SAFER CORNWALL
Kernow Salwa

Cornwall Community Safety Partnership

Domestic Homicide Review

Into the death of Lucy (pseudonym)

in March 2020

OVERVIEW REPORT

David Warren QPM, LLB, BA, Dip. NEBSS
Independent Domestic Homicide Review Chair and Report Author

Review Completed: 20 July 2021

Table of Contents

Appendices

Family Tribute to Lucy

This is written to offer an understanding of Lucy, the person she was and what she meant to us as a family. When we think of Lucy we smile and we remember her as loving, caring and putting others first. She was a dedicated mother who lived for her boys, they were her life. Lucy liked to do things her own way but was always considerate of others. Lucy could be mischievous and liked to play tricks on people to cheer them up, for example putting sweets in their drinks, she had a giggly little laugh, which we heard a lot when she was in a happy place. Lucy was very good at art, she loved to paint, this made her happy as did family holidays to Benidorm, this was her favourite place to be.

We miss her deeply.

Section One: Preface

1.1. The Domestic Homicide Review Chair and Panel wish to express their deepest sympathy to Lucy's family and all who have been affected by Lucy's untimely death.

1.2. This Domestic Homicide Review (DHR) is held in compliance with legislation and follows statutory guidance. Its purpose is to identify improvements which could be made to community and organisational responses to allegations of domestic abuse and to try to prevent future incidents. Actions taken to improve services as a result of this Review, will be part of Lucy's legacy.

1.3. DHRs are not disciplinary inquiries nor are they inquiries into how a person died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

1.4. This review has been undertaken in an open and constructive way with those agencies, both voluntary and statutory that had contact with Lucy, entering into the process from her viewpoint. This has ensured that the Review Panel has been able to

consider the circumstances of Lucy's death in a meaningful way and address with candour the issues that it has raised.

1.5. The Chair and Panel thank all who have contributed to the review for their time, patience and cooperation. In particular the DHR Chair thanks Alison Parrott for the consistent high standard of her administration of this Review.

Section Two - Introduction

2.1. This report of the Domestic Homicide Review (DHR) examines agency responses and support given to Lucy (pseudonym), a resident of St Austell, prior to the point of her death in March 2020.

2.2. In addition to agency involvement the Review also examines the past, to identify any relevant background or possible abuse before Lucy's death; whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the Review seeks to identify appropriate solutions to make the future safer.

2.3. A summary of the circumstances that led to a review being undertaken in this case is:

2.3.1. In February 2020, Lucy separated from her partner Lee (pseudonym), the father of her two children after a reported incident of domestic abuse on her and their five-month-old child Samuel (pseudonym chosen by family). Subsequently Cornwall Family Court directed Lucy and the children into a 12 week foster care placement as a place of safety and to help her with her parenting skills.

2.3.2. Lucy was depressed about being in the placement and was worried about going to Court in relation to the domestic abuse she had suffered as Lee continuously contacted her in contravention to the conditions of his bail, pleading with her to drop the charges.

2.3.3. A few weeks into the placement, Lucy left her children with the Foster Carer and travelled to her mother's address in St Austell. Her mother was out, but her brother found Lucy in the kitchen, going through her mother's prescribed medication. Whilst he was phoning his mother to tell her that Lucy had unexpectedly turned up, he saw Lucy leave the house.

2.3.4. The following morning, concerned for Lucy's welfare, as she had not been answering her phone, Lucy's mother, sister and step-father went to her flat in St Austell. They found Lucy in the bath, They made 999 calls for an Ambulance and commenced CPR on her. When the paramedics arrived, they continued trying to resuscitate Lucy but were unsuccessful.

2.3.5. A forensic postmortem was carried out and concluded that there was no evidence of third-party involvement. Toxicology results indicated a cause of death as 'Zopiclone intoxication' (a sleeping aid). The Coroner's Inquest was not held until 10 January 2022; the conclusion of the Coroner as to the death was *Accident* (see 14.8).

2.4.6. The Review has considered all known contact/involvement agencies had with Lucy, Lee and their children during the period from 1 January 2017 to the death of Lucy in March 2020, as well as contacts prior to that period which could be relevant to domestic abuse, violence, self-harm, substance abuse or mental health issues.

2.5.7. The key purpose for undertaking DHRs is to enable lessons to be learned where there are reasons to suspect a person's death may be related to domestic abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change to reduce the risk of such tragedies occurring in the future.

Section Three - Timescales

3.1. During August 2020 staff from the local Hospital asked Cornwall Community Safety Partnership if the Partnership had been notified about Lucy's death in March 2020.They explained that although they believed Lucy had taken her own life, they were of the opinion it might meet the criteria for a DHR.

3.2. Devon and Cornwall Police were contacted and after an internal review, apologised that there had been an oversight, as Lucy's death had not been associated with domestic abuse. On re-examining the circumstances it was confirmed that at the time of Lucy's death, Lee, her ex-partner had been on bail for assaulting her by 'slapping her and grabbing her around the throat'. The Police also confirmed that shortly before her death Lucy had been the subject of a Multi-Agency Risk Assessment Conference (MARAC) referral in respect of domestic abuse.

3.3. Anticipating a formal notification from the Police, the Community Safety Partnership decided that a Domestic Homicide Review should be established as promptly as possible and on 9 October 2020 the Home Office was informed of this decision.

3.4. Subsequently on 22 October 2020 the Police formally notified the Chair of the Cornwall Community Safety Partnership that the circumstances surrounding Lucy's death met the criteria for a DHR and acknowledged that this should have been done immediately after her death.

3.5. On 27October 2020 agencies were informed of the Review and on the 24 November 2020, the DHR Panel was appointed and held its opening meeting.

3.6. The Review was concluded on 20 July 2021. Normally DHRs, in accordance with national guidance, would be completed within six months of the commencement of the Review, however in this case due to extraordinary high demands on the Cornwall Hospital Trusts, the Home Office authorised an extension to allow NHS organisations to have additional time to conduct their Individual Management Reviews.

Section Four - Confidentiality

4.1. In accordance with statutory Guidance[1], the findings of this Review are restricted to only participating officers/professionals, their line managers, Lucy's mother, step-father, her siblings and the family's Advocate from Advocacy After Fatal Domestic Abuse (AAFDA) until after this report has been approved for publication by the Home Office Quality Assurance Panel. With the agreement of the Home Office a copy of the Overview Report has also been provided to the Cornwall Coroner and to the Devon and Cornwall Police Crime Commissioner. Lee declined the opportunity to participate in the Review and did not wish to have any further contact with the DHR.

---

[1]Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. para 72 (Home Office. December 2016)

4.2. As recommended within the Guidance, to protect the identity of the deceased and her family, pseudonyms have been used throughout this report. The pseudonyms for the deceased, her children and her ex-partner were chosen respectively by the deceased's mother and by her ex-partner.

4.3. Lucy who was a white British national, was aged 19 at the time of her death. Lee who is also a white British national was at that time aged 28. Their children, Jake was two years of age and Samuel was five months old. Their dates of birth and the date of Lucy's death have been redacted from this report to protect their identities and for the privacy of Lucy's family.

Section Five - Terms of Reference (As set out at the commencement of the review)

5.1. Agencies that have had contact with the deceased, Lucy (pseudonym) and/or her ex-partner Lee (pseudonym)[2] and/or her children Jake and Samuel (pseudonyms) should identify any lessons to be learnt from their contacts. They should also set out provisional actions to address them as early as possible for the safety of future suspected victims of domestic abuse, particularly those who are vulnerable through age, mental health issues and/or substance misuse.

5.2. This DHR which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

5.3. The Domestic Homicide Review will consider:

5.3.1. Each agency's involvement with the following, from 1 January 2017 (in case of Education and Police 1 January 2014) to the date of Lucy's death in March 2020, as well as all contact prior to that period which could be relevant to domestic abuse, violence, stalking, controlling behaviour, self-harm or other mental health issues.

a. Lucy, who was 19 years of age at date of her death.

b. Lee, who was 28 years of age at the time of Lucy's death.

c. Jake, who was two years of age at the time of Lucy's death

d. Samuel, who was five months at the time of Lucy 's death

5.3.2. Whether there was any history of abusive behaviour towards the deceased and whether this was known to any agencies?

5.3.3. Whether there was any history of mental health problems and if so whether that was known to any agency or multi-agency forum?

5.3.4. Whether family or friends want to participate in the Review. If so, ascertain whether they were aware of any abusive behaviour to Lucy prior to her death?

[2] Lee after initially agreeing to participate in this DHR later withdrew his consent.

5.3.5. Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

5.3.6. Could improvement in any of the following have led to a different outcome for consideration:

- Communication and information sharing between services?
- Information sharing between services with regard to the safeguarding of adults and children?
- Communication within services?
- Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services?

5.3.7. Whether the work undertaken by services in this case are consistent with each organisation's:

- Professional standards?
- Domestic Abuse policy, procedures and protocols?

5.3.8. The response of the relevant agencies to any referrals relating to Lucy, her children or Lee concerning domestic abuse, controlling behaviour, stalking, harassment, other significant harm, mental health, or any Safeguarding issue. It will seek to understand what decisions were taken and what actions were carried out or not and establish the reasons. In particular, the following areas will be explored:

- Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Lucy.
- Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective?
- Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made?
- The quality of any risk assessments undertaken by each agency in respect of Lucy, Lee or their children.

5.3.9. Whether organisations' thresholds for levels of intervention were set appropriately and/or applied correctly, in this case?

5.3.10. Whether practices by agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded?

5.3.11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner?

5.3.12. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services?

5.3.13. If any other statutory Inquiry or Review is established to examine the circumstances surrounding the death of Lucy the DHR will liaise with the organisations involved to avoid unnecessary duplication and to take due notice of any findings or recommendations made by such an Inquiry or Review subject to the final shape of the review meeting the requirements as set out in the statutory guidance.

5.3.14. Whether agencies are fully aware of the statutory requirement to notify the Chair of the Community Safety Partnership of domestic abuse related suicides, in particular those that have been the subject of a MARAC referral.

5.3.15. The Review will consider any other information that is found to be relevant.

Section Six - Methodology

6.1. The method for conducting a DHR is prescribed by Home Office Guidance. As previously stated, upon receiving verbal notification of Lucy's death from the local hospital, which was later confirmed by Devon and Cornwall Police, a decision to undertake a DHR was taken by the Chair of the Cornwall Community Safety Partnership during consultation with Partnership members. The Partnership noted that although it was accepted that Lucy had probably taken her own life, there were records to indicate that she may have been a victim of domestic abuse and that she had been the subject of a Multi-Agency Risk Assessment Conference (MARAC). The Home Office was informed of this decision on 9 October 2020.

6.2. Agencies in the Cornwall area were instructed to search for any contact they may have had with Lucy, Lee and or their children. If there was any contact then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review. This allowed the individual agency to reflect on their contacts and identify areas which could be improved and to make relevant recommendations to enhance the delivery of services for the benefit of individuals in Lucy's circumstances in the future.

6.3. The DHR Panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs) and other reports of participating agencies and multi-agency forums including the Cornwall Multi Agency Risk Assessment Conference (MARAC)
- Cornwall Coroner
- The Pathologist Report
- Discussions with Lucy's mother, step-father and one of her sisters

- Discussions with Lucy's ex-partner Lee, his mother and uncle.
- Discussions during Review Panel meetings

Section Seven - Involvement of Family and Friends

7.1. Lucy's mother and step-father and Lee, his mother and uncle, were contacted at the commencement of the Review by letter, followed by several telephone conversations. During the first of those, the Review Chair explained separately to Lucy's mother, step-father, to Lee, his mother and his uncle the purpose of the Review and why it was being held.

7.2. Although the Chair took time to explain that the Review was not about blame but was about agencies learning and addressing lessons from their contacts with Lucy, Lee and their children, Lee and his mother were particularly concerned about the title of 'Domestic Homicide Review'. They worried that it may appear to others, that Lee was suspected of murdering Lucy. The Chair promised that their views on the title of the Review would be included in the Review's final report. Lee chose the pseudonym to be used for himself and confirmed that he was happy with the pseudonyms provided, for Lucy and their children, which had been chosen by Lucy's mother.

7.3. Lee informed the Review that he had never hit Lucy but that they did have frequent arguments. He said the reason he had been arrested was because during a loud argument she had run into the bathroom and locked the door. He had been afraid she was going to cut her wrists as she had tried this in the past, so he had broken the door down and grabbed hold of her to prevent her injuring herself. Lee's mother told the Chair that she was aware that Lucy was very depressed after Samuel's birth.

7.4. The Review Chair offered to contact an independent support service to provide an advocacy function for Lee and his family. Lee's mother said they would consider it. Regrettably, after a few weeks Lee decided he did not wish to continue his or his family's engagement with the Review and he retracted his consent for the DHR to access his medical records. He explained to the DHR Chair that his drug dependency had got more chaotic and that he had left Cornwall. He declined the offer of help to access a substance abuse support agency as he did not wish anyone to know where he was living and said he did not want to be contacted again.

7.5. The Review Chair spoke to Lucy's mother regularly throughout the course of the Review. During those conversations she informed the Chair that Lucy was about 12 years of age when she first met Lee who was a friend of her elder sister. She said as Lee started to spend more time with Lucy there were noticeable changes in Lucy's behaviour. She suspected that Lee had introduced Lucy to using illegal drugs, firstly cannabis then cocaine. Lucy had never been interested in drugs prior to meeting Lee, who was a known drug user. When Lucy was 14 years of age, she had self-harmed by using a blade from a pencil sharpener to cut her arms and after taking two of her mother's sleeping tablets collapsed at school. Approximately two months later she was excluded from the school after being found on school premises in possession of a knife. Her mother described Lucy as very quiet and lacking in confidence. She found it difficult to speak to officials or people she did not know.

7.6. Lucy's mother had been concerned about Lucy for a few weeks before her death. She said Lucy was finding it difficult to cope with two young children. In her opinion Lucy was

suffering from post-natal depression. After Lee had been arrested for assaulting her, Lucy had been put into foster care to help her with parenting skills. She said Lucy had difficulties communicating with the Foster Carer who was a stranger to her and she found the placement restrictive. At the same time she was worried about giving evidence in Court, as Lee was continually contacting her, breaching his bail conditions, pleading with her not to give evidence against him. He even told Lucy he was having a heart attack due to the worry of being sent to prison.

7.7. The Review Chair informed Lucy's mother and step-father about the advocacy support the family could receive from AAFDA. She asked the Chair to arrange for an AAFDA Advocate on her behalf. This was done and during the Review the Advocate assisted the family and was kept informed of the progress of the Review by the Chair. Lucy's mother signed a consent form for the Review to access confidential information relating to Lucy which was held by agencies. Lucy's mother also confirmed that there had been no barriers stopping the family reporting incidents of domestic abuse prior to Lucy's death.

7.8. At the conclusion of the DHR, Lucy's mother and Advocate were given copies of the draft Overview Report and Executive Summary to read in private. Care has been taken to ensure that Lee's and Lucy's mother's comments are reflected within this final report.

7.9. Lucy's mother, step-father and elder sister attended the DHR Panel meeting on 20 July 2021. The Chair welcomed them to the Panel members who individually introduced themselves. The Panel Chair told the family that he had amended the report on a point they had raised after reading the OV Report and Executive Summary and told them of other minor changes that had been made since they had read it. He undertook to send them a copy of the final reports once they had been updated after the meeting. Lucy's mother thanked the Panel for the thorough and thoughtful manner in which the Review had been conducted. The family were invited to ask Panel members any questions they might have. On behalf of the family Lucy's mother asked; why the charges against Lee had been dropped after Lucy's death. Both the police panel member and the police IMR Author who were present, gave clear detailed answers explaining that they believed that this decision was made too hastily and this had not only been brought to the attention of the officers concerned but the all Devon and Cornwall Police personnel had been reminded of the Force policy on Evidence Led Prosecutions. (Which was explained to the family). The IMR Author pointed out that at the time the decision making officers had never been notified that Lee had been constantly contacting Lucy in breach of his bail conditions. Nor were they aware of the evidence that has since been uncovered during this review. Lucy's mother thanked the officers for their honest response.

Section Eight Contributors to the Review

8.1. Whilst there is a statutory duty on bodies including the Police, local authority, probation trusts and health bodies to engage in a DHR, other organisations can voluntarily participate; in this case the following eighteen organisations were contacted by the review:

- **Advocacy After Fatal Domestic Abuse (AAFDA):** This specialist Charity is providing an advocacy service for Lucy's family. It had no previous involvement with either Lucy or Lee.

- **Kernow Clinical Commissioning Group (CCG):** A senior member of this organisation who is independent of any contact with Lucy or Lee is a DHR Panel member.

- **Cornwall Council Adult Social Care:** This Department had no relevant contacts with Lucy or Lee. A senior member of this agency is a DHR Panel member.

- **Cornwall Council Adult Safeguarding:** This service had no relevant contacts with Lucy or Lee.

- **Cornwall Council Children and Family Services, Together for Families:** Three services within this Department had relevant contacts with Lucy and her children and a joint Individual Management review (IMR) was completed. A member of this organisation who is independent of any contact with Lucy or her children is a DHR Panel member.

- **Cornwall Hospital Trusts: [Includes Cornwall Foundation Trust (CFT) and Royal Cornwall Hospital Trust RCHT)]** These Trusts had relevant contacts with Lucy and her children and a combined IMR was completed. A member of the RCHT who is independent of any contact with Lucy or her children is a DHR Panel member.

- **Cornwall Housing Ltd:** This service had no relevant contacts with Lucy or Lee. A senior member of this agency is a DHR Panel member.

- **Cornwall Multi Agency Risk Assessment Conference (MARAC):** The current Cornwall MARAC Chair responded to a DHR Memorandum of Agreement confirming that Lucy had been referred to a MARAC meeting. The MARAC Chair who is also a Panel member, provided an IMR report setting out her review of this referral. She had no previous involvement with Lucy, Lee or their children.

- **Devon and Cornwall Crown Prosecution Service:** This service had one relevant contact relating to Lee and an IMR was completed. The Service declined the opportunity to appoint a Panel member to the Review in view of their limited involvement.

- **Devon and Cornwall Police:** This Police Force had relevant contacts with Lucy and Lee and an IMR was completed. A member of this organisation who is independent of any contact with Lucy or Lee is a DHR Panel member.

- **First Light:** This domestic abuse support service has provided an Internal Management Review (IMR) report in relation to Lucy. A senior member of this Charity, who has had a limited supervisory role in relation to Lucy's contact with the organisation, is a DHR Panel member. Due to the size of this Charity, it has been necessary for the Panel member to also be the IMR Author.

- **Home Group:** This organisation ran the Benen Chy housing programme for young parents and their babies. It had relevant contacts with Lucy and her baby Jake. An IMR was completed. A member of the organisation who is independent of any contact with Lucy or her children is a DHR Panel member.

- **Ocean Housing:** This service had relevant contacts with Lucy and provided an IMR. A senior member of the organisation who had no previous relevant contacts is a Panel member.

- **Surgery. A:** This GP Practice provided an IMR in relation to contacts with Lucy. The IMR Author had no previous contact with Lucy or her children.

- **National Probation Service:** This service had no relevant contacts with Lucy or Lee. A senior member of this agency is a DHR Panel member.

- **South Western Ambulance Service NHS Trust:** This service provided an IMR in relation to contacts with Lucy. The IMR Author is also a Panel member, he had no previous contacts with Lucy, Lee or their children.

- **Victim Support**: This service notified the DHR that it had no relevant contacts to report.

- **We Are With You**: (Drug and Alcohol Service re Positive People employability programme). This organisation notified the DHR that they had a limited contact with Lucy in as much as they offered her a placement on the Positive People programme but she declined the opportunity. They did have contacts with Lee but as he refused his consent for the information to be shared with the DHR, it has not been included. A senior member of the organisation is a Panel member.

8.2 Eleven of those agencies/multi-agency conferences have completed Individual Management Reviews (IMRs) or reports. It should be noted however that Together For Families has completed an IMR with three sections in relation to different areas of the Department's responsibilities and the Cornwall Hospital Trusts have provided combined IMRs in relation to Lucy and her children.

8.3. All but one of the IMR/Report Authors have confirmed that they are independent of any direct or indirect contact with any of the relevant parties subject to this Review. The Service Manager of First Light has notified the DHR Panel that while she had no direct involvement with Lucy, she did have ultimate supervisory responsibilities however due to the size of the organisation there is no one else available with the experience of conducting an IMR.

8.4. Lee and Lucy's family have also provided information to the DHR.

8.5. The Cornwall Coroner has given the DHR access to the report and statements provided to him for the purposes of the Inquest.

Section Nine - Review Panel

9.1. The DHR Panel consists of experienced, senior officers from relevant statutory and non-statutory agencies. Other than Mel Francis of First Light, who had supervisory responsibilities for the First Light staff supporting Lucy, none of the other the Panel members had any prior contact with Lucy, Lee or their children.

9.2. The Panel members are:

Alexandra Morgan-Thompson: Quality and Information Manager, Cornwall Housing Ltd

Sandy Williams: Adult Safeguarding Service Manager, Cornwall Council Adult Social Care

Laura Ball: Domestic Abuse and Sexual Violence Strategy Lead; Cornwall Council

Anna MacGregor: Domestic Abuse Co-ordinator and Multi Agency Risk Assessment Conference(MARAC) Chair; Cornwall Council

Sid Willett: Drug Related Death Prevention Co-ordinator, Cornwall Council Drug and Alcohol Team

Rebecca Sargent: Head of Children and Families Services East Cornwall, Cornwall Council Together For Families

Ben Beckerleg: Superintendent; Devon and Cornwall Police

Mel Francis: Service Manager, First Light

Victoria Martin: Senior Client Service Manager, Home Group

David Hooper: Regional Manager, Ocean Housing

Wayne Derbyshire: Senior Probation Officer, National Probation Service

John Groom: Director for Planned Care and Integrated Care, NHS Kernow Clinical Commissioning Group (CCG)

Chris Rogers: Named Safeguarding Professional,South Western Ambulance Service Trust

Paula Chappell: Public Health Practitioner (Mental Health and Suicide Prevention), Cornwall Council

Zoe Cooper: Consultant Nurse for Integrated Safeguarding Services for CFT and RCHT Freedom to Speak Out Champion,RCHT Prevent Lead, Royal Cornwall Hospital Trust & Cornwall Foundation Trust

Sam Dixon: Team Leader, We Are With You (Drug and Alcohol Service re Positive People employability programme)

David Warren: Home Office Accredited Independent Chair

Police Safeguarding Lead: Detective Sergeant Rob Gordon; Devon and Cornwall Police

Review Administrator: Laura Ball, Cornwall Council

Panel Meeting Minute Taker: Alison Parrott, Cornwall Council

9.3. Expert advice regarding domestic abuse service delivery in Cornwall has been provided to the Panel by Mel Francis of First Light which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in Cornwall. Specialist advice regarding self-harming and suicide has been provided to the Panel by Paula Chappell Suicide Prevention Lead, Public Health, Cornwall Council.

9.4. The DHR Panel met formally four times. (Due to Covid restrictions all meetings were held on ‘Teams’) The schedule of the meetings was rearranged after the first meeting to provide more time for Hospital Trusts to complete their IMRs.

24 November 2020

20 April 2021,

25 May 2021

20 July 2021

Section Ten - Chair of the Review and Author of the Overview Report

10.1. The Chair of the DHR Panel is legally qualified and is an accredited Independent Domestic Homicide Review Chair. He has passed the Home Office commissioned Domestic Homicide Review Chairs' courses and possesses the qualifications and experience set out in paragraph 37 of the Home Office Multi-Agency Statutory Guidance (2016).

10.2. He has no previous connection with the Safer Cornwall, the Community Safety Partnership and is independent of the agencies involved in the Review. He has had no previous dealings with Lucy, Lee or their children.

10.3. He has an extensive knowledge and experience working in the field of domestic abuse and sexual violence at local, regional and national level. Between 2004 and 2011 he was the Home Office Criminal Justice System Manager for the South West. Amongst his responsibilities were the funding and monitoring of the delivery of local services to address domestic violence and sexual crime. He was a member of a number of Central Government committees, including those relating to the development of Violence Against Women and Children policies, the national development and implementation of DHRs and the national funding of local domestic and sexual abuse services.

10.4. Since 2011 he has chaired numerous statutory reviews including Serious Case Reviews, Mental Health Reviews, Drug Related Death Reviews and DHRs across the country He has been a keynote speaker at several National Conferences on domestic and sexual abuse, most recently in 2020 on the particular issues facing Domestic Homicide Reviews in cases relating to Suicides.

10.5. For a number of years he carried out voluntary work as the chair of a substance abuse support charity and has provided pro-bono legal work for a refuge and its residents.

Section Eleven - Parallel Reviews

11.1. Coroner's Inquest: In March 2020 the Cornwall Coroner opened and adjourned an Inquest in order to allow the Devon and Cornwall Police time to gather information relating to the circumstances of Lucy's death. The DHR Panel thanks the Coroner for sharing the information and reports he has obtained for the purposes of the Inquest. The DHR Chair attended a Pre-Inquest Review on 30 November 2020. The Inquest has yet to be held.

Section Twelve - Equality and Diversity

12.1. The Panel and the agencies taking part in this Review have been committed within the spirit of the Equality Act 2010 to an ethos of fairness, equality, openness, and transparency. All nine protected characteristics in the Equality Act were considered and the

Panel was satisfied that services provided were generally appropriate. Lucy's age, gender and vulnerability were considered to be of particular relevance.

12.2. **Ethnicity:** There is no evidence to suggest that Lucy, Lee or their children being white British citizens were ever an issue in the manner in which agencies delivered services to them.

12.3. **Gender:** The Panel, when considering Lucy's vulnerability as a woman, was satisfied that all of the agencies, recognised and responded with empathy to her vulnerability. However Lucy's gender was a key issue with regards the abuse she endured from older men with whom she had contact.

12.5. **Mental Health:** When Lucy was 14 years of age, her mother took her to the GP as she had been depressed and had self harmed by taking an overdose of her mother's medication. The GP while treating her anxieties appropriately referred her to Child and Adolescent Mental Health Service (CAMHS). She had two assessments, Lucy scored 32 on the Mood and Feeling questionnaire (MFQ). She denied having any current suicidal ideation and as she was receiving support at school and at home, she declined the offer of further sessions at that stage. However a few months later, after an alleged overdose of Zopiclone and cocaine, Lucy was again referred to CAMHS. A Vulnerable Child Alert was added to her clinical records. A thorough assessment was made and appropriate multi-agency support was provided involving CAMHS, a Social Worker, the school nurse, Police, Youth Offending Team. Concerns were raised about possible grooming by a 28 year old male friend, Marcus (pseudonym).

12.6. **Age:** The DHR Panel is satisfied that Lucy's vulnerability through her age and inexperience was, when known, given appropriate consideration by agencies when responding to her problems of caring for two young children whilst in a chaotic relationship. See paras 15.10 re CAMHS involvement. Paras 15.13 & 15.14. re Midwife's concerns and referral to the Specialist Perinatal Mental Health Team. Her vulnerability was also the focus of support at Benen Chy (paras 163-16.8) and later through the intervention of Social Service and the Police, the Family Court made an Interim Care Orders for a parent and child placement for both children and Lucy, for their well-being and safety and to assist Lucy with her parenting skills.(See Para 16.22. this was followed by a MARAC involvement (see para 16.23). There was only one earlier occasion when there were concerns about her association with an older male, when Lucy was 14 years of age. Lucy's and her friend's association with Marcus was investigated by the police. The Police and her parents were satisfied that there was nothing to suggest anything other than Marcus would talk to the girls when they were at the friend's home. (See para 15.7. and 18.3.7.).

Section Thirteen - Dissemination

13.1. Each of the Panel members, the IMR authors, the Chair and members of the Safer Cornwall, Community Safety Partnership have received copies of this report. A copy has also been sent to the Devon and Cornwall Police and Crime Commissioner and to the Cornwall Coroner. In accordance with statutory Guidance[3], the findings of this review are restricted to only participating officers/professionals, their line managers, Lucy's mother and her AAFDA Advocate until after this report has been approved for publication by the Home Office Quality Assurance Panel.

---

[3]Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. para 72 (Home Office. December 2016)

13.2. Lucy's mother and her AAFDA Advocate have been given electronic copies of this report and the Executive Summary to enable them to have the opportunity to read the reports at length and in private.

Section Fourteen - Background information (The Facts)[4]

14.1. On 3 December 2018 Lucy moved from Benen Chy, young parents' accommodation with Jake, her 9 month old baby, into a rented ground floor flat in St Austell. While Lucy was the named tenant it is now known that Lee, Jake's father frequently stayed over. Subsequently in October 2019 Lucy gave birth to Samuel.

14.2. On 4 February 2020 the Police were called to Lucy's flat after Lucy was seen and heard shouting for help, by a member of the public. When the officers arrived, they heard a disturbance was going on with sounds of an argument and children screaming. Lucy who appeared intoxicated, told the officers that Lee had slapped her twice to the face, strangled her with both hands and pushed her into a hot shower. Lee was arrested and told the Officers he had taken Xanax and cocaine and had been bingeing on cocaine for the previous 48 hours. He was given Police bail with conditions not to contact Lucy in any way and not to go to her home address. A high-risk DASH was completed and the children were taken to Lucy's mother for safeguarding purposes.

14.3. Three days later, on 7 February 2020 as a result of concerns about Lucy's welfare and ability to cope on her own with two young children, an emergency Family Court hearing was held. A parent and child placement order was made for Lucy and the children, who became subject to Interim Care Orders.

14.4. Lucy's family were aware that she had not been herself and had been struggling psychologically since the domestic violence. Lucy's mother told the DHR Chair that Lee continued to contact Lucy, in breach of his bail conditions, to plead with her to drop the charge of assault. She said Lucy became very distressed but was afraid to report these breaches to the Police. At the time, Lucy was also finding the Court placement restrictive and was having trouble bonding with her baby Samuel. Her mother was of the opinion that she was suffering from postnatal depression although she did not think that Lucy ever voiced this to anyone.

14.5. The day before her death, Lucy contacted her mother and step-father separately asking for money so that she could leave the parent and child placement for a break. They both refused as they were planning to visit her the next day and they did not want her to breach the placement order. However later that evening Lucy turned up unexpectedly at her mother's address in St Austell. Her mother was out, but her brother found Lucy in the kitchen going through her mother's prescribed medication. Whilst he was phoning his mother to tell her that Lucy was at the house, he saw Lucy leave.

14.6. The following morning, concerned for Lucy's welfare, as she had not been answering her phone, Lucy's mother, sister and step-father went to her flat in St Austell. After getting no reply, they entered the property with a spare key and found Lucy in the bath, clothed in her pyjamas and with the hot tap still running. While her head was not under water, her eyes were closed and there was foam at her mouth. Her step-father lifted her out of the bath and he tried to carry out resuscitation but he could not open her mouth, her jaw was

---

[4] This section sets out the information required in Appendix Three of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office December 2016)

stiff. An ambulance arrived and Paramedics took over the resuscitation, but Lucy could not be revived.

14.7. The Pathologist, after conducting a post mortem and considering the toxicology evidence reported that there were no ante-mortem injuries to the body to cause or contribute to death, nor were there natural disease on naked eye examination or under the microscope to cause or contribute to the death. There was no indication that Lucy had consumed alcohol in the few hours before death. However toxicology showed 'a level of Zopiclone, a sleeping tablet, that lies within the range seen in cases where death was attributed to clone intoxication (0.4-3.9 mg/L)'. The Pathologist explained that Zopiclone can cause dizziness, respiratory depression, coma with slow heart rate and death. Any individual with severe respiratory depression can develop some froth in the airway. Toxic effects of Zopiclone would account for the post-mortem findings and the death. Whilst there appeared to be six old parallel linear horizontal red/white scars, each up to 3 cm on Lucy's left arm, there were no visible injury or bruising to suggest injuries caused by a third party.

14.8. The Coroner's Inquest was not held until 10 January 2022. The Coroner stated "*(Lucy)* was a 19-year-old woman who was in a parent and child foster placement after being assaulted. Care proceedings had been instituted and her ability to care for her children was being assessed. *Lucy* found the arrangements difficult and struggled to cope. She indicated to her GP that she wanted mental health support but when contacted by clinicians declined their assistance. On 21/3/20, she left the placement and travelled to her parents' address. She removed medication prescribed to her mother. She then travelled to her flat in St Austell. The next day she was found deceased in the bath in her pyjamas with the hot tap running. On the evidence it is more likely than not that *Lucy* took the medication deliberately but there is no evidence she intended to take her own life. The outcome was unanticipated." 'Conclusion of the Coroner as to the death: **Accident.'**

14.9. In August 2020 the Safer Cornwall the Community Safety Partnership received an enquiry from a Safeguarding Officer from the local hospital, asking why no consideration had been given to establishing a DHR into the circumstances surrounding Lucy's death, as hospital staff had witnessed Lucy being subjected to abusive and controlling behaviour by Lee while she had been in hospital with her baby. Safer Cornwall made enquiries with Devon and Cornwall Police and in October 2020 received a formal notification that Lucy's death met the criteria for a DHR as per para 18 of the Statutory Guidance as at the time of her death her ex-partner was on Police bail for an assault on her.

Section Fifteen - Chronology

15.1. The events described in this section explain the background history of Lucy prior to the timescales under review as stated in the Terms of Reference. They have been collated from the chronologies of agencies that had contact with Lucy and from information provided by Lee and Lucy's family.

15.1. Lucy, Lee and their children were all brought up in Cornwall.

15.2. Lucy who was born in 2000, has an elder sister, an elder brother and a step-sister. She lived for the whole of her childhood with her mother and for the majority of her childhood with her step-father.

15.3. When Lucy's family moved from Devon to Cornwall in 2003 the then Royal Devon and Exeter Healthcare records were transferred to what was the Cornwall Healthcare

Trust. They noted that Lucy had been left alone with a Section 1 offender who was a family friend. There was a letter from a Social Worker requesting that the children were not left alone with the named person otherwise it would go to the 'Child Protection arena'.

15.4. The first referral made to Cornwall Children's Social Care was recorded in March 2009, following a historical allegation of familial sexual abuse.

15.5. In November 2012 a referral was made by the Police to Cornwall Council Children and Family Services, (Together For Families), following a report by Lucy's mother that Lucy had been the victim of a sexual assault by a 12 year old fellow pupil. No child protection concerns were identified and Lucy received ongoing support provided by her school.

15.6. In 2012 when she was about 12 years of age, Lucy first met Lee who was going out with her elder sister. Lucy's mother and step-father were concerned that Lee, who they believed was a drug user, may introduce the girls to illegal drugs, they therefore banned him from coming to their home and warned the girls about him. It was not until two or three years later that they learnt that Lee had started to meet up with Lucy away from the house. Lucy's mother who always attended the GP Practice with Lucy is clear that Lucy was not sexually active at that time.

15.7. In October 2014 Lucy's mother took her to see her GP regarding low mood and self-harming including an overdose of diabetic medication. Her mother believed it was triggered by an incident on 23 September 2014 when Lucy was at a friend's house and witnessed Marcus, a 28-year-old neighbour who (she said to police officers), she was friends with, being aggressive towards her friend's mother. The Police were called and Lucy saw Marcus chase the officers with a machete. Lucy admitted being scared at the time, but said she missed seeing Marcus as 'he was someone she could confide in'. Officers spoke with the families of the two girls and discovered that both families were concerned about the relationship that their girls had with Marcus although all agreed that they did not believe there to be anything sexual or inappropriate happening. Officers gave words of advice to both Marcus and the parents. No criminal offences were uncovered and an intelligence submission was made. A referral to Together for Families (TFF) was made and a social work assessment was completed with a subsequent multi-agency Child in Need plan until August 2015. This included education services, Youth Offending Service and CAMHS involvement. During this period of 'Child in Need' there were concerns raised in relation to Lucy's emotional and behavioural wellbeing, including drug use and child sexual exploitation.

15.8. In March 2015 a referral was made to the Children's Social Care and Lucy's GP by South Western Ambulance Service regarding Lucy's welfare, describing that she had gone home at lunch time from school had taken two of her mother's prescribed sleeping tablets, without her mother's knowledge and then returned to school under their influence. Whilst there was a suggestion that she had also taken illicit drugs, no evidence of this was uncovered.

15.9. While Lucy was at secondary school there were 194 behavioural incidents recorded about her. The final one being in May 2015 when she was found on school property, in possession of a 4 inch lock knife. On the advice of the Youth Offending Team (YOT) she was charged and sentenced to a six month referral order and ordered to pay costs and a victim surcharge. She was excluded from her school and moved to Academy A in Redruth.

Lucy's mother has explained Lucy had taken the knife from a male student to prevent him from being arrested.

15.10. As referred to previously, Lucy had Child and Adolescent Mental Health Services (CAMHS) assessments in 2014 and 2015 which both described 'concerns around Lucy being withdrawn, quiet, possibly low in mood and anxious. Also some self-harm at this time in the form of taking overdoses of medication she could find around the house.' CAMHS offered Lucy anxiety management work in 2014 but she declined this, claiming she was not depressed and was receiving adequate support from the school and at home.

15.11. When she was 16, she attended Cornwall College from the commencement of the term, September 2016 until January 2018. A month before she left college due to her pregnancy with Jake, her mother took her to the GP surgery as she was concerned that Lucy was depressed as she could not get her to go to college. She told the GP, Lucy would breakdown crying and lock herself in the toilet.

15.12. On 30 January 2017 Lucy's mother contacted the GP Surgery to say Lucy was 'feeling suicidal' and had cut her wrists at the weekend. She was prescribed Sertraline and this was reviewed weekly. By 24 February 2017 some improvement was noted and she was switched to citalopram liquid as she did not like taking tablets. By April 2017 ongoing progress was noted although she was still appearing 'flat and quiet'.

15.13. On 19 December 2017, Lucy's midwife being aware of her history of self harming, referred her to the Cornwall Foundation Trust (CFT) Specialist Perinatal Mental HealthTeam as she was presenting as 'extremely anxious' and there were concerns about her vulnerability and risk of exploitation.

15.14. The following is a part of a letter given to Lucy and copied to her Midwife which summarised her assessment by the Mental Health Team.

"You described how prior to 2014 you were a "bubbly", happy and chatty young person. However, you experienced a number of difficult social situations around this time which appear to have had a significant impact on your self-esteem and confidence at a critical time in your emotional development. I won't repeat the details of past assessments but briefly these included:

- An incident involving a machete with an older man called ……. *(This related to Marcus, not Lee who Lucy had not spoken about)* whom you had considered a close friend. I know there were concerns at the time that he might have been controlling of you.
- You were charged with possession of a knife in school grounds and later excluded. You had to appear in court and do community service. You and Mum explained that an ex-student had brought the knife into school and you took it off him in order to try to protect him from getting into trouble. Exclusion had a big impact on your friendship group at the time and you described how "they stopped talking to you" and you also stopped talking to them.
- Your best friend was taken into care. She started to put you in difficult situations and, to protect yourself, you had to stop having contact with her.

It was around this time that your Mum started to notice you becoming quieter, more withdrawn, staying in more and generally seeming less social. It was around this time that you started to notice feeling anxious especially in social situations which involve talking to

other people ..... Lucy, you do not describe feeling depressed or low in mood. You rated your mood as average and you describe feeling, “happy but scared” about the prospect of becoming a Mum… ”

15 15. Lucy gave birth to Jake in March 2018.

Section Sixteen - Overview

16.1. This section summarises what information was known to the agencies and professionals involved in the Review about Lucy and her children. It also includes relevant information provided by Lee and Lucy’s family.

16.2. As Lee has denied ever assaulting Lucy, in order to present the extent of the information given to agencies by Lucy and the detail of the contemporaneous observations of professionals that explain why Safer Cornwall Community Safety Partnership decided there was sufficient reason to believe Lucy’s death met the criteria for a DHR, there is significantly more detail in this and following sections than would normally be the case.

16.3. After Jake’s birth in March 2018, Lucy and the baby moved into Benen Chy, a young parents’ supported accommodation in St Austell. Her referral information included that Lucy presented as extremely anxious and there were concerns about her vulnerability and risk of exploitation. Lucy had claimed that she had ‘got pregnant’ by someone she had met on holiday but did not know who he was, however the Midwife was of the opinion that Lucy was never truly open regarding her history and was hiding a relationship. During the time she was at Benen Chy, she had two key support workers, who described her as being ‘a very quiet and shy young lady’, but as she got to know the staff and other residents, she seemed to gain confidence and started to pay more attention to her education. However they noticed that when Lee (who she claimed was her cousin) visited her, she reverted to being subdued and nervous. Later staff learnt of the relationship between Lucy and Lee from other residents, who being worried about his behaviour towards Lucy, reported disturbances caused by him when staff were not on the premises.

16.4. When staff checked the premise’s CCTV they saw Lee turning up at 3am and waking Lucy. They reminded Lucy about the regulations relating to visitors and informed her of the concerns of her fellow residents that Lee’s behaviour appeared to be controlling and abusive towards her. While Lucy denied this, there were two incidents which were captured on CCTV which led staff to be particularly worried for Lucy’s safety.

16.5. On 30 September 2018 Lee called the Police to state that he was outside of Lucy’s address (Benen Chy) and wanted to speak with her but that she was refusing to speak with him. He stated that her step-father who he did not get on with, had also turned up. Officers attended but Lee had apparently already left the area. They later spoke with him on the phone and he said that he had had a disagreement with Lucy on the phone over child contact. Officers updated the log to say that no domestic incident had occurred and there was no other help they could offer Lee. The log was subsequently closed. The IMR Author found nothing to indicate that the Officers ever spoke to Lucy or her step-father about this incident.

16.6. On 18 October 2018, after being informed about Lee turning up at Benen Chy in the early hours and abusing Lucy, staff examined CCTV footage and saw Lee throwing Lucy around the upstairs communal corridor ‘like a rag doll’. Lucy did not want the Police involved at that stage but an immediate referral for Lucy was made to ‘First Light' the domestic abuse support service as a high risk victim of domestic violence.

16.7. The second incident was at 4am on 23 October 2018. Lucy had herself telephoned the Police to report that 'her ex-partner', Lee, had phoned stating he had left some of her belongings outside Benen Chy. When she had gone out to retrieve these belongings, she found that he had been hiding nearby and jumped out on her and tried to barge his way inside. She managed to lock herself inside, but he was still present and was constantly shouting to her and phoning her. She explained that he had been violent to her in the past but on this occasion, she got away from him quickly enough to avoid any further violence. Although Lee had left prior to the arrival of Police officers, a DASH assessment was completed which evidenced fear on Lucy's part and a worry of a change in Lee's behaviour as a result of drink and controlled drugs. The assessment explained that Lucy already had a good support network from various agencies including her key workers at the mother and baby unit, Social Care, her GP, and her parents. Lucy told the officers that Lee had pushed her and it was on the Benen Chy CCTV. She added that he had also grabbed her by the throat in her accommodation. The officer requested this CCTV footage, but Lucy later declined to make a complaint and there was no further Police action. The Officers did not view the CCTV or appear to consider initiating an evidence-led prosecution.

16.8. On 29 November 2018 after liaison between the Benen Chy key workers and Jake's Social Worker about her progress and ability to look after Jake, the Children's Services case was closed. However as Lucy was soon to move into a rented flat with Jake, concerns were voiced about the increased risks they would face. Lucy had disclosed to a Social Worker that Lee forced her to drink vodka throughout her pregnancy and she was worried that it had affected Jake as he was showing delay. The Social Worker notified the Health Visitor Service to recommend that they make contact with Children's Services if there are any concerns following this disclosure.

16.9. As Lucy was back in an 'on/off relationship with Lee, the First Light IDVA wrote to Ocean Housing, the property owners, to check on the level of sanctuary measures at the premises. Whilst the necessary security levels were already in place, Ocean Housing arranged for additional support for Lucy under their 'Vulnerable Tenant' scheme. This entailed regular telephone calls to offer support, which Lucy declined, explaining that although she had occasional contact with Lee, there had been no further abuse. Nevertheless a few months later a 'Cause for Concern" flag was raised by Ocean Housing, after trade staff could not gain entrance to carry out repairs. When contact was eventually made with Lucy, she claimed she had been on holiday and was all right.

16.10. On 15 May 2019 Lucy, who was almost ten weeks pregnant, accompanied by Lee and Jake, met with a Midwife who asked them about Children's Services input during her previous pregnancy. Lucy disclosed that she suffered from social anxiety and that she was known to Children's Services since she was a child, Lee admitted that he had ADHD[5] for which he was being treated with medication. It was recorded that he told the Midwife that in his past, he had attacked his mother and had served a custodial sentence.

16.11. On 5 July 2019, Police received a call from Lucy's mother stating that Lee was at Lucy's address and following an argument, was attempting to abduct Jake who was 9 months old. She also reported that he had taken Lucy's phone. Lee had left the flat before the arrival of Police officers who learnt that Lucy had found where Lee had hidden her phone and that as her mother was there, he had not been able to take Jake. The reason for the initial argument was because Lee had brought cocaine with him into Lucy's flat and she had flushed it down the toilet as she did not want it around Jake. Lucy declined to

[5] attention deficit hyperactivity disorder

complete the DASH risk assessment, nevertheless one was submitted, graded medium based on the information officers gleaned at their attendance.

16.12. On 21 September 2019 Lucy took Jake to hospital with nappy rash and feeling unwell. Whilst they were at the hospital, concerns were raised about Lucy. She had been subdued and difficult to communicate with and struggled to hold Jake for examination. She was 28 weeks pregnant and her waters had broken two weeks earlier. Both Lucy and Jake were admitted for assessment.

16.13. Two senior hospital staff documented concerns about Lee's attitude towards both Lucy and the baby whilst they were on the ward. Lucy was tearful and appeared scared of Lee. When it was safe to do so the Midwife asked Lucy about domestic abuse and Lucy confirmed verbal abuse from Lee but not physical violence. The Midwife explained what support was available, but Lucy declined all offers of help. It was noted that when Lee returned to the ward, 'he was openly aggressive and forceful with Lucy, he was short tempered with Jake and frequently swearing'.

16.14. Subsequently a referral was made by the hospital safeguarