected death of a family member is never easy to come to terms with, particularly following a suicide, which often leaves so many unanswered questions for the loved ones left behind. We hope this Domestic Homicide Review helps to answer some important questions relating to the events leading up to Adult A's tragic death.

The Independent Chair and Author of the Review would also like to express her appreciation for the time, commitment, and valuable contributions of the Review Panel Members and the authors of the Individual Management Reviews from which the foundation of the analysis of the main Overview Report and this Executive Summary is formed.

This Review has been complex in terms of its timescale for review and the level of agency contact prior to Adult A's death. The Panel has carefully considered many issues concerning Adult A and her past and most recent relationships to shape these findings. We believe there is important learning for all agencies from this Review, chiefly when responding to individuals and couples who lead complex, chaotic and conflict-ridden lifestyles.

In undertaking this Domestic Homicide Review, the Safer Cornwall Review Panel aims to raise awareness of suicide and the links to often controlling or damaging relationships. Although this Review does not seek to identify who, if anyone, was culpable for Adult A's suicide, it does hope to highlight areas of potential improvement for professionals and agencies in how they respond and support couples who wish to stay together, despite the warnings and high risks.

Contents

THE REVIEW PROCESS

1) This summary outlines the process undertaken by the Safer Cornwall Partnership Domestic Homicide Review Panel in reviewing the death of a resident in the county of Cornwall.

2) Following an emergency 999 call for an ambulance in March 2017, the body of Adult A was found hanging from a tree at a local park. In the hour leading up to the event, Adult A had been arguing with her husband, Adult B. They became separated during the disagreement and Adult A sent a text message to her sister, who had been socialising with the couple during the course of the evening, stating that she could no longer cope with the relationship. Paramedics arrived at the scene and administered CPR. Adult A was conveyed to hospital and placed on life support. Life support was removed 24 hours later, and Adult A was pronounced deceased on (redacted) March 2017

3) Although Adult A took her own life, a routine check of her information against a database for high risk domestic abuse cases (Multi Agency Risk Assessment Conferences (MARACs) revealed that she was known to professional agencies. Consequently, and in line with Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016), a Review was commissioned by Cornwall Council on behalf of Safer Cornwall (Cornwall's Community Safety Partnership) to establish if abusive behaviours contributed to Adult A's decision to end her life.

4) The Home Office was notified of this decision on 25th April 2017 as required by statute. The Review was concluded 12th September 2018. This is over the statutory guidance timescale for the completion of a Domestic Homicide Review due to delays receiving full Individual Management Reviews (IMRs) from statutory agencies and the unexpected departure of the Strategy Lead for Domestic Abuse & Sexual Violence and Serious & Organised Crime from the Safer Cornwall Partnership in May 2018. The Review remained confidential until the Safer Cornwall Partnership received approval for publication by the Home Office Quality Assurance Panel.

5) The Domestic Homicide Review examined agency responses and support given to Adult A from the commencement of her relationship with Adult B in 2013 leading up to the point of her death in March 2017. In addition to agency involvement, the Review also examined her early family life and past relationships to identify any relevant background or history of abuse before her suicide.

Agencies Participating in the Review

6) A total of 16 agencies were contacted at the start of the Review to establish any engagement with Adult A or Adult B. 12 organisations responded has having had involvement with the individuals involved; 3 had no contact and one charitable agency did not respond to requests. Agencies participating in this Review and the method of their contributions were:

B. Agency/Professional	Information obtained
(REDACTED) General Medical Practice	Chronology and IMR
Children's Family Services	Chronology and IMR
Devon and Cornwall Police	Chronology and IMR
Dorset, Devon and Cornwall Community Rehabilitation Company	Chronology and IMR
Cornwall Hospitals NHS Trust	Chronology
Addaction (Drug and Alcohol Service)	Chronology and IMR
Cornwall Partnership NHS Foundation Trust (Mental Health Services)	Chronology and IMR
Education and Early Years	Chronology and IMR
Cornwall Housing	Chronology and IMR
Southwest Ambulance Trust	Chronology and IMR
Cornwall Council Anti-Social Behaviour Team	Chronology and IMR
Commissioned Domestic Abuse Provider (Voluntary Organisation)	Chronology and IMR

7) In line with statutory guidance pseudonyms have been used for the victim and perpetrator throughout the Review to protect their identity and those of their family members. To fulfil this duty the Independent Chair asked Adult A's mother for an appropriate pseudonym for the Overview Report and Executive Summary. After some consideration, Adult A's mother preferred to proceed with the initial allocation of Adult A. This pseudonym was used throughout the Review. Her husband is referred to as Adult B.

8) Adult A was 36 years old at the time of her death. Her husband, Adult B, is 37 (at the date of this report). Both were/are white British Nationals with no physical or learning disabilities. Adult A and Adult B were married in August 2016. They were in a relationship for approximately 5 years. They did not have any children together. Adult A had two children from a previous relationship who were cared for full-time by their maternal grandmother and Adult B has two children from a previous relationship. They remain estranged.

9) There is no evidence that Adult A or Adult B were directly or indirectly discriminated against by any agency based on the nine protected characteristics of people who use services under the Equality Act 2010 (e.g. disability, sex (gender), gender reassignment, pregnancy and maternity, race, Religion or belief, sexual orientation, age, marriage or civil partnership).

Purpose of the Review:

10) 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; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- To seek to establish whether the events leading to the homicide could have been predicted or prevented.

Specific Terms of Reference for this Review:

- To review events between 1st January 2013 up to the date of the death of Adult A on (REDACTED) March 2017 (the duration of the relationship between Adult A and Adult B) and any relevant events from Adult A's early life and relationships as deemed pertinent by the Independent Chair;

- To review the actions of the agencies involved with Adult A and address whether the incident in which Adult A died was a 'one off' or whether there were any warning signs that would indicate that more could be done in Cornwall to raise awareness of services available to vulnerable victims and couples experiencing domestic abuse;

- To seek to involve family, friends, neighbours or colleagues to participate in the Review and establish whether they were aware of any abusive or concerning behaviour from Adult B towards Adult A (or other persons), prior to the suicide and include their potential contribution to the Review in the way set out within the Review framework;

- To establish whether there were any barriers experienced by the family/ friends/colleagues in reporting any abuse or concerns in Cornwall or elsewhere, including whether they (or Adult A) knew how to report domestic abuse had they wanted to;

- To identify whether there were opportunities for Professionals to enquire or raise concerns about domestic abuse (financial or otherwise) experienced by Adult A;

- To establish whether Adult B had any previous concerning conduct or a history of abusive behaviour to an intimate partner and whether this was known to any agencies;

- To identify whether there were opportunities for agency intervention in relation to Adult B (e.g. behavioural difficulties, education, criminal activities or drug/alcohol addictions) that were missed;

- To identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the county;

- To give appropriate consideration to any equality and diversity issues that appear pertinent to Adult A, Adult B or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

- To consider any other information that is found to be relevant

11) This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for the Coroner's Office.

Involvement of Family and Friends

12) As soon as a Domestic Homicide Review was commissioned, the family of Adult A were notified in writing with an invitation to participate in the Review. A Home Office leaflet for friends and family members was included. A meeting was scheduled at a local hotel (their preferred venue) on the 9th February 2018. Four members of the Review Panel were present together with six family members and associates of Adult A.

13) Adult B was contacted separately. He contributed to the Review via a telephone conference call. All discussions were recorded and transcribed. The purpose of the discussions was to hear about Adult A's life according to those who loved and cared about her. The discussions were frank, honest and deeply insightful.

