SAFER CORNWALL
Kernow Salwa

Safer Cornwall

Domestic Homicide Overview Report

DHR 8 - Regarding the death of Dolly
Death reported May 2017

Prepared by:

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Tribute from Dolly's mother.

Dolly was a such a kind and caring person and she loved her children. She would do anything for anyone and adored animals.
In every picture I have of her she is smiling. That is how we remember her. She was a really happy person and had so many friends. Everyone loved her. We all miss her terribly and not a day goes by when we don't think about her.

1. Introduction

1. This Domestic Homicide Review (DHR) Overview Report examines agency responses and support given to the victim (Dolly), a resident of Cornwall, prior to her death, the exact date of which is not known, but which was reported in May 2017.

2. The homicide was notified to Safer Cornwall on commencement of the police investigation in May 2017. The police involvement commenced following concerns from a family member of the perpetrator about messages posted on social media by the perpetrator.

3. Safer Cornwall determined that this case met the criteria for a DHR. The purpose of a DHR is to:

   a) 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;

   b) 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;

   c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

   d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

   e) contribute to a better understanding of the nature of domestic violence and abuse; and

   f) highlight good practice.

4. In addition to agency involvement the DHR has examined the past to identify any relevant background or incidences of domestic abuse or violence before the homicide, whether support was accessed with the community and

whether there were any barriers to accessing support. By taking a holistic approach this DHR has sought to identify key issues for learning and to make appropriate recommendations for action.

2. Timescales

5. In August 2017 an open tendering process was completed to appoint an independent chair and author and the formal contract was agreed in October 2017. The DHR formally commenced in January 2018 and concluded in November 2019. The DHR panel met three times in person, as well as additional discussions by tele-conference. The Chair also held discussions by phone with the DHR lead within Cornwall Council.

6. There were delays to the commencement of the review as a result of the trial. This was a complex criminal case, which is explained later in this Overview Report. Added to this there were lengthy delays in securing IMRs from relevant organisations, IMRs that had to be revised and further information gathered and a change of DHR commissioner in 2018.

3. Confidentiality

7. The DHR was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until Safer Cornwall accepts the Overview Report, Executive Summary and Action Plan.

8. Pseudonyms have been used in this Overview Report to ensure confidentiality. The victim is represented by the name Dolly, this was chosen by the victim's mother. The perpetrator is represented by the name Adult B.

9. The victim was believed to be aged 32 at the time her death was notified. The perpetrator (adult B) was aged 33 at the time of the victim's death being notified. Both were white British.

4. Terms of Reference

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard the family.

- Identify what the lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter-agency responses were appropriate leading up to and at the time of the incident, suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policy and procedures to respond to domestic abuse and to recommend changes as a result of the review process.

- Contribute to a better understanding of the nature of domestic violence and abuse.

- Highlight good practice.

- Consider the period of two years prior to the events subject to any information that emerges that prompts a review of any earlier incidents or events that are relevant. Dates for IMRs were 1.1.2015 to 18.5.2017 for the review as this period was deemed to gather the most learning from the panel members. However, anything relevant outside of this time period was included within the review and learning was sought from this.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals through the process of the review.

- Seek the involvement of family, employers, neighbours and friends to provide a robust analysis of the events.

- Produce a report that summarises the chronology of events, including the actions of involved agencies, analysis and comments on the actions taken, and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

5. Methodology

10. The decision to undertake the DHR was made by Safer Cornwall having received information from the police about the nature of the homicide and relationship between the victim and the perpetrator. Safer Cornwall was satisfied that the case met the criteria for undertaking a DHR.

6. Involvement of family, friends, work colleagues, neighbours and wider community

11. The family were provided with the Home Office leaflets and were provided with information about specialist advocacy through AAFDA, but chose not to take up this offer.

12. Dolly's mother, known as Maria for this report's purpose, reviewed the Terms of Reference for the DHR and did not make any amendments. A worker from Victim Support, whom she reports as having been very helpful, has supported her. This support is ongoing. She also complimented her police Family Liaison Officer who she said had been very supportive and helpful.

13. Maria did not meet the panel but the Chair of the DHR conducted a consultative interview via the phone with her to gather information about Dolly's background, her circumstances and any other relevant information.

14. After this initial contact with Maria, there was limited contact from the Chair. This was due to the Chair believing Maria did not want to participate. Since completion of the review it has been made clear that this was not the case and not Maria's choice. This understandably caused significant distress and a feeling of being let down with the DHR process. The CSP was neither aware of this, nor the fact that the overview report had not been shared with the family, until Victim Support got in contact with the DHR lead. This is not acceptable and as soon as the CSP was made aware a formal apology was provided to Maria alongside the offer to review and make any changes/amendments to the report where appropriate, as well as the offer of support. Learning from this will be embedded in future reviews to ensure families are integral to reviews, well supported and considered a key stakeholder in future.

15. Neither Dolly nor Adult B were in employment. Their network of friends was unclear, apparently most were known to them through their substance use. It was not possible to ascertain contact details to seek any input to the DHR.

16. The landlord of the property in which Dolly and Adult B lived prior to her death was contacted by letter to seek engagement in the DHR, but there was no response.

17. Adult B was advised of the DHR process but declined to participate in the process. The family of adult B was also contacted but declined involvement.

7. Contributors to the review

18. A number of agencies contributed to the review through the submission of IMRs and the provision of initial scoping information. Those agencies were:

- We Are With You (Formally Addaction) – the contract holder for drug and alcohol services
- Cornwall Partnership NHS Foundation Trust
- NHS Kernow Clinical Commissioning Group – primary care
- Cosgarne Hall – Supported Housing provider
- Devon and Cornwall Police
- Outlook South West – contract holder for psychological therapy services
- South West Ambulance NHS Foundation Trust

19. In addition, Dolly's mother contributed to the DHR during an interview with the Chair, via telephone.

20. Scoping information was received from:

- Cheshire Police
- Merseyside Police
- Devon Partnership NHS Foundation Trust

21. Following receipt of information those organisations were not requested to submit IMRs.

22. People who were independent, in that they had no knowledge or connection with the case had produced all the IMRs received. For one IMR, an independent consultant was engaged to conduct the IMR.

8. The review panel members

Original panel member	2nd panel member	3rd Panel member	Organisation
Steve Appleton	**Steve Appleton**		**Independent chair and author**
Ben Beckerleg and Chris Chowd		**Ben Beckerleg**	**Devon and Cornwall Police**
Julie Ann Carter	**Natalie Jones**		**NHS Kernow Clinical Commissioning Group**
Michelle Davies	**Kim Hager**	**Laura Ball**	**Safer Cornwall**
Tom Dingwall	**Helen Boardman**	**Mel Francis**	**First Light – Domestic abuse charity**
Jane Hampton	**Rebecca Sargent**	**Rebecca Sargent**	**Children and Family Services**
Russ Hayton			**Drug and Alcohol Action Team**
Karen Howard	**Jane Wilkinson**	**Zoe Cooper**	**Cornwall Partnership NHS Foundation Trust**

23. The members of the panel were independent and had no prior contact with the subjects of the DHR or knowledge of the case. As indicated, some panel members have left the roles and organisations detailed above prior to the submission of the Overview Report. Those who took over on the panel are also listed in the table.

9. Chair of the review panel and author of the Overview Report

24. The independent Chair of the panel and author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time, he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently, he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

25. Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care and has worked with a wide range of NHS organisations, local authorities and

third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

26. Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written a number of DHRs for local authority Community Safety Partnerships, including two previous reviews for this CSP. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation

27. Steve has had no previous involvement with the subjects of the review or the case.

10. Parallel reviews

28. There were no parallel reviews undertaken in relation to this case.

11. Equality and diversity

29. The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Dolly and Adult B and if this played any part in how services responded to their needs.

30. "The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation."[1] There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

31. The nine protected characteristics in the Equality Act were considered by the panel and two were found to have direct relevance to the review. These were age and disability.

32. The victim and perpetrator were adults, with a history of substance misuse. The victim was a mother, though her children had been the subjects of care proceedings and were not in her custody or care.

[1] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47
[2] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

33. The panel ensured that the review always considered issues relating to the nine characteristics in their thinking about the engagement and involvement of organisations and professionals and where identified, the impact of them on decision making and whether these presented a barrier to accessing support and assistance.

12. Dissemination

34. The Overview Report will be sent to all the organisations that contributed to the DHR. In addition, an appropriately anonymised electronic version of the Overview Report will be posted on the Safer Cornwall website. A copy will be provided to the Police and Crime Commissioner. It will also be available on the Safeguarding Adults Board website.

13. Background information (The Facts)

35. Dolly and Adult B had been living together in a privately rented basement flat in south Cornwall. They lived alone, and although Dolly did have children they were not in her care. The children, two boys aged 12 and 9 and a daughter aged 10 were not resident with Dolly and Adult B. Adult B was the father of the younger children but not the eldest boy.

36. Dolly and Adult B had known each other since they were at school but had been in a relationship since 2008, when Dolly was about 23 years of age.

37. In May 2017, Devon and Cornwall Police received a disclosure from their counterparts at Merseyside Police. This followed receipt of concerns from a member of Adult B's family in Cheshire about posts he had made on social media. These contained details about Dolly that were of concern to the family member.

38. Following investigations by Devon and Cornwall Police, they attended Dolly and Adult B's flat. They found blood on the walls of the flat and Adult B said that he had killed Dolly. A weapon was discovered at the property. Adult B later provided police with a version of events, which included an allegation that Dolly had been beaten and raped by another man, whose name Adult B provided. Police investigations revealed that the man did not exist. Adult B also claimed that Dolly was simply missing and had gone to South Africa.

39. Adult B was charged with murder. In disclosure he said that he had killed Dolly and then dismembered her body before disposing of it. He was found guilty of murder in May 2018 and was sentenced to life imprisonment, with a minimum term of 28 years.

40. Dolly's body has not been found. As a consequence, no inquest has been held.

14. Chronology

41. A combined chronology has been developed and is provided in a separate appendix to this Overview Report. The detail of dates and types of contact are contained in the chronology document and have been drawn from the IMRs and their chronologies.

15. The views of Dolly's mother

42. The Chair of the DHR spoke with Dolly's mother in an attempt to gather further insights and ensure that she had the chance to input to the review. For the purposes of the DHR and to maintain confidentiality, Dolly's mother is represented by the name Maria.

43. Maria and her husband live in the north west of England and Dolly was born and brought up in that region. Maria has an elder daughter and also had a foster son, who remains in regular contact with her.

44. Maria described Dolly as a bright child, who made friends easily and had a vivid imagination. She said that Dolly had done well at school and had achieved good examination results. When Dolly left school, she got a job working in social care working with older people and people living with disability. She apparently held this job for a few years.

45. During this time, she had a couple of boyfriends and in 2007 Dolly had her first child, a boy. Maria also described how she had looked after the child following the intervention of children's services and described the subsequent removal of Dolly's other children. She said that Dolly had been distressed by these events.

46. Maria described how Dolly had known Adult B since childhood and that they were at school together. She said that she and Dolly knew that Adult B had a history of criminal behaviour, related to assault on others and that he used drugs. Maria said that in 2008 Dolly moved away and lived in another part of the north west before moving to Cornwall with Adult B in 2012. Maria said that Adult B had actively stopped Dolly from having contact with the family and that as a result they had been estranged ever since.

47. Maria said she had no knowledge of how Dolly and Adult B were living, where they were or what they were doing. She was therefore unable to offer any insights into the nature of their relationship.

48. Maria described Dolly as a kind-hearted person, and that everyone loved her. Maria talked about the impact of Dolly's death and how hard it had been to accept, particularly as her body has not been found. Maria said that Dolly's death was something she would never get over. She welcomed the DHR being undertaken and was grateful for the opportunity to take part in it.

16. Overview

49. Drawing on information from the IMRs, this section provides an overview of the contact between agencies and Dolly and Adult B. It summarises what information was known to the agencies and professionals about Dolly and Adult B and any other relevant facts. It is deliberately structured by agency as the appendicised chronology already provides a lateral timeline.

NHS Kernow – primary care

50. Dolly's early contact with primary care services was unremarkable and related to the usual span of childhood illnesses. When a young woman aged around 20 she experienced a miscarriage, three years later she had her first child. She then experienced a further miscarriage a year later, followed by a planned termination. When she was around 25 years of age, she gave birth to her second child.

51. In the period 2010-2012 Dolly had regular contact with her GP surgery, much of this was related to lower back pain, eczema and contraception. There was one consultation in late 2011 during which she reported low mood and thoughts of suicide although she was clear she would not act upon those thoughts. The GP completed the recognised screening tool, the PHQ9 and prescribed an anti-depressant.

52. In mid-2012 Dolly saw her GP and reported that she had been having relationship counselling, she had been with Adult B for five years by this point. She described feeling stressed, smoking cannabis but denied taking any other drugs. Anti-depressant medication was again prescribed. She attended this appointment with Adult B.

53. By late 2012 the use of substances appeared to be increasing, with reported alcohol dependence and use of ecstasy. Dolly met with her GP following her presentation as homeless, having been sleeping in a tent locally with Adult B.

54. In January 2013 the GP practice was advised by the local housing team that Adult B might be pressuring Dolly into buying drugs. It is reported that Adult Social Care were now involved. In March 2013 the GP attempted to make an adult safeguarding referral but noted that the phone number was constantly engaged and there was no ability to leave a message. Later that month Dolly was again homeless. She was reported to be experiencing thoughts about self-harm and her medication was increased.

55. Dolly was referred to mental health services by her GP in May 2013. She did not respond to appointment requests, but self-referred later that year, in October. She described a complex history, with reports of sexual assault against her as child and also said she heard voices.

56. Throughout 2014 there was routine contact with the GP practice, Dolly was awaiting a counselling appointment. Her drug use was continuing although there was some respite from that during the summer of 2014.

57. Through 2015 Dolly consulted her GP at regular intervals, often in relation to physical health issues, notably in relation to thyroid problems.

58. In December 2015 she moved into new accommodation and registered with the local GP practice. The only real contact of note during the time between December 2015 and October 2016 is when Adult B contacted the GP demanding an emergency appointment by phone. Dolly took the phone from him and stated she had a large cut 'down below' and that she needed treatment. Adult B then contacted the ambulance service who attended.

59. There was no contact between the practice and Dolly from that point on.

60. The IMR author did not include the details of Adult B's contact with primary care as he did not give his consent for his medical records to be accessed.

Cosgarne Hall

61. Cosgarne Hall is a housing support service and at the time covered by the Domestic Homicide Review, it was the contract holding provider for such services in the part of Cornwall in which Dolly resided. Since the time of the incident the service has changed to a new provider.

62. Dolly and Adult B lived in accommodation where they were supported by Cosgarne Hall between April and August 2015. They occupied separate rooms as per the couples' policy in place at the time. The IMR indicates that Cosgarne Hall had been advised by the Police not to take Dolly and Adult B as clients but decided to do so anyway. They were both advised that their tenancy would be at risk if they were suspected of drug use.

63. Dolly's initial engagement with the staff at Cosgarne Hall appears to have been positive and she provided them with a full history in relation to her life, her

addiction and mental health issues, and the fact that her children were not in her custody or care.

64. In May 2015 Dolly was instructed in the use of Naloxone, a drug that reverses the effects of opioid use and overdose. It is administered by injection and Dolly was instructed in how to do this. During this period Dolly admitted to staff at Cosgarne Hall that she had used heroin.

65. Throughout the period of May and June 2015 Cosgarne Hall staff supported Dolly with a range of tasks, including making GP appointments, meeting with staff from Addaction (now named We Are With You), the drug treatment service and other support services both within the project and outside.

66. In mid-June 2015 the IMR states that an incident took place when Dolly called the police. Two other residents had been invited by Dolly into her room and though initially she was comfortable about this, the conversations became sexual in nature with remarks made by the other residents about Dolly. There was then an alleged assault which is believed to have taken place in the kitchen area, when one of the other residents is believed to have slapped Dolly on her buttocks. It is believed that Adult B was present and intervened physically. This incident brought back difficult memories for Dolly in relation to her experiences as a child.

67. Through the rest of June Cosgarne Hall staff continued to support Dolly with a variety of issues including matters relating to welfare benefits.

68. At the start of July 2015 there were concerns about the state of Dolly's room, which was insanitary. There was some concern that she was losing weight and was feeling unwell. Dolly did admit to using heroin at this time but that she was not injecting it. It is believed she was using heroin on a daily basis.

69. By the end of July 2015 Dolly was also using cannabis and was doing so in her room. She was reminded of the zero-tolerance policy relating to drug use on the premises. Her opiate substitute prescription was stopped as she had consistently failed to collect it from the local pharmacy. This was later reinstated following a meeting with Addaction (now named We Are With You) staff.

70. In mid-August Dolly and Adult B were served with notice of eviction. This followed a breach of the rules, where they had shared a room together.

Cosgarne Hall staff were not aware of where Dolly and Adult B went or where they planned to live once they left. This was their last contact with the couple.

Addaction

71. Addaction provides a range of drug and alcohol recovery and support services. Both Dolly and Adult B were provided with drug treatment services by Addaction between May and August 2015. This was during the period when they were resident at Cosgarne Hall. Their involvement with Dolly and Adult B was limited when Dolly and Adult B moved away from Cosgarne Hall to another part of Cornwall.

72. Addaction not only provided support to Dolly while she was at Cosgarne Hall, but also once she left, they supported her while she was resident at the night shelter during the period of homelessness prior to moving into private rented housing with Adult B.

73. The Addaction IMR states that throughout their contact with Dolly she was stable and there were no reported incidents or risks in relation to neglect or domestic abuse.

74. During her engagement with Addaction, Dolly was assessed for opiate substitute prescribing and she was engaged in discussions about her treatment throughout. However, Dolly experienced numerous obstacles and barriers to engagement, including her relationship with adult B, need for other services and help, and multiple vulnerabilities including mental health problems.

Outlook South West

75. Outlook South West is a Primary Care Mental Health Service and is part of the national Improving Access to Psychological Therapies (IAPT) programme. The service works with people who are experiencing common mental health problems. These problems include depression and anxiety disorders such as phobias, generalised anxiety, post-traumatic stress disorder, social anxiety and obsessive-compulsive disorder.

76. Outlook South West received a referral for Dolly in April 2013 and conducted an assessment with her four days after the receipt of the referral. She was assessed by a qualified psychological therapist.

77. The assessment of Dolly indicated an absence of family support and a sexual abuse history. She was noted to experience frequent suicidal ideation and was highly self-critical. These factors precipitated a referral to CMHT on the same day as the assessment had taken place.

78. Outlook South West had no further contact with Dolly.

Cornwall Partnership NHS Foundation Trust

79. Cornwall Partnership NHS Foundation Trust (CPFT) is the commissioned specialist secondary care mental health service provider for Cornwall.

80. Dolly's first referral to CPFT's mental health services was in April 2013 when Outlook Southwest made a routine referral to the Community Mental Health Team that covered the area where she was living at the time.

81. Dolly was self-harming by cutting her arms to release tension. She was reported to be using cannabis but denied any other drug use.

82. Multiple attempts were made to contact Dolly to arrange an assessment, without success and following discussion with the team manager, an appointment was sent to Dolly for mid-May 2013.

83. Dolly did not attend the CMHT appointment. The Single Point of Access (SPOA) were notified that Dolly had moved and therefore the referral was transferred to a different CMHT and an assessment appointment offered via Dolly's new address for early June 2013.

84. Dolly did not attend this CMHT appointment and following failed attempts to contact her by telephone, another appointment was offered for mid-June 2013.

85. Dolly did not attend the CMHT assessment appointment and following discussion at the CMHT Multi-disciplinary meeting a two week opt in letter was sent asking Dolly to make contact if she would like an appointment. She did not make contact and the referral was discharged.

86. In August 2013 Dolly contacted the CMHT requesting an assessment. The team provided her with the details for the self- referral process and at the start of October 2013 she self-referred to the CMHT. Towards the end of October 2013 Dolly attended an assessment. She engaged well and a full assessment,

including Mental State Examination and risk assessment was undertaken.

87. Dolly described living with feeling angry and frustrated due to past experiences, being raped twice by the same man at the ages of 14 and 18. Dolly reported experiencing 'flashbacks' ever present, particularly when she tried to sleep. Flashbacks were described as 'extreme in their reality, even down to smell'. Dolly reported during these episodes to be able to 'smell the man that raped her', she reported this man was her father's best friend. She described that when she had flashbacks, she often hyperventilated to a point where she blacked out and collapsed. Dolly reported she did not like the dark and struggled to sleep.

88. Dolly informed the assessor she had a supportive partner but that she did not live with him, reporting that he had his own mental health issues and she didn't want to burden him. Dolly said she was a past intravenous heroin user but had been abstinent over the previous six months, continuing to smoke cannabis regularly, which she said helped her sleep and calmed her down.

89. Dolly reported constant thoughts of suicide and self-harm and a history of cutting herself but had not done so for the previous two months and had no current plan in place to take her life by suicide. Out of Hours numbers were provided in case of further suicidal ideation and Dolly was recorded as happy to use the numbers if necessary. She also reported three previous attempts at suicide in 2010, 2012 and in the two months prior to the assessment.

90. Dolly explained that in 2009 (as detailed previously), she engaged briefly with Outlook Southwest but did not find this helpful. She reported no previous formal contact with a CMHT.

91. Following discussion at the multi-disciplinary team meeting it was concluded that Dolly would benefit from access to specialist counselling services to process her experiences. This was fed back to her and she was provided with the contact details of Women's Rape and Sexual Abuse Centre (WRASAC), now known as The Women's Centre, Cornwall to arrange this.

92. Dolly was discharged from the CMHT at the end of October 2013. There was no further contact between CPFT and Dolly until October 2015 when she was referred for physiotherapy relating to back pain, but she did not respond to the letter requesting her to make an appointment and was 'discharged' in mid-November 2015.

Contact between Adult B and CPFT

93. Adult B had a range of contact with CPFT, some of which fell outside the timescale covered by this Domestic Homicide Review. However, he had contact with a CPFT Community Mental Health Team in 2012 following a routine referral. He was offered an appointment in August 2012 but did not attend. He subsequently did attend an assessment appointment in September 2012. He was requesting help with anxiety problems and it recorded risks relating to self-harm, suicidality and drug and alcohol use. Some of this was, according to Adult B, related to the removal of his and Dolly's children. A referral was made to Outlook South West for anxiety management.

94. In November 2012, while living in a tent with Dolly in another part of Cornwall, Adult B was referred to another CPFT Community Mental Health Team. Following a series of attempts to contact him and then discovering he had moved away from the area; the Community Mental Health Team closed the case in January 2013.

95. Following contact with the Criminal Justice Liaison & Diversion Service in early 2013, follow up from which he did not attend, Adult B was subsequently referred to a Community Mental Health Team via the SPoA. Numerous attempts were made to contact him during May 2013, and he was eventually seen in July 2013. Adult B attended the CMHT assessment with Dolly and reported experiencing panic attacks in public places, nightmares, bouts of tearfulness, mood swings, self-harming two weeks earlier, cutting with a razor, and said he often goes months without self-harming. He stated when low his hygiene suffers, and he misses appointments. He reported an unspecified overdose 8-12 months earlier, and he went to hospital. He said he did not tell anyone, but that Dolly made him go to hospital. Adult B also described an overdose 4-6 years previously of 50 ecstasy pills, he had bought in bulk because it was cheaper. After a night out, all his friends went to bed; he took the tablets, called an ambulance and was taken to hospital.

96. Adult B stated he wanted to "get better". He reported suicidal ideation but stated that he would not act on these thoughts, denied any thoughts to harm others and there was no evidence of any formal thought disorder found.

97. The last contact between Adult B and CPFT was at the end of July 2013 when he was assessed by the Home Treatment Team following a referral from the

local general hospital. He had presented there after taking a combination of painkillers. As no acute mental illness was present during the assessment, there was no further input of action from the Home Treatment Team.

Devon and Cornwall Police (DCP)

98. Devon and Cornwall Police (DCP) first had contact with Dolly and Adult B in 2010, when officers took their new-born child into police protection. At that time the DCP enquiries established that the couple had had two other children removed prior to living in the Cornwall area. The first was in 2007 when their then three-year old son suffered injuries that were not believed to be accidental. Adult B was arrested for this, but no further action was taken.

99. A finding of fact case at family court determined that both Dolly and Adult B and one other adult were all culpable for the injury. Neither Dolly nor Adult B engaged with the assessment or court process. Following this Dolly and her one-year old daughter were placed in a mother and baby unit without Adult B. In April 2010 Dolly left the mother and baby unit and had no contact with the child from that point on. The child has since been adopted.

100. Dolly and Adult B moved to Torquay and when she became pregnant again, they failed to inform local children's services and failed to engage in any pre-natal care. When the child was born neither Dolly or Adult B were believed to be able to care for the child and they also gave false details to the midwife and maternity unit which prompted the intervention of children's services and DCP. The child was later adopted, and Dolly and Adult B had no further contact with him.

101. The police national computer shows no convictions for Dolly. Adult B has a history of offences in the Cheshire area, believed to be 16 offences, of which one was related to domestic abuse. This was in 2007 when he punched his ex-girlfriend. His last and only conviction prior to the murder conviction was in December 2012 for a public order offence.

102. Prior to 2015 DCP have three recorded domestic abuse incidents between Dolly and Adult B. These were in February 2014, March 2014 and November 2014. DASH assessments were completed and were all graded low/standard risk. These reports did not lead to a referral to local support services.

103. In May 2015 DCP officers attended Cosgarne Hall following a report from a third party. There had been an argument between Dolly and Adult B

and officers identified the incident as domestic abuse. A safeguarding concern was raised. Dolly and Adult B refused to assist with the completion of the DASH. It appears that no historical checks were done by officers in relation to previous domestic abuse between the couple.

104. Following their eviction from Cosgarne Hall, there were a number of contacts between DCP officers, Adult B and Dolly. These related to incidents relating to drug and alcohol use and drug possession.

105. Dolly's last two contacts with DCP were in November 2015 following the theft of her handbag and in January 2016 when she reported the theft of her mobile phone. The day after the reported theft Dolly contacted the police to say the phone had been returned to her.

106. DCP commenced their murder investigation in relation to Dolly's death in May 2017.

South West Ambulance Service

107. South West Ambulance Service (SWAST) had two contacts with Dolly in the timeframe covered by this Domestic Homicide Review.

108. The first of these was in February 2016 when a 999 call was received from Adult B in the early hours of the morning, stating that Dolly was experiencing an asthma attack. An ambulance attended and following an assessment by SWAST paramedics, Dolly was given medication to improve her breathing. Dolly being unable to locate her inhaler had exacerbated the asthma episode. The ambulance crew gave her further advice about contacting her GP to obtain a new inhaler.

109. In April 2016 SWAST received a 999 call at around 9.00am. Dolly made the call and stated that she had a deep cut in her perineum area. She could be heard talking to someone else, presumed to be Adult B. The call handler questioned Dolly and she stated there was no blood loss. Dolly explained to the call handler that she had been to see some friends the previous evening and believed she may have been drugged and raped. She said she had no evidence that this had happened but was unsure why she would have the injury otherwise.

110. An all-female ambulance crew was dispatched to Dolly, as were the police. On examination by the ambulance crew, no laceration could be found.

Adult B confirmed to the ambulance crew that Dolly had not been out of his presence during the preceding evening. There was no further intervention from the ambulance service, other than noting that Dolly had mentioned that she had experienced discomfort around that area of her body and now thought it might be the result of washing her clothes with cheap shower gel.

111. There was no further contact from SWAST.

17. Analysis

112. The organisations that supplied IMRs all had some form of contact with Dolly or Adult B. This section of the report examines the information that was known and shared, or not, and the decisions and actions taken, or not by the agencies involved.

Primary care

113. Dolly was registered with GP practice covered by the IMR between March 2016 and the notification of her death in May 2017. Dolly was only registered with the practice for a short period and the GPs did not know her well.

114. The IMR demonstrates that there was no evidence that the GP practice was aware that Dolly was at risk from any individual although she had told them that she and Adult B argued. She specifically told them that he was not violent towards her. The GP practice was aware of the risks Dolly posed to herself, particularly in relation to her drug misuse and her history of overdoses. It is less clear that there was any exploration of her relationship with Adult B and their mutual reliance on drugs, nor how that relationship may have influenced or impacted on her drug and alcohol use.

115. The GP practice did appropriately refer Dolly for specialist mental health service support and the GP's were aware of her mental health problems. They also explored other options such as counselling and the input of Outlook South West.

116. The GP practice did demonstrate that it had shared information about Dolly with other health agencies and with homelessness services. The extent to which homelessness services went beyond verbal information sharing with the GP's is less clear.

117. There is limited evidence that the GP practice was proactive in following up on reports of her non-attendance for appointments with services to which they had referred her or had been in contact with on her behalf.

118. The GP practice did not have any specific concerns about Dolly or her safety in the period immediately prior to her disappearance and subsequent notification of her death. It is not clear why no safeguarding referral was ever

made, given the known history and complex needs. Guidance on referral routes into adult social care need to be reissued, including the ability to email referrals if phone access is limited. Recommendation 6.

119. There is one example of a discussion between Dolly and her GP about her relationship with Adult B and the possibility of domestic abuse. This appears to have related to arguments and not physical abuse. Dolly indicated that Adult B had never physically abused her. It is not clear that the GP explored this in any more detail in an attempt to ascertain the extent of the arguments or gain a deeper picture of the relationship.

120. The GP records do contain accurate and appropriate information about Dolly's history and background, including her childhood trauma relating to violence and sexual assault.

121. The GP practice demonstrated that it had sound policies and procedures in place in relation to adult safeguarding. It is noted that the GP's at the practice had received some domestic violence training as part of wider safeguarding training, but there is no evidence of more specific relevant domestic abuse training or awareness. The practice has no named domestic abuse or domestic violence lead.

122. The primary care IMR makes five recommendations for local action and these are set out in Section Four.

Cosgarne Hall

123. During the period that Dolly and Adult B resided with Cosgarne Hall, the organisation was aware of the risks they presented to themselves and of Adult B's previous convictions. Their policy was followed in relation to the couple being offered places but in separate rooms.

124. Cosgarne Hall conducted an appropriate risk assessment process and housing needs assessment. Suitably experienced Senior Support Workers conducted these assessments. They had an appropriate range of training including some of which was specific to domestic abuse and domestic violence. However, there is no evidence of any routine enquiry in relation to domestic abuse.

125. There was limited information sharing between Cosgarne Hall and other agencies. In part this appears to have been due to the lack of information

that Cosgarne Hall had about Dolly and Adult B. How this was done, and its frequency is much less clear and although the IMR states that staff know how and when to share information, evidence is lacking that provides assurance about the process, protocols and procedures operated by Cosgarne Hall for such sharing of information.

126. Given the nature of the service provided and the client group served, Cosgarne Hall operates a high tolerance in relation to the complex needs of people living with them. Decisions to accommodate are made based on current risk and the decisions relating to this are the responsibility of the Support Manager and ultimately the Operations Director. There is little evidence of a structured process for decision making in relation to risk management.

127. The IMR states that risk during Dolly and Adult B's stay was managed effectively and that there were no significant incidents until the eviction. It also states that there was no reported evidence of domestic abuse between Dolly and Adult B during their time at Cosgarne Hall. This is contrary to the DCP IMR, which clearly states their attendance in relation to a verbal argument that was classified as domestic abuse.

128. There is evidence that Cosgrane Hall staff did recognise and understand Dolly and Adult B's complex needs, but it is much less clear that they were able to assist them in addressing those needs. The focus appears to have been almost exclusively on accommodating them, rather than a broader view of the impact of other factors that had led them to utilise the Cosgarne Hall service. It is fair to say that accommodation is the central focus of the service, but the 'supported' element of that accommodation is not well evidenced.

129. In terms of good practice, Cosgarne Hall did appropriately accommodate Dolly and Adult B in separate rooms, having identified the need to provide a service that could meet the needs of vulnerable women with domestic violence, drug/alcohol issues and mental health problems. What is less clear is whether, having identified these needs in Dolly, there was any further exploration of the potential risks to her resulting from those needs or her relationship with Adult B.

130. Cosgarne Hall evicted Dolly and Adult B from the property due to their drug dealing on site. This was a breach of the rules of the organisation.

131. Despite support being offered to complete the IMR, the Chair and the panel were concerned about the quality of the IMR. It took considerable time for the IMR to be provided and this impacted on the timescale for concluding the DHR.

Addaction

132. Addaction were in contact with Dolly throughout her time at Cosgarne Hall, and once evicted, when she was at the local night shelter and then in private rented housing.

133. There is evidence of appropriate assessments for the prescription of opiate substitute treatment and that these were done in a timely manner and were properly recorded.

134. The primary risk identified by Addaction in relation to Dolly was related to her drug use. Indeed, the IMR is clear that there were no other risks identified. The lack of a more holistic view of Dolly, and matters relating to the factors that may have had an influence on her drug use is noticeable and of concern. It would appear that a narrow focus was applied that meant a broader and more informed view was not available. This meant that a number of factors relating to Dolly's childhood experiences, the removal of her children and the relationship with Adult B did not feature prominently in the thinking of those considering her risk in relation to drug use. There was no consideration of risk to Dolly from Adult B.

135. It is important to state that Dolly was not consistent in her engagement with Addaction's psychosocial interventions. This does not appear to have been considered in depth or brought about any changes in approach. The IMR makes clear that Addaction staff believed that Dolly and Adult B were actively choosing to live a particular lifestyle. This demonstrates a lack of understanding about domestic abuse, in particular how coercion and control can impact on a person's ability to engage in service provision. How well Addaction staff were equipped to consider alternative strategies for engagement is not clear from the IMR.

136. Addaction did communicate and share information with other professionals and agencies and attempted to work in a multi-agency way. What is not clear is the process for that information sharing and how those links with other agencies were made or followed up.

Outlook South West

137. The involvement of Outlook South West was confined to an assessment of Dolly in 2013. The assessment was undertaken by an appropriately trained and experienced professional. It was conducted thoroughly and included the taking of a clear history which enabled the worker to gain clear insights into the factors that were affecting Dolly's mental health and were influencing her thoughts of suicide at the time.

138. Outlook South West appropriately and swiftly referred Dolly to a Community Mental Health Team and shared all the necessary and relevant information with that team as part of the referral. They also shared details of the assessment and the referral action with Dolly's GP at the time.

139. From the information reviewed, the decision to refer to specialist secondary care mental health services was appropriate and was done in recognition of the complex issues Dolly was dealing with, which were beyond the threshold for the service provided by Outlook South West, which is a primary care service that specialise in brief psychological intervention for people with mild to moderate mental health problems.

Cornwall Partnership NHS Foundation Trust

140. Cornwall Partnership NHS Foundation Trust (CPFT) had a range of contacts, the majority of which were with Adult B during the period covered by this DHR. Dolly was not in contact with CPFT services during the period covered by this DHR but did accompany Adult B to one of his assessment appointments.

141. During that particular assessment there was no indication of risk to Dolly, either in the content of the assessment discussion or from the information CPFT had from other agencies including Cosgarne Hall and Addaction. Dolly did have the opportunity to contribute to the assessment discussion, during which she highlighted the positive benefits of medication for Adult B and noting that his use of drugs and alcohol were coping strategies, which in fact increased his risk to himself.

142. Dolly was referred to CPFT for a physiotherapy appointment relating to her lower back pain, but she did not respond to this. The subsequent contacts

from the physiotherapy service and the GP were appropriate and in line with good practice.

143. The risk assessments that were conducted in relation to Adult B appear to have been thorough and extensive. They noted in detail his history of an abusive childhood, violence towards fellow school pupils, his previous convictions and imprisonment and the removal of his (and Dolly's) children.

144. Routine enquiry in relation to domestic abuse was undertaken during the assessment by CPFT for input from the Community Mental Health Team in June 2015. This was the only assessment conducted within the timeframe covered by this DHR. This revealed to the assessor Adult B's history of conviction for assault on a previous girlfriend. The matter was recorded as an assault in the assessment rather than as an incident of domestic abuse and recorded risk in relation to children and the public rather than to Dolly. The assessor was not in possession of historical information from an assessment undertaken in 2013 in relation to domestic abuse. Had they not undertaken routine enquiry this information would not have come to light.

145. It cannot be said with certainty that if it had been recorded differently that this would have impacted on the approach of CPFT or to the eventual outcome. However, it may have had the effect of minimising the view of risk towards Dolly that was posed by Adult B and his behaviour.

146. Discussion of Adult B took place within a multi-disciplinary team meeting and a clear plan for continuation of Addaction input was agreed. Also agreed was a referral to a specialist service for childhood trauma and abuse, and the option for Adult B to self-refer back to the Community Mental Health Team.

147. The decision not to offer input to Adult B, but to refer to other services, or to ensure ongoing contact with them, was made in a clear and well evidenced way and followed local practice and policy. Appropriate use of the expertise of other staff colleagues and managers was made in the decision-making process.

148. CPFT staff clearly demonstrated to have had training in relation to domestic abuse and the use of routine enquiry. It is also clear that the staff who assessed Adult B were up to date with all their mandatory training.

149. There is evidence of good liaison between the Community Mental Health Team and other services, in particular with Addaction, where the assessor (a Community Psychiatric Nurse) made direct contact to check on future appointments for Adult B with Addaction and that the CPN also feedback the outcome of the assessment to Adult B, who was content with the plan being proposed. It has not been possible to establish if the CPN wrote to Adult B's GP to advise of the outcome of the assessment.

150. There were two principle gaps in the intervention from CPFT in relation to Adult B. The first of these is the limited recording of the telephone screening assessment. This appears to have impacted on the prioritisation of the full assessment appointment. Secondly, the lack of information about domestic abuse from the 2013 assessment and the subsequent recording of this incident in the 2015 assessment.

151. The CPFT IMR makes one recommendation, which can be found in Section Four.

Devon and Cornwall Police (DCP)

152. The domestic abuse history between Dolly and Adult B in relation to police contact covered three incidents and one assault. There were other non-domestic abuse contacts and other contacts related to drug use.

153. DCP had clear policies in place when dealing with matters of domestic abuse. In their contact with Dolly and Adult B, the couple did not consent to provide information that would contribute to the DASH. These incidents appear to have been graded appropriately based on the nature of the incidents and the information available to DCP officers at the time.

154. The domestic abuse incidents in 2014 and 2015 occurred prior to DCP introducing a Single Safeguarding Process, and the information gleaned during those incidents would now prompt the completion of the DCP Vulnerability Screening Tool (ViST).

155. There was no escalation by DCP in the perceived risks posed by Dolly and Adult B, either to each other or to others in the two years before Dolly's death. The contact between the couple was minimal and there was nothing that indicated any change in risk when they did come to the attention of DCP.

156. The level of risk was regarded as low due to the one incident of domestic abuse assault, which was treated as low level as no injury was received and Adult B denied the incident at the time. Adult B did have previous convictions for violent behaviour, but it appears that as these were not directed towards Dolly, they were not seen as directly relevant to any risk he may have posed to her. DCP had no information about any risk posed by him to Dolly. DCP appear to have taken an incident by incident approach, and the previous history did not directly influence or inform further risk assessment or intervention decision making.

157. DCP did make appropriate use of the DASH and given the low risk grading this did not prompt any more specific multi-agency work. There is evidence that DCP appropriately shared information with other agencies when necessary, in particular with health care colleagues.

158. Neither Dolly nor Adult B were able to provide more detail to officers in relation to the incidents that DCP attended. This impacted on those officers' ability to build a wider picture of their relationship and affected the depth of their assessment of the situation between the couple.

159. DCP did make offers of other support services to Dolly when she attended in relation to domestic abuse concerns. She was unable to engage with these and wasn't able to consent to her information being passed to the Independent Domestic Abuse Advisor or to local Women's Aid services.

160. There was no contact between Dolly and DCP in the 16 months prior to the notification of her death and the commencement of the murder inquiry. This meant that the police had no sight or knowledge of any changes in Dolly's relationship with Adult B, or of changes in his behaviour or his mental health. The IMR makes the point that there may have been 'hidden harm' but it is not possible to do anything other than hypothesise about this.

161. The recording of contact between DCP and Dolly and Adult B was accurate, and the decisions made by officers are well evidenced and made in line with practice, policy and legislation. DCP had and continue to have policies in place in relation to domestic abuse, and have put in place further tools, such as the ViST to enhance their practice.

South West Ambulance Service NHS Trust (SWAST)

162. The SWAST IMR states that as a reactive service, responding on a case by case basis, SWAST were not aware of the input or contact of other services with Dolly and Adult B. It also states that they would not have any information about any risks Adult B may have posed to Dolly or others. This highlights the gaps in knowledge that ambulance services have when they attend incidents, however, it is not clear what measures SWAST could have taken to gather that information.

163. Dolly or Adult B were not classified as frequent users of SWAST services, in the timeframe covered by this DHR there were only two contacts. The first of these appears to have been routine, in the sense that SWAST provided reassurance, limited appropriate treatment and advice following Dolly's asthma attack and not being able to locate her inhaler.

164. The second attendance relates to Dolly's report of an injury, which she initially suggested was the result of some form of assault. It does not appear that the detail around this was explored further, and no safeguarding referral was made.

165. The SWAST crew did note that Dolly was washing her clothes with shower gel and that this, combined with poor personal hygiene may have been a factor in her presentation.

166. There is no record that the attending crew had any concern about Dolly's risk or vulnerability and no disclosure of domestic abuse. However, it does not appear that any enquiry about this was made during the attendance. This suggests that the knowledge of when to make such a referral may not be as well embedded in practice as would be hoped. It may be that a lack of professional curiosity, and a focus on the 'medical' issues affected the decision-making process. DCP were also in attendance during this incident, and it appears that the SWAST crew worked on the assumption that the police would speak to Dolly about her concerns about a possible sexual assault. It does appear that the crew did pass this information to DCP officers.

167. There is no evidence that there are any other gaps in relation to practice, but there does appear to have been a lack of depth of knowledge about domestic abuse, safeguarding and taking account of matters of self-neglect.

168. The dispatching of an all-female ambulance crew after Dolly had called with concerns she had been raped should be highlighted and recognised as good practice.

18. Conclusions

169. Dolly and Adult B had a complex relationship. Their life together was characterised by drug use, alcohol use and homelessness. They both experienced issues with their mental health, and their relationships with their families were poor.

170. In Dolly's case, she had been estranged from her family for a number of years.

171. Dolly had experienced significant trauma in her childhood. She had spent time away from her parents following reports of domestic abuse between them. Dolly was raped twice, on both occasions by the same man, when she was 14 and then 18 years old. The effect of these events had a lasting impact on her, which is not unexpected. The lack of support to address the trauma she experienced contributed to her poor mental health in adulthood.

172. In addition to those traumatic experiences, Dolly then faced the loss of her children as a result of the intervention of the police and children's services. Her children have been in the care of public services for many years, although one of her children was in the care of Dolly's mother for a period. It is unclear whether the impact of the removal of her children was considered by services and whether support was offered to Dolly by services.

173. The links between poor parent/child relationships and past trauma and how this can have an impact on adult health and outcomes are well known. More recently the part that Adverse Childhood Experiences can play in a person's later life has gained greater recognition and prominence. Adverse Childhood Experiences are stressful events occurring in childhood. The term was originally developed in the USA for the Adverse Childhood Experiences survey, which found that as the number of Adverse Childhood Experiences increased in the population studied, so did the risk of experiencing a range of health conditions in adulthood. There have been numerous other studies that have reached similar findings including in Wales and England.[3]

174. Dolly had experienced significant emotional distress during her childhood, which included physical and sexual abuse. The impact of these Adverse Childhood Experiences on her psychological health and wellbeing

[3] Adverse Childhood Experiences International Questionnaire. WHO https://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/

does not appear to have sufficiently informed the thinking of those professionals who encountered her.

175. We have now introduced Routine Enquiry into ACES in drugs, alcohol, mental health and DASV services.

176. Dolly's reliance on alcohol was long standing, having developed when she was a teenager, often drinking five or six litres of cider a day at that time. Her reliance on drugs, including heroin and cannabis followed and was a persistent feature of her life.

177. Dolly and Adult B's combined mental health and alcohol problems were of long-standing and were never fully addressed, Over the past two years, a Dual Diagnosis Strategy and Implementation plan have progressed joint working over these issues to prevent people falling through gaps between services and promoting better joint working and support.

178. The agencies that had contact with the couple recognised that they had complex needs. It is less clear that all those agencies were equipped to respond to these, although their regular moving from place to place impacted this. This is now addressed through the Adult Social Care High Risk Behaviour Panel, multiagency meetings and joint working and through Making Ever Adult Matter, locally.

179. Dolly and Adult B were socially isolated. They do not appear to have had many friends; other than those people they knew as a result of their drug use. This meant that there was no informal network of support for either of them.

180. The engagement of Dolly and Adult B with CPFT services was also characterised by their transience, in that they regularly moved between different parts of Cornwall. This made it harder for services to engage them, and required regular updates and information sharing between organisations and teams in different parts of the county.

181. In relation to mental health services in particular, it also impacted on the continuity of input and made it harder for professionals to build any form of therapeutic relationship with Adult B.

182. Each risk assessment conducted in relation to Dolly and Adult B was done in isolation. There were gaps in knowledge and recording of information,

in particular in relation to domestic abuse. This meant that no one organisation or professional had a clear view of the whole history or the current situation.

183. Due the multiple vulnerabilities experienced, services did not fully recognise the relationship between these vulnerabilities and the domestic abuse that occurred, or to identify the DA at a sufficiently high level. The couple's drug and alcohol use hid the domestic abuse that occurred. The small number of incidents that came to the attention of the police are the only ones known about. However, the nature of the relationship suggests that there may have been more that are not known about, particularly in relation to issues of control.

184. Dolly did not respond to offers of appointments and other services. This meant that the issues that they faced both individually and as a couple were never fully explored or addressed in a way that might have helped them. Dolly and Adult B were unable to engage with help and support, and either did not give their consent for information to be shared or for referrals to be made.

185. The agencies involved tended to focus narrowly on their own specific role. They did not take account of wider factors or determinants in relation to the issues that Dolly and Adult B experienced. Dolly does not seem to have been 'on the radar' as at risk with any organisation.

186. Each vulnerability was dealt with in isolation rather than the combined impact of them all. This meant that each incident or issue was seen in its own context, rather than building on past experiences and as such no fuller or holistic picture emerged about Dolly.

187. Dolly appears to have been effectively hidden from the view of organisations in respect of the risks she faced. Her drug and alcohol use, and the previous history of Adult B were not adequately considered. Although the domestic abuse incidents that occurred within the timeframe covered by the DHR were classified as low level, there was an established history of assaultive behaviour by Adult B but this does not appear to have influenced any of the decision making in relation to risk.

188. There are gaps in the recording of contact and intervention between agencies. However, these do not appear to have had any direct impact on the eventual incident.

189. The levels of knowledge in relation to both safeguarding and domestic abuse were variable. This was further compounded by the wider complex needs that Dolly and Adult B had. In particular, if domestic abuse and complex needs had been better understood then there would have been a deeper understanding of the risk of the situations which were attended

19. Learning

190. Based on the analysis and the conclusions the learning has been grouped in 3 key themes:

- **Professionals recognition of domestic abuse, particularly where there are other vulnerabilities**.

191. The levels of knowledge and understanding of domestic abuse across non-domestic abuse services were variable. It was evident that the levels of complexities often masked the DA and led services to not engage in routine enquiry or 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 – recommendation 1

- **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.

192. The need for robust and routine liaison between agencies, in particular following referral and assessment, is a learning point from this DHR. In particular CPFT have highlighted the need to liaise with external agencies to check information and to prioritise response to referrals - recommendation 4.

193. The need for accurate and timely recording of interventions and decisions has also emerged as a learning point. In particular the need to ensure multi-disciplinary discussions of complex presentations and to properly record those discussions in sufficient detail.

194. Throughout the DHR it has been clear that agencies regarded Dolly as vulnerable. DHRs in other parts of the country have highlighted similar issues but have also noted that the word vulnerable means different things to different agencies. As such a learning point to emerge is to ensure what is meant by the term, and whether it remains valid or useful. The consideration

of whether an adult is at risk is a more reliable test, given that it is clearly defined in legislation.

195. This case highlights the challenges of providing persistent and assertive engagement with individuals who are at risk and who have multiple vulnerabilities It also highlights the need for better understanding of the impact of trauma and its effect on future behaviour, relationships, health and wellbeing – recommendation 5

196. A lot of work has been done between the time of this review and receiving feedback from the Home Office. A number of key bits of work have been developed, including a joint drug and alcohol and domestic abuse protocol, a dual diagnosis strategy and a complex needs strategy. All of these pieces of work look at the needs of those with multiple vulnerabilities, including the impact domestic abuse, specifically coercion and control, can have on engagement with services. There is clear need to further embed this work to better support those with multiple vulnerabilities. The Cornwall CSP also commissioned DASV 3-tiered training, in which all 3 tiers are rooted in power and control and cover the impact of coercion. The continuation of these pieces of work has been highlighted as a recommendation in this review – recommendation 5.

- **Domestic Homicide Review Process in Cornwall**

197. This DHR highlighted the need for better and more consistent family support across 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 integral stakeholders to the review at all stages. Since this review the DHR process has been better defined in Cornwall to ensure families are contacted at the earliest opportunity. The contract with the DHR chair has also been amended to ensure it better emphasises the importance of family involvement and the role the chair has in supporting this. The CSP need to ensure this contract and the DHR statutory guidance is followed for all future DHRs – recommendation 3

198. This DHR has highlighted the need for organisations to be better equipped to respond to requests for IMRs and to more fully understand both the need to prioritise their completion, to do so in a meaningful way and to seek and accept support in their completion when needed – recommendation 2

Recommendations

This section of the Overview Report sets out the recommendations of the DHR panel and also the recommendations from the IMRs.

DHR panel recommendations

1) We recommend that professionals across Cornwall be updated in their training in relation to domestic abuse and violence to ensure thorough and up to date knowledge. They should also be encouraged and supported to use routine enquiry when appropriate. Particular focus should be given to third sector and independent organisations locally including Cosgarne Hall and Addaction.

2) Training/information should be offered at the beginning of each DHR to support agencies in the completion of IMRs. The CSP should ensure the standard SLA with DHR chairs is updated to reflect this.

3) Family members should be an integral part of DHRs. Family members should be involved at the earliest opportunity and support should be provided to ensure they can remain key stakeholders throughout the process. The CSP should ensure Chairs adhere to the DHR Statutory Guidance to ensure this is the case for all future DHRs.

4) We recommend that a process be developed by the CCG, the NHS Trusts, the police and adult social care, and other relevant organisations, to examine the process for information exchange between them, with specific focus on how best to do so when working with transient or homeless people.

5) We recommend the development of a multi-agency approach to working with people, particularly couples, experiencing multiple vulnerabilities. The continued delivery of the DAAT/DASV joint working protocol and dual Diagnosis Strategy and complex needs strategy should be prioritised, rolled out and embedded. This should include the need for services to engage in assertive outreach to engage with those with multiple vulnerabilities. As part of the Complex Needs Strategy we recommend that work be undertaken to improve the understanding of Adverse Childhood Experiences and the development of effective trauma pathways in Cornwall.

6) Adult Safeguarding to reissue guidance about how to make Adult Safeguarding referrals, i.e. can be made via email.

IMR recommendations

Primary Care IMR recommendations

- A Domestic Violence Policy should be in place in the GP surgery
- Domestic violence awareness / training should be arranged for staff.
- The Children's Safeguarding policy is dated 8.10.2014 and contains clear information that it will be reviewed annually. This is overdue.
- Consideration of any enhancement to medical notes/information transfer where individuals are known to be homeless/in supported lodgings.
- There are regular Multi-agency MH hub meetings held at the GP Practice, which recently have been less well attended by MH. Patients to be discussed at meetings should be known in advance to ensure maximum efficiency of practitioner's time, and outline reports sent, if attendance is not possible.
- To continue to raise awareness and provide training for professionals regarding support and advice for children who experience physical or sexual violence in order to minimise the impact it has on their long-term health and emotional wellbeing outcomes.

Cornwall Partnership NHS Foundation Trust IMR recommendations

- Services must record a brief summary of any clinical discussion held in the MDT using the SBARD tool (Situation, Background, Assessment, Recommendation, and Decision). This to be recorded as a minimum in the patient's clinical record, live in the MDT to avoid loss of information. The Nurse Consultants for each area to measure compliance and quality of information recorded.

Cosgarne Hall IMR recommendations

- A dedicated database specifically aimed at transient couples or perpetrators that are accessed by professional agencies who provide accommodation, to collate information on domestic abuse victims allowing relevant professionals to extract the required up to date information for their offered service which could determine trends and highlight risk escalation.