14) A copy of the full Overview Report was shared with Adult A's family on the 19th September 2018 at a local hotel. Adult B viewed it separately on the 9th October 2018. They were each given a whole day in private to read the full report. Both the Independent Chair and the Panel Member representing Drug and Alcohol Services were available to hear feedback, answer questions and receive suggested amendments/clarifications.

Panel Members and Independent Chair

15) 10 professionals from 9 different organisations were appointed as Panel Members according to the specific modus operandi of the Domestic Homicide Review. The Safer Cornwall Partnership commissioned Martine Cotter, a Home Office accredited DHR Chair, as Independent Chair 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.

16) The Panel Members and Independent Chair all confirmed that they did not have direct line management of any professional involved with Adult A or Adult B, nor did they have any contact, personally or professionally with Adult A, Adult B or their family. The Independent Chair was completely independent of the Safer Cornwall Partnership and any associated organisations in Cornwall.

THE FACTS

15. Adult A was born in 1980 and lived in Cornwall with her husband Adult B in a council property. The tenancy was in Adult A's name. The property was shared with a young male friend of Adult A (G1) who Adult A rescued from the streets when he was 15 years old. Other family members were also known to stay at the property from time to time.

16. Adult A and Adult B met in 2013 following Adult B's release from prison for a domestic abuse offence against a previous partner. From the beginning, the relationship was often volatile. The first Police call-out for violence was recorded just 3 weeks into the new relationship. Adult B worked briefly at the start of the relationship, but within weeks, surrendered his employment. For the remaining duration of their relationship, neither partner was in paid employment. Both accessed professional support for problems linked to low-mood, self-harming, alcohol and substance misuse.

17. Adult A was a prolific shoplifter for much of her youth and adult life. She was arrested and convicted in excess of 30 times for theft. A custodial sentence in 2008 for shoplifting resulted in Adult A's children being placed full-time with their maternal grandmother. Adult A never regained custody of her children. She was an amphetamine user and heavy drinker, for which she sought professional help but did not commit to treatment.

18. Adult B also has a long history of offending with at least 25 convictions for over 63 offences including vehicle related crimes, theft, burglary, violence offences including ABH, battery and assaults on Police. Adult B has a propensity for violence and has disclosed his severe aggression to professionals, identifying alcohol as a trigger. He was classed as a Domestic Abuse Serious and

Serial Perpetrator (DASSP) between 2013 and 2014. During the course of their relationship, Adult B was ordered to undertake an alcohol treatment programme. He stopped drinking habitually which he feels removed an important trigger for previous violence. He continued to use cannabis.

19. Adult A and Adult B lived chaotic lifestyles, plagued by episodes of alcohol, drugs, crime and violence. They argued and fought frequently but often declined support when it was offered and refused to separate, despite a court order and pleas from family and friends. Their relationship was conflict-ridden with numerous triggers that caused verbal aggression to escalate to physical violence.

20. In the early hours of (REDACTED) March 2017, the couple had been socialising with Adult A's sister and were returning from a venue following a night out. An argument ensued between Adult A and Adult B which caused Adult B to run off. Adult A encouraged her sister to chase him. They returned to Adult A's home address where he and Adult A's sister continued to argue. Adult A stayed near the city centre (the distance between the two locations being approximately one mile). Frantic with concern for her sister and husband, Adult A stopped a passing ambulance on a 999 call. The paramedics tried to calm Adult A in the back of the ambulance, but she was incoherent, repeating in an upset and disjointed manner, "I NEED HELP, RUNNING OUT OF MEDICATION, BOYFRIEND, SISTER…' before running out. An Ambulance Clinician gave chase but could not keep up. He returned to the ambulance, informed the control room, and resumed to their original 999 call. In the meantime, Adult A sent a series of text messages to her sister stating that she could no longer cope with the relationship and was preparing to take her own life.

21. The first text message sent at 02.05am read; *"Sorry (REDACTED - SISTER) I can't do this no more. Remember I love u all and I'm sorry ok xxxxxx", followed* by, *"My phone is gona die. Can you make sure (REDACTED CHILD) gets my phone. Sorry (REDACTED - SISTER) don't mean to hurt any of u. I just can't b in this world anymore it's not for me. I'm sorry n I love u and (REDACTED CHILD) and (REDACTED CHILD). I'm so sorry bye xxx".* A third text message sent moments later read; *"Tell (REDACTED HUSBAND) I'm sorry [sad emoji] I just can't cope no more (REDACTED SISTER) he treats me like sh*t then runs away wtf have I done. I don't deserve to die nor do my kids need this pain but I'm sorry he don't give a f*ck about me".* The fourth and final text message simply read, *"Help".*

22. On receiving the text messages, Adult A's sister called for an ambulance and informed them of her likely location. Paramedics arrived and found Adult A hanging from a tree by a rope with no pulse. Ambulance Clinicians instigated advanced life support which resulted in a return of spontaneous circulation and Adult A was rushed to the nearest hospital. She remained on life support until it was switched off the following day.

23. A Post Mortem was carried out in Plymouth on the (REDACTED) by Pathologist Dr. P. Malcolm. The cause of death was recorded as hypoxic brain injury caused by hanging. A Coroner's Inquest was opened and adjourned.

24. No persons have been charged in relation to Adult A's death. There is no ongoing criminal investigation, however Devon and Cornwall Police did undertake preliminary investigations into the events surrounding Adult A's decision to take her own life.

25. In view of the text message sent by Adult A minutes prior to her hanging, outlining her dissatisfaction at her relationship with Adult B, and Adult A's family's belief that she would still be here today if it was not for the violence she encountered from Adult B, the Safer Cornwall Partnership commissioned this Domestic Homicide Review to better understand the role of domestic violence in Adult A's suicide.

Early History

26. Adult A and Adult B both experienced adverse childhood events. They both witnessed serious domestic abuse as children and were both taken into care at an early age. Both Adult A and Adult B experimented with drugs and alcohol during their teenage years and were placed in secure residential establishments before the age of 16 for criminal activity. Adult A reported living on the streets periodically from the age of 13. Both were first assessed by Mental Health Services aged 17.

27. Adult A discovered she was pregnant in prison when she was 18 years old (1998). She was very happy about becoming a mum and wanted to give her child the life she craved so badly. On release from prison, aged 19, Adult A was drug, drink and crime free. Her partner at the time, and father of the child, was supportive and considered a good influence. Adult A fell pregnant quickly after her

first child was born (2nd child born 11 months after the 1st). After the birth of her second child, Adult A began to drink and consume drugs again, resulting in her partner leaving the family home. In May 2002 both children were placed on a Child Protection Register for neglect for a period of 12 months. They were later removed from her care permanently and placed full time with Adult A's mother.

28. Adult B's first child was born in 1998 when Adult B was 18 years old. His second child was born two years later. He has had no recent contact with his children and does not know where they are.

29. Adult A was diagnosed with an emotionally unstable personality disorder aged 17. Adult B was diagnosed with an emotionally unstable personality disorder with some anti-social personality traits aged 21 (which was confirmed again in 2005 whilst he was in prison).

Agency Involvement

30. The IMR's recorded over 165 individual contacts with Adult A and Adult B during the scope of the Review (2013 – 2017). 40 contacts were recorded in 2013, 54 in 2014, 19 during 2015, 32 in 2016 and 9 in the first three months of 2017.

31. Adult A was comprehensively assessed 8 times by the Psychiatric Liaison Service and Community Mental Health Team (CMHT) during the scope of the Review. Adult B was assessed by Psychiatric Services 5 times. Adult A's case was open to Mental Health Services on one occasion for a short period of time but was closed soon after due to non-engagement. Adult B was denied long-term therapeutic intervention until he sought to resolve his drug and alcohol addictions.

32. Adult A and Adult B"s diagnosis of emotionally unstable personality disorder 'EUPD' (with Adult B's additional anti-social personality traits) added a further level of complexity for clinical professionals as their behaviours were largely attributable to their clinical diagnosis. Their offending behaviour, homelessness, substance misuse, self-harming and domestic abuse, together with their long-standing patterns of violence and aggression were exacerbated by aspects of their personality disorders. Their behaviour was often viewed through the lens of their clinical diagnosis with little evidence of professionals recognising and documenting their understanding of how their clinical presentation significantly increased the social risk of domestic abuse.

33. Adult A required medical intervention for deliberate self-harm on 11 occasions during the scope of the Review, usually whilst intoxicated with alcohol, and against a backdrop of psycho-social stressors, of which 6 were serious attempts on her life. Adult B also deliberately self-harmed, usually by cutting or overdose, and reported attempts to Mental Health Services on 5 occasions between 2013 and 2017.

34. Adult A was a regular attendee or caller to her GP practice during the scope of the review with at least 118 face-to-face or telephone contacts recorded for issues linked to low mood, self-harm, addiction, domestic abuse, suicidal thoughts and medication needs. Adult A became increasingly desperate and erratic in her attempts to gain prescribed medication in her final weeks of life, requesting medication over 30 times from 8 different GPs, causing concern and instigating a further referral to Mental Health Services in 2017, which Adult A sadly did not attend. Her very last words to an Ambulance Clinician on the evening of the (REDACTED) March 2017, when she stopped a passing ambulance on a 999 call-out was *'I NEED HELP, RUNNING OUT OF MEDICATION, BOYFRIEND, SISTER...'* – evidencing that her desperation for medication was still an issue right up to the very last moments of her life.

35. Both Adult A and Adult B were ordered to attend an Alcohol Treatment Requirement (ATR) during the scope of the Review. They attended Addaction a total of 29 times between 2013 and 2015 and failed to attend 38 times. On completion of the ATR's Adult B purported to be abstinent of alcohol but continued to use cannabis. Adult A did not successfully address her alcohol and substance misuse issues. Her pattern of binge drinking, attempted periods of abstinence, relapses and repeated efforts to reduce consumption remained a constant battle for Adult A during the 5 years examined by the Review Panel. She openly discussed her alcohol consumption, cannabis and amphetamine use, and her misuse of prescribed medication with her GP Practice, Addaction, Psychiatric Liaison (REDACTED Hospital), The Criminal Justice Diversion Team, the Community Mental Health Team, Outlook Southwest and the National Probation Service.

36. Devon and Cornwall Police were called to 10 incidents involving Adult A and Adult B during the Scope of the Review. Of these 9 were domestic abuse incidents, of which 7 required the attendance of the Southwest Ambulance Service. Adult A's case was referred to MARAC on two occasions (2013 and 2014). Devon and Cornwall Police pursued a victimless prosecution and

applied for a DVPO in 2014 but Adult A threatened to kill herself if the court applied a no-contact restriction on them. Adult B was monitored as a Domestic Abuse Serial and Serious Perpetrator (DASSP) between January 2013 and October 2014. On all 9 occasions the Police were contacted for domestic abuse incidents, Adult A refused to undertake a DASH risk assessment. She did not have a positive view of the Police and would regularly plead to neighbours, friends and family not to contact them. On all but two occasions, Adult A's risk was defaulted to 'standard' because the context of the domestic abuse she was experiencing could not be quantified. This practice by first response Officers has since been flagged and addressed as an area of improvement.

37. Adult A and Adult B were the subject of an Anti-Social Behaviour Warning for a 3-month period in 2016 following a mass brawl in the city centre involving Adult A and Adult B and a group of individuals. Those who were involved were intoxicated. Adult A and Adult B were cited as the individuals causing anti-social behaviour. The Police and an Anti-Social Behaviour Caseworker attended the property of Adult A and Adult B to issue them with a Stage-2 anti-social behaviour warning. They were both considered a risk to others when under the influence of alcohol. They were not considered a risk to each other.

38. Both Adult A and Adult B were supervised by the Devon, Dorset and Cornwall Rehabilitation Company (previously the Probation Service) for much of their adult life, including during the scope of the Review (2013 – 2015) for criminal offences linked to theft and assault. They both successfully satisfied the conditions of their sentence with the last contact completed in January 2015.

39. Long-term professional support, beyond that of crisis intervention, was challenging for all agencies as there was a constant problem with long-term engagement for both Adult A and Adult B. They failed to attend more appointments that they managed to attend during the scope of the Review. Adult A and Adult B's multiple complex ongoing needs required a commitment from them to overcome, yet, their chaotic lifestyle made engagement with long-term treatment problematic. Additionally, some treatment options were conditional on addressing one issue at a time (e.g. Mental Health Services required alcohol and drug misuse to be addressed first), which contributed to their challenges and presented barriers to support.

40. Overall, Adult A's complex needs, and chaotic lifestyle was well known by over 15 statutory and voluntary organisations, and 8 organisations for Adult B (based on information available to the Review panel). They were familiar individuals in the area in which they lived. As such, they were frequent attendees to drug/alcohol/health services and the custody suite. They engaged

intermittently with services and made some effort to seek help for their issues but struggled to commit to long-term treatment. There is evidence that their requests were taken seriously by professionals, even if there was a sense of not knowing what else could be achieved to help them.

CONCLUSIONS

Conclusion 1:

1. Nobody saw a 'victim'. Adult A's life was a woeful tale of addiction, abuse, loss and depression. The five years examined during this Review provides a mere glimpse into the daily struggles Adult A endured during her short life. Externally she portrayed a strong and resilient woman. Her friends and family talked of a tough, hardy and spirited person, always smiling and seemingly happy with the madness of her life. Professionals observed Adult A as a strong and independent lady who did not present with any vulnerability. Yet this representation did not correspond with the desperate, fragile and vulnerable woman who masked the pain of her childhood through addiction - often inflicting horrific wounds to herself - whilst resisting violence from her husband, funding her safety and his illicit drug habit through stealing, and trying to maintain a relationship with her children, all the while mourning the loss of a parent and sibling. Even though there was a genuine risk to Adult A's safety, health and wellbeing, which was very evident, professionals did not consider Adult A to be vulnerable (in practice), and therefore never escalated concerns to management or raised internal safeguarding referrals/alerts as per company policy.

Conclusion 2:

2. There was a gap between *what was known* and *what to do with what was known*. Lack of knowledge was not an issue in this Review. The amount of information known to professionals was quite troubling. The challenge was pulling it all together to form the bigger picture. However, even if all the information available had been shared, and understood, there was always a sense of not knowing what else to do to help. A diagnosis of emotionally unstable personality disorder added an extra layer of difficulty in terms of Adult A and Adult B accessing and engaging with services. There are no easy solutions to address the behaviours associated with EUPD. Adult A and Adult B's multiple complex ongoing needs required a commitment from them to overcome, yet, their chaotic lifestyle made engagement with long-term treatment problematic. To some extent, Adult A and Adult B were caught in a *'catch 22'* position. They needed help to access help.

Conclusion 3:

3. **There was a shortcoming in the response of agencies to create a formal multi-professional, multi-agency joint care plan to treat Adult A or Adult B, who were both complex individuals with multiple needs.** The current system requires individuals to *mould* their issues to bypass the referral criteria for acceptance for treatment, which encourages service users to be untruthful about their real situation to avoid a decline in assistance. This was evidenced by Adult A and Adult B's attempts to minimise their alcohol consumption to access help from Mental Health Services. Rather than *'working with what is presented'* and assessing the needs of the whole person, Adult A and Adult B's issues were decompartmentalised and addressed separately in a sequential fashion (e.g. alcohol/drugs/mental health/domestic abuse/criminal offending/parenting/self-harm) with no clear responsibility for decisions and actions

Conclusion 4:

4. **Professionals made assumptions.** Engagement remained the greatest stumbling block for professionals. Even Adult A's family felt that the effectiveness of agencies to help Adult A was always hindered by her willingness to engage with services. This posed an ethical debate around mental capacity, with some professionals viewing Adult A and Adult B's willingness and commitment to engage with help as a matter of choice (with them both having the mental capacity to make that decision (CMHT), yet, little consideration was given to coercive control and whether Adult A was experiencing duress or intimidation. This was evident in the practice of defaulting the risk to standard when Adult A refused a DASH risk assessment or closing her case due to non-attendance. Assumptions were made about her liberty to act or engage with help, without fear or retribution. Professionals never even attempted to rule out a power and control dynamic in the wake of a domestic abuse disclosure. Adult A's version of events, and her reassurances, were always accepted without question. There was no evidence to suggest that professionals considered the context of the violence between Adult A and Adult B, which highlights a concern about their readiness to respond to, and report, the new offence of Controlling or Coercive Behaviour in an Intimate or Family Relationship under section 76 of the Serious Crime Act 2015.

Conclusion 5:

5. **There was no triangulation of information or intelligence to enable practitioners to accurately identify, assess and manage the level of risk.** Different systems used by criminal justice agencies, charities, healthcare providers and mental health services resulted in most incidents being viewed in isolation of each other. Even when intelligence was available, professionals did not exhibit

enough professional curiosity to establish if there was a previous pattern of behaviours or a relevant history of events. Similarly, there was no way of tracking Adult B's behaviour or anticipating the importance and significance of information held about him, or indirectly linked to him. For example, Housing Services held a vital piece of information which identified an emerging MO for Adult B, which indicated a dangerous level of escalation for Adult A. Its significance was missed because there was no prior information or reason to believe that it was suspicious (he was not supposed to be living there). Only when this full Review was commissioned, after the tragic death of Adult A, did this information come to light - yet it was always available and accessible. This raises a crucial ethical question; *'if we know it can be done, why do we wait until after a death to do it?*

Conclusion 6:

6. Professionals did not communicate with each other. The lack of multi-agency communication enabled Adult A to take full advantage and tell different accounts of events to different professionals. These accounts were accepted as the truth and no attempts were made to validate information by contacting professional partners. For example, Adult A told Housing Services that a domestic abuse incident on the 8th September 2013 was actually screaming from a football match. A simple call to the Police to validate this account would have revealed an entirely different version of events. If electronic systems between agencies do not 'talk', then it is imperative that professionals overcome this barrier by finding ways to communicate information between departments/organisations. On occasions, the communication between teams working within the same organisation was also inadequate, particularly around the management of MARAC information (CMHT and Probation), with some practitioners communicating that they still do not fully understand the purpose or benefit of this information exchange.

Conclusion 7:

7. Professionals did what they have always done, because that's the way they've always done it. Agencies responded to Adult A and Adult B as separate individuals, with separate needs, even though their lives were intrinsically linked to each other's behaviour. Throughout the scope of the Review Adult A and Adult B often attended appointments immediately after each other (GP, Addaction and Probation). Whilst current practice would promote independent appointments, providing individuals with the opportunity to speak freely, there is also an argument for combining appointments when two people express a desire to be seen together (see Adult B's contribution). It would also enable professionals to observe the interaction and behaviour between couples, at least for a period of time, to establish the presence, or absence, of a power and control dynamic (following disclosures of domestic abuse). Adult A clearly communicated her desire to stay with

Adult B, even though she knew the risks. Any attempt to separate them, by family members or professionals, only served to increase their stress and create more conflict – thus increase the risk. It is therefore important that professionals consider new ways of working to reduce risk, increase engagement and achieve better outcomes. Domestic abuse is not a unitary phenomenon and a one-size fits-all response is not always productive. Seeing Adult A and Adult B as a complex couple, rather than complex individuals – and listening to their requests – could have created a good starting point for progress, particularly around their communication needs, conflict resolution, detox and alcohol/drug treatment.

Conclusion 8:

8. Agencies did not risk assess their own intervention. Adult A and Adult B's relationship was fraught with problems, many of which were exacerbated by their EUPD, lifestyle and addictions. The risk was always dynamic and could intensify quickly and dangerously, resulting in physical injuries and serious incidents of deliberate self-harm or suicide attempts. There was little evidence that this precarious dynamic was understood when professionals risk assessed an incident (often concluding that Adult A was at standard or moderate risk of harm), or when adopting strategies for responding to episodes of crisis (e.g. pursuing a victimless prosecution or enforcing a DVPO without multi-agency discussion/clinical opinion). It did not take much to add stress to Adult A's life. The refusal of a script, or the delivery of an anti-social behaviour warning simply added pressure to an already troubled existence. Whilst these sanctions are necessary, agencies should evidence that they have at least considered and recorded the potential consequences of professional intervention and tried to mitigate against the increased risk to Adult A's life.

Conclusion 9:

9. Risk still exists. The Review examined three high-risk domestic abuse relationships between Adult A, Adult B and two previous partners (P2 and P3). Adult A was in a long-standing relationship with P2 for a period of 8-10 years. During their relationship, there were reports of sexual abuse towards Adult A's children, a gun being held to her eldest child, incidents of high-risk domestic abuse, financial control, jealousy, surveillance and criminal activity. P3 was a professional who breached his position of trust to take advantage of Adult A. He was investigated and discharged from his post for coercive and controlling abuse, including stalking and harassment of Adult A. Finally, Adult B had a history of domestic abuse, including a previous conviction for false imprisonment and assault. Yet all three individuals were living in our communities completely unmonitored. Devon and Cornwall Police have since added an intelligence marker to Adult B's name in view of this DHR to request that Officers call the Serious Case Review Team for further instruction if they are called to another incident involving Adult B. However, Safer Cornwall will need to consider a

similar risk management strategy for other known high-risk domestic abuse perpetrators throughout the county who pose a significant ongoing risk to future partners and children.

Correspondingly, there is also an ongoing risk that children in Cornwall who are currently experiencing multiple adverse childhood experiences will not receive the help they need at the time they need it to prevent them from adopting poor coping strategies that develop into risky behaviours and damaging and destructive lifestyles similar to Adult A's, Adult B's and thousands of others throughout the UK. With Child and Adolescent Mental Health Services (CAHMS) already under immense pressure, Commissioners will need to work resourcefully to plan and implement the appropriate prevention and early intervention services to meet the needs of vulnerable children across Cornwall.

Conclusion 10:

10. **There was a lack of awareness of suicide risk within the context of domestic abuse.** This Review has been pivotal for raising awareness of the risk of suicide as a consequence of domestic violence. Although there is currently no offence of 'liability for suicide', nor can this case be attributed solely to Adult A's relationship with Adult B, it did play a significant role in the events of the (REDACTED) March 2017. Self-harm and suicide can be warning signs of a type of domestic abuse, commonly referred to as 'desperate resistance'. In some instances, victims of domestic abuse feel so trapped by their circumstances, and unable to seek help, that they take desperate measures to free themselves. This can sadly lead to suicide, or in some rare cases, the homicide of the perpetrator. Although the Review cannot conclude accurately whether Adult A was the victim of coercive and controlling abuse, or conflict-based violence caused by everyday triggers, professionals should have at least ruled out the presence, or potential of, violent resistance from controlling abuse on each occasion she disclosed deliberate self-harm.

Conclusion 11:

11. **Training and policy compliance is paramount to the success of domestic abuse prevention.** It was alarming to discover in 2018 that some agencies still do not have a stand-alone policy for domestic abuse, either for the workforce or the service users (DDC CRC) or to find them incorporated into wider safeguarding policy documents, or even out of date policies (GPs). For accountable practice to be measured there must be a set of minimum standards to refer to. It is not good enough to expect a practitioner to use professional judgement without the support of company guidance and a clear escalation process. Professionals should know where to find the policy and how to enact it. This did not help in those agencies, where the knowledge and understanding of domestic abuse was already insufficient. Without adequate training, accompanied by a workable

policy, professionals are operating unsafely with consequences to their own practice and the safety of the people they are employed to support.

LEARNING

LESSON ONE:

INFORMATION AND COMMUNICATION

12. MARAC - There were lessons to be learnt about the way in which MARAC information was shared with departments/teams within specific organisations by MARAC representatives. The Review identified that some teams/practitioners are still unsure about the purpose of a MARAC, the importance of its role within an organisation, how it relates to patients/service-users or where/how to access this intelligence (CMHT). There is also a need to ensure that MARAC information is not lost over time, and that actions are overseen by management and acted upon.

13. INTELLIGENCE - Whilst information was shared on occasions between Adult A's GP, Addaction, CMHT and her Probation Support Worker, it was only in response to a particular referral/incident. Information was not shared proactively to create a joint working plan, or to validate information provided by Adult A or Adult B. This enabled them to provide different accounts without challenge. Some agencies did not share information at all (Housing, Anti-Social Behaviour Team, Probation) and others implemented sanctions without all information being available (Anti-Social Behaviour Team, Housing). This had the potential to escalate the risk to Adult A. Equally, intelligence linked to Adult B's propensity for violence and his history of domestic abuse was not known formally to all agencies (GP, Addaction) which would impact on assessment outcomes, particularly around risk management. There is no guarantee that intelligence linked to Adult B is being shared or monitored to protect future partners or children either.

14. UNDERSTANDING THE SIGNIFICANCE OF INFORMATION – If every contact in this case was classed as a jigsaw piece puzzle, it would be easy to see which agencies were holding important pieces of information, which would have exposed the picture, if only they understood its significance and importance to the landscape (e.g. Housing and the maintenance report of a broken door). The Author had the benefit of analysing all of the pieces together, but the reality is, even without the benefit of hindsight, every piece of the final picture was available to see before Adult A died. Whilst MARAC had the potential to pull information from different agencies together, it was reliant on the initiative of a professional to raise the alarm and make the referral. Even so, in view of the time restrictions and number of cases referred to MARAC each month, it is doubtful that it

would have supported a thorough analysis such as the one undertaken for this Review. This highlights the benefit of experienced domestic abuse specialists, with the experience to understand the significance of information, analysing complex high-risk cases in a proactive way to identify possible resolutions, rather than reactive lessons learnt.

15. HISTORY – This Review highlighted the ongoing issue of viewing each separate incident or contact with Adult A or Adult B independently of everything else going on. Police Officers continue to default the risk grading to standard for a verbal argument without undertaking any history of call-outs or offences. Adult A had over 165 contacts with agencies during the scope of the Review – enough information to establish that a verbal argument was not an isolated incident. Professionals need to examine their own systems, at the very least, to obtain a comprehensive history before arriving at a conclusion, particularly if it involves doing nothing. If this background history was obtained by Police during the call-outs for verbal arguments, it would have resulted in her case being escalated to a specialist Domestic Abuse Officer, which might have resulted in a different outcome. That said, Adult A's view of the Police was well known, both to Devon and Cornwall Police and her friends and family. Even if Adult A's case was escalated to a Domestic Abuse Officer there is no guarantee that Adult A would have responded positively or engaged willingly. This highlights the benefits of working in a multi-agency environment when responding to complex individuals who are difficult to engage.

LESSON TWO:

DOMESTIC ABUSE AWARENESS

16. TYPOLOGY AWARENESS – This Review highlights the importance of professionals understanding the different types of domestic abuse, particularly the cause or motivation for the violence within the relationship. It is difficult to assess whether the violence between Adult A and Adult B was caused by everyday triggers that started with verbal aggression and escalated to violence (exacerbated by their communication deficiencies) or as a consequence of Adult B's attempt to control and dominate Adult A. There was no evidence within case files of any professional giving adequate consideration to the absence or presence of a power and control dynamic. Assumptions were made that separation would reduce the risk to Adult A (which is not always the outcome) and nobody sought to ask them about the cause of their arguments. Had professionals known how to differentiate between the types of domestic abuse, they could have made enquiries with Adult A and Adult B with a view to tailoring the professional response. This would have achieved more meaningful outcomes for the couple, who obviously wished to stay together.

17. VICTIMOLOGY – It is incredulous given the complexity of Adult A's life and the number of contacts she had with agencies, (notwithstanding the issue of non-engagement), that there was not a

single attempt by any professional to escalate Adult A's case to management or to raise a safe-guarding referral or alert, despite company policy dictating that a disclosure of domestic abuse should generate such an action. The Author can only conclude that nobody deemed Adult A to be a) at risk of domestic abuse, b) vulnerable to domestic abuse, or c) a victim. Adult A's Housing Officer provided an insight into her own observations *e.g. Adult A was a strong independent woman who presented with no vulnerabilities*. It is possible the Adult A's steely exterior fooled or reassured her Housing Officer into believing that she was coping. Similarly, her behaviour and outward presentation could have been expected and accepted by mental health professionals well-versed with emotionally unstable personality disorders. Regardless of how Adult A presented, it cannot be contested that she disclosed domestic abuse on a number of occasions throughout the scope of the Review. As such, all professionals should have looked beyond the external presentation to consider and explore the context of the domestic abuse she disclosed. Questions should have been asked and safeguarding procedures should have been followed, without exception.

18. SUICIDE RISK AWARENESS – Adult A's serious self-harming incidents and suicide attempts all immediately followed a domestic dispute with Adult B. Although this could be viewed through the lens of her EUPD, Adult A's additional disclosures of domestic abuse should have raised an alarm for *desperate acts of resistance* - a type of domestic violence linked to coercive and controlling domestic abuse, whereby the victim can see no other way out of her situation. Although the Review identified possible explanations for Adult A's pattern of self-harming, no evidence was found of professional scrutiny or curiosity of such incidents to satisfy the Author that high risk domestic abuse was even considered. Had professionals identified the pattern between Adult A's self-harming and the domestic abuse she experienced (rarely did one happen without the other during the scope of the Review), they would have been able to respond to the escalating risk of deliberate self-harm as a form of desperate resistance.

19. MODUS OPERANDI – Perpetrators of high-risk domestic abuse, particularly of the coercive and controlling type, learn tactics to dominate, supress, humiliate, intimidate and punish their victims. Overtime, these tactics can become synonymous with a perpetrator's MO – the way they do things. In this case, there was a clue that Adult B had learnt and applied a tactic to prevent his victims from leaving the property and raising the alarm. He snapped the key in the door. It is important that professionals working with high-risk domestic abuse look for the individual modus operandi and share this information with agencies (under the prevention of crime and disorder) to protect future victims and ensure seemingly insignificant warning signs are not lost. It would be good practice to encourage victims to think about the unique behaviours of domestic abuse perpetrators and record this information within case files and DASH risk assessments.

20. HIGH RISK FACTORS – There are 15 high risk factors of domestic abuse. Adult A experienced at least 10 of these; (1 -Child contact: restricting her from seeing her children, 2-Drugs and alcohol abuse, 3 – Animal abuse (suspected assault on a dog), 4 – suicide and self-harm, 5-strangulation, 6-credible threats to kill (threats never to see her children again), 7 – escalation, 8 – isolation (not going out), 9 - possessive and jealous behaviour (checking phone, vetting mail), 10 – child abuse (bullying of a 15-year old tenant). This level of risk was missed by every agency, which highlights a significant concern about the level of knowledge and professional confidence around the signs and symptoms of dangerous domestic abuse.

21. CASE CLOSURE – There were lessons to be learnt about the way in which Adult A's case was closed by Addaction and CMHT for non-engagement. Assumptions were made that Adult A had free access to correspondence sent by post and that she had the liberty to access services freely without fear or duress. Whilst it cannot be proved that either of these issues were present, the Author would expect to see evidence of professional consideration. In view of Adult A's serious disclosures of domestic abuse, professionals should have at least considered the risk of coercive and controlling abuse (which might have hindered her autonomy and freedom of choice) before closing her case.

22. TRAINING & POLICY IMPLEMENTATION – The Author understands that Safer Cornwall Partnership has commissioned domestic abuse training for over 5000 professionals to date and that this training is ongoing until at least 2025. With such training available, and free to professionals, there is no excuse for practitioners to not possess sufficient knowledge and skills to respond to disclosures of domestic abuse in their own workplace. In particular, GP knowledge of domestic abuse needs to improve, even if it is to know 'what not to say' during a consultation *(e.g. stay away from your boyfriend).* As a minimum, all professionals within the agencies involved in this Review should know how to identify the 15 high risk factors of domestic abuse, the three primary types of domestic abuse and knowledge of how to refer to the commissioned pathways. Any training should be accompanied by a workable policy with clear expectations, systems for escalating to senior management and directions for signposting in line with the local strategy for Cornwall. This Review identified at least two agencies which did not operate a stand-alone domestic abuse policy – for either it own workforce or service users. A bespoke policy, written for the organisation concerned, will increase professional confidence and create an accountable benchmark to monitor performance.

LESSON THREE:

PROFESSIONAL CURIOSITY

23. PROFESSIONAL CURIOSITY – Throughout the entire Review, there was a distinct lack of professional curiosity. Practitioners failed to view historic records, triangulate incidents, validate information, challenge accounts, ask questions, seek opinions (from Adult A and Adult B) or engage Adult A and Adult B in conversations about their own care. There was evidence of professionals noting an issue of Adult A's problem engaging with services, but no real explanation as to why. This insight could have been invaluable.

LESSON FOUR:

NEW WAYS OF WORKING

24. WHAT WORKS? - Adult A and Adult B were a complex couple, engaged with numerous agencies at the same time. During the course of the review it is difficult to establish what worked well and achieved results. For example, Adult B seemed to address his alcohol dependency but replaced alcohol with cannabis, effectively substituting violence for paranoia – both of which were directed towards Adult A. Likewise, Adult A struggled to engage with some services, but did appear to hold others in high regard (i.e. Open Project). Establishing what works well, and what doesn't work well for complex individuals is the first step to understanding what they care about and what they value, thus enabling professionals to respond with a bespoke joint care plan, which can be amended and updated as goals are achieved, or challenges are met.

25. CARE PLANS – This Review identified the absence of a cohesive multi-agency approach to complex, conflict-ridden couples. Instead, agencies worked independently to address specific issues. Adult A and Adult B would have benefited from a multi-professional, multi-agency joint care plan with clear responsibility for actions and decisions.

26. WORKING WITH WHAT IS PRESENTED – Adult A and Adult B both mislead professionals about their alcohol and drug use in order to bypass referral processes or avoid penalties. This distorted the whole picture and made it almost impossible to establish the true extent of the challenges they faced. The current system encourages complex couples, particularly with dual diagnosis, to lie about their needs at the point when they are most desperate for help. Then, when they are unable to live up to the untruth or professional expectation, they experience another perceived rejection. The whole cycle does not bode well for trusting relationships or the foundation by which meaningful treatment can begin. The lessons to be learnt from Adult A and Adult B's experiences reach the very heart of how we respond to complex couples with multiple needs. Do we mould them to a

set criterion, or simply work together to address the whole person/couple in 'real time', rather than a siloed or sequential approach, however challenging that is?

27. WORKING SMARTER, NOT HARDER - '*That's the way it's always been done around here'* is said to be one of the most dangerous phrases in any industry. It is especially true when professionals hit a proverbial brick wall, and nothing seems to work. As a dependent street drinker, with multiple other needs, Adult A posed a significant challenge for professionals, with some agencies feeling powerless to help (i.e. GP). Many resorted to fire-fighting (CMHT) or scare-tactics (Housing/ASB/Police). Nothing really worked. This Review presents an opportunity for professionals to come together, and analyse the findings, to establish a smarter, more innovative way of working (within existing resources if necessary) to improve outcomes for complex individuals/couples.

28. TRIALING NEW APPROACHES – When Adult B was asked what key recommendation he would like to offer Professionals, he replied, *'Fighting couples who want to stay together should be seen together and offered couples therapy or counselling. That is what we both wanted'.* This Review identified that some professionals still viewed separation as the only way to overcome domestic abuse (i.e. GP), yet research into domestic abuse typology shows that some conflict-ridden couples can be helped to overcome the communication barriers and triggers which cause conflict and violence in the relationship. As such, professionals need to respond to emerging research by altering their mindset and practice to achieve better outcomes. For examples, seeing Adult A and Adult B as a chaotic couple rather than chaotic individuals could have helped professionals connect information, observe behaviours, interactions, relationship dynamics, communication deficiencies and trigger points for conflict. Seeing them together, at least for a period of time, would have removed their opportunity to collude over events and accounts, which might have exposed the true magnitude of their happiness or unhappiness in their relationship.

29. TRACKING 'HOT DOTS' - A study by the US Department of Justice in 2002 looking into hot spot areas of car crime, discovered that it was more effective and economical to track the perpetrators of crime – the *hot dots* - in the reduction of automobile offences, than to police the neighbourhoods where car crime mostly took place (hot spots). They realised that when the '*hot dots'* moved, professionals were able to establish where the next crime would take place, thus, enabling them to allocate resources and adopt a pro-active approach to prevention. This model was later rolled out to perpetrators of domestic abuse and the principle was just as successful. This Review identified that there is no formal model or method to trace or track Adult A's previous partners, Adult B or any serious and serial domestic abuse perpetrator to establish the safety of current partners of unwitting new relationships. The Safer Cornwall Partnership will need to think innovatively, within the remits of the law, to develop a risk management strategy for known dangerous

domestic abuse perpetrators living in Cornwall unchecked.

LESSON FIVE:

RISK ASSESSMENT

30. RISK IS DYNAMIC – There were lessons to be learnt about the way in which professionals' risk assessed the domestic violence between Adult A and Adult B. There was little evidence of consideration for their chaotic lifestyle, which could escalate the level of risk to dangerous levels rapidly and without warning. Not taking their complex lifestyle into consideration provided a false sense of security for professionals involved in her care and communicated to Adult A that professionals were not concerned. Overall it is difficult to understand how so many professionals could have concluded that there were '*no significant indicators of harm'* in Adult A's life at any duration throughout the scope of the Review. This identifies a training issue and a problem with the application of the DASH risk assessment.

31. NEW OFFENCE – This Review examined the closure of Adult A's case due to non-engagement and discovered that little or no consideration was given to coercive control and abuse, which might prohibit a victim from accessing means of support. Police Officers also downgraded the risk to standard on the basis of 'no visible injuries', once again showing little thought of the typology of abuse where victims live in abject terror of the threat of violence. Perpetrators of control-motivated abuse do not always need to use violence as the victim already knows what they are capable of, and therefore the threat is enough. The Author is concerned that professionals are not ready for the new offence of 'Controlling or Coercive Behaviour in an Intimate or Family Relationship' under section 76 of the Serious Crime Act 2015. Without adequate knowledge of what to look for, and the subtle signs of this insidious type of abuse, there is a risk that vulnerable victims will fall through the net.

32. DASH RISK ASSESSMENT – The Review Panel was surprised to learn that no other agency, bar the Police undertook a DASH Risk Assessment during the scope of the Review or referred for one to be completed by a specialist agency. The Author hopes that the commissioning of DASH Risk Assessment Training since 2016 will improve its usage in non-police agencies, however, all professionals involved in this Review should have taken steps to ask, complete or signpost for a DASH Risk Assessment, even if Adult A declined. On rare occasions, when the victim continuously declines a risk assessment, the professional may need to complete one to the best of their knowledge on the basis of the information they have available to them. The nature of coercive and controlling abuse means that the isolation may be so severe that access to the victim is impossible or unsafe. In this instance, professionals should use their initiative to establish as much information as possible, or even refer to a MARAC on the principle of high risk isolation, and the suspicion of a breach

of Article 5 of the Human Rights Act - the right of a person not to be arbitrarily deprived of their liberty. Thinking *'outside of the box'* to combat Adult A's non-engagement might have led to better information sharing between agencies, and an effective strategy for support.

33. AGENCY INTERVENTION – Good practice cannot be classed as successful simply by its implementation. Good practice should be considered successful based on the outcomes. This Review highlighted the flaw in agencies not undertaking a risk assessment of their own intervention. Any intervention from professional agencies has the potential to start a chain of events, which can lead to lethal consequences, particularly for victims of high-risk coercive and controlling abuse. A DHR in Plymouth in 2014 was caused by the perpetrator discovering the intervention of a family lawyer. A series of revenge suicides in the same year were attributed to police arrests. As a matter of routine practice, professionals should evidence that they have thought through the possible consequences of professional intervention and mitigated against as much risk as possible.

RECOMMENDATIONS

34. The recommendations (below) have been informed by the findings of this Review, learning from individual Management Reports (IMRs), the analysis undertaken by the Independent Chair and deliberation by the Review Panel.

RECOMMENDATION 1: COSTING PAPER

35. The professional response experienced by Adult A and Adult B is largely reflective of today's multi-agency approach to complex individuals, therefore, The Safer Cornwall Partnership should use the detailed analysis of this Domestic Homicide Review as a case study to establish whether the current countywide approach is still acceptable, effective and cost-efficient. To assist with this exercise, the Safer Cornwall Partnership should seek to;

    a) Appoint a senior analyst to undertake a comprehensive costing paper, using this case study as a benchmark, with a comparative study of the progress achieved during the scope of the Review. The findings of the costing paper should form a dialogue between partners to accurately appraise the quality and value of the current response.

b) Share the detailed learning from this Review and the cost analysis with relevant partners[1] to communicate and coordinate agencies to work together towards a new, integrated joint working protocol.

c) Form a Task and Finish Group made up of panel members and other senior representatives of relevant agencies to address the recommendations from this Review and champion an improved multi-agency working protocol for chaotic residents with complex needs and multiple vulnerabilities (Leading to Recommendations 2- 7).

RECOMMENDATION 2: COMPLEX NEEDS STRATEGY

36. The Safer Cornwall Partnership's 'Task and Finish Group 'should lead on the creation of a county-wide 'Complex Needs Strategy' to inform the multi-agency, multi-professional response to complex individuals, couples and families with multiple vulnerabilities across Cornwall, including (but not limited to) ongoing homelessness, drug and alcohol addiction, mental illness, criminality, anti-social behaviour, adverse childhood experiences, domestic abuse and family breakdown. This should link to, or reference, the Dual Diagnosis Strategy as recommended within a previous Domestic Homicide Review in Cornwall (2016), the local ACE[2] Strategy and the new Local Authority Self Neglect Strategy (which offers a good practice template for a similar model).

RECOMMENDATION 3: JOINT CARE PLANS

37. The Complex Needs Strategy should include a blueprint for the creation of a bespoke joint care plan with clear responsibilities and actions for chaotic individuals and couples who are difficult to engage or struggling to meet existing referral criteria for support. The focus should be based on the unique presentation of the individual/s concerned. Agencies will need to work resourcefully to find solutions around referral/exclusion criterions and restrictions to some services (e.g. mental health therapies) to ensure joint care plans are integrated when appropriate, and not sequential. This should link to the previous work undertaken by NHS Kernow (Commissioners of Mental

[1] Panel Members and other senior-level representatives of agencies involved in the care of treatment of complex individuals/couples
[2] Adverse Childhood Experience Strategy

Health Services) around a working protocol and implementation plan for patients with a dual diagnosis.[3]

RECOMMENDATION 4: COORDINATION OF MULTI-AGENCY JOINT CARE PLANS

38. The Complex Needs Strategy for Cornwall should consider how joint care plans will be coordinated to ensure all involved parties are kept abreast of live incidents and/or changes in circumstances/planned intervention (e.g. arrest, eviction or hospitalisation). The Partnership will need to consider how joint care plans are monitored, evaluated and modified efficiently and effectively to reflect the rapidly changing chaotic nature of complex clients. Thought should be given to the continuity of care and the legal management of intelligence and information to improve multi-agency information sharing, risk assessments, decision making and care development. Communication and engagement with complex individuals/couples/families should seek to understand *'the person amongst the chaos'* and establish what works for them, what they care about, what they value and what they want to achieve to overcome fears or barriers to treatment and increase the likelihood of positive, meaningful engagement and outcomes.

39. Complex Care Teams (or those responsible for the delivery of the complex care strategy) should seek to create a genogram of all individuals connected to the complex-needs individual or couple, including children and ex-partners, who may also be subject to professional intervention or at risk of harm to ensure that links are made, interventions are interconnected and care plans are developed to encompass the wider picture.

RECOMMENDATION 5: LINK TO ADVERSE CHILDHOOD EXPERIENCE STRATEGY

40. The Safer Cornwall Partnership's 'Task and Finish Group' should seek to combine the Complex Needs Strategy with the current countywide response for children experiencing multiple adverse childhood experiences (ACEs) in Cornwall and the Isles of Scilly. The Safer Cornwall Partnership should be satisfied that children who cross the age threshold from childhood to adulthood are not left unsupported or subject to a discontinuation of care. The combined strategy should include a prevention plan to mitigate the risk of today's vulnerable ACE children becoming tomorrow's complex adults.

[3] Recommendation from DHR 3 in Cornwall (2016) to form a working group to review and develop a dual diagnosis strategy, pathway and protocols, with training and a conflict resolution process.

RECOMMENDATION 6: RISK OF PROFESSIONAL INTERVENTION

41. The Task and Finish Group should consider the risks associated to professional intervention from all agencies involved in the care, treatment and supervision of complex individuals and couples involved in high risk domestic abuse relationships. Any intervention from professional agencies has the potential to start a chain of events, which can inadvertently increase the risk to the victim (through retaliation or revenge from the perpetrator) and on rare occasions lead to lethal consequences, particularly for victims of high-risk coercive and controlling abuse. As a matter of routine practice, professionals should evidence that they have at least considered the possible consequences of professional intervention and mitigated against as much risk as possible. The Safer Cornwall Partnership may wish to consider piloting a formal Professional Intervention Risk Assessment to record planned and coordinated interventions for complex individuals subject to a joint complex need care plan.

RECOMMENDATION 7: CASE CLOSURES

42. Case closures due to a lack of engagement should be prohibited for all individuals subject to a Complex Needs Joint Care Plan without appropriate negotiation and risk assessment by professionals involved in their treatment or care. All agencies involved in this Review should revisit their case-closure policies to ensure that it is considerate of the new offence of coercive and controlling behaviour **(**Section 76 of the Serious Crime Act 2015) following disclosures of domestic abuse. Appropriate action should be taken to ensure no case is closed in Cornwall for non-engagement without evidence that the principal professional involved in the care of the service-user has given due consideration to coercive duress or the restriction of liberty.

RECOMMENDATION 8: HIGH RISK PERPETRATOR MANAGEMENT* subject to National Recommendation 15 (below)

43. The Safer Cornwall Partnership's Task and Finish Group' should consider a legal information sharing framework for serious and serial high-risk domestic abuse perpetrators ('hot dots') across Cornwall (in line with GDPR regulations) who do not meet the threshold for MAPPA or have an active case open with MARAC.

44. The Safer Cornwall Partnership's 'Task and Finish Group' may wish to consider a prevention strategy which sets out a multi-agency legal framework to empower professionals to share personal information about known high-risk domestic abuse perpetrators to safeguard unsuspecting partners and families at risk of repeat or new incidents of domestic abuse - drawing upon existing legal powers such as Clare's Law/Osman Warnings/DASSP etc. if necessary.

45. Consideration should be given to who is responsible and accountable for recording information and intelligence and how information will be shared legally with external departments or agencies which may need to be notified (i.e. of a person's professional position, such as the Local Authority Designated Officer (LADO) in this case), or other organisations such as the RSPCA if there is sufficient concern about the welfare of an animal.

RECOMMENDATION 9: INTELLIGENCE MANAGEMENT* subject to National Recommendation 15 (below)

46. The Task and Finish Group should consider how they gather, share and store intelligence (legally) pertaining to the unique behaviours of known serious and serial domestic abuse perpetrators. The Task and Finish Group should consider a working protocol that encourages victims and professionals to think about, and share, obscure behaviours, rules or punishments that form a distinctive Modus Operandi (MO) of a high-risk perpetrator. The working protocol should outline the methods by which information is recorded within case files or clinical records to communicate warning markers for professionals and unsuspecting new partners to ensure that vital behavioural patterns or tactics are not missed, unobserved or lost over a period of time (for example; in this case, snapping a key in a lock to prevent escape).

RECOMMENDATION 10: POLICY AND PRACTICE

47. All agencies involved in this Review should ensure that there is an up-to-date standalone domestic abuse policy for the workforce and service users, to include organisational expectations, clinical standards, training requirements and a clear escalation process for raising concerns. All staff should know where to access the policy and possess the appropriate knowledge to comply with its terms. Each domestic abuse policy should reflect changes in national legislation and the introduction of new Acts. It should also be updated annually to ensure that it reflects strategic changes to local multi-agency, multi-professional joint working protocols. This was a recommendation for GP surgeries in two previous Domestic Homicides in Cornwall (action completed September 2017) but should remain as a recommendation for other relevant agencies involved in this Review (e.g.

Community Rehabilitation Company).

RECOMMENDATION 11: TRAINING

48. Without exception, all professionals[4] involved in the care or treatment of complex individuals/couples or victims/perpetrators of domestic abuse across Cornwall and the Isles of Scilly should attend commissioned domestic abuse training. This should be supported by senior management and considered an important requirement for professional development. As a minimum, professionals should feel confident and capable of managing a first disclosure of domestic abuse and know how to identify each domestic abuse typology and associated high-risk factors in addition to signposting individuals and couples for assessment and ongoing risk management. In particular, the Community Safety Partnership should take forward a motion to the Chief Executive Group for Cornwall to present a formal request to the General Medical Council (GMC), The Nursing and Midwifery Council (NMC) and The Health and Care Professions Council (HCPC) at a national level to consider how a training syllabus for GP's, Nurses and Allied Healthcare Professionals can be introduced, and notify the Coroner for Cornwall of an ongoing concern regarding the knowledge of GP's responding to domestic abuse across the county, requesting that this is raised nationally with the GMC by the Coroner's Office.

RECOMMENDATION 12: IMPLEMENTATION OF MARAC IMPROVEMENT PLAN

49. Following a MARAC Improvement Plan (undertaken recently in Cornwall), the Safer Cornwall Partnership should seek to update the 2012 multi-agency MARAC Protocol as a matter of priority to include learning from the review and reflect changes outlined in the improvement plan. All agencies that use or adopt the Multi-Agency MARAC Protocol should ensure that the updated version is circulated to all staff and dovetailed with existing complimentary policies if applicable. Staff should know where to access the MARAC Protocol and understand the guidelines for accurate recording keeping. Where possible, A MARAC summary should be pinned separately to electronic or written case records to prevent vital intelligence being lost or hidden over time.

[4] Priority given to Police, Probation, Mental Health, Housing, Drug and Alcohol, GP's, Emergency Services and healthcare professionals

RECOMMENDATION 13: SUICIDE AWARENESS

50. Professionals[5] involved in the care or support of victims of domestic abuse should all know about the risks of suicide in abusive relationships, particularly for those experiencing additional complex needs or coercive and controlling abuse. Equally, professionals should also be alert to the act of, or threat of suicide, by the perpetrator as a means of punishment or retribution. It would be good practice for all agencies involved in this Review to include 'Suicide Risk' within company Domestic Abuse Policies to ensure all staff know how to recognise the signs and escalate their concerns. Suicide risk as an 'act of desperate resistance' should be included in the commissioned domestic abuse training contract.

RECOMMENDATION 14: SHARING LEARNING

51. All panel members and agencies involved in this Domestic Homicide Review should share the findings of this Review, together with the lessons learnt, with all staff and volunteers to provide context to the above recommendations and procure their support in advance of the recommendations being actioned.

NATIONAL RECOMMENDATION 15:

52. The Review Panel expressly request a national legal framework for the sharing of information between agencies for serious and serial high-risk domestic abuse perpetrators who do not meet existing monitoring thresholds (e.g. MAPPA/MARAC) due to 1) not having a current supervision order, or 2) not having an open MARAC case (perhaps because a relationship has ended, or a previous partner is deceased). The Safer Cornwall Partnership are seeking specific clarification that it is acceptable and legal to share relevant information about a known high-risk domestic abuse perpetrator (where an extensive history of repeat offending can be evidenced) for the purposes of prevention and to alert affected parties to the risks. Specifically, the Safer Cornwall Partnership request confirmation that such sharing of personal data would be covered by one or more of the following;

    a) Prevention and detection of crime - s.115 Crime and Disorder Act 1998

[5] Priority given to Police, Probation, Mental Health, Housing, Drug and Alcohol, GP's, Emergency Services and healthcare professionals

b) To protect vital interests of the data subject; serious harm or matter of life or death - Schedule 8, DPA 2018

c) For the administration of justice (usually bringing perpetrators to justice) - Part 3 & Schedule 8 DPA 2018

d) For the purposes of the prevention, investigation, detection or prosecution of criminal offences or the execution of criminal penalties, including the safeguarding against and the prevention of threats to public security - Part 3 s.31 & 35 DPA 2018

e) Child protection. Disclosure to Children's Social Care or the Police for the exercise of functions under - Children Act 1989 & 2004

f) Overriding public interest - Common law

g) Right to life Right to be free from torture or inhuman or degrading treatment - Human Rights Act, Articles 2 & 3

h) Prevention of Abuse and Neglect - The Care Act 2014

The Review Panel feel that recent changes to Data Protection Regulations has reduced the confidence of professionals to share information, particularly around offending behaviour, either suspected, feared or disclosed. Clear and concise advice from the Home Office would be welcomed to increase confidence and practice around management and prevention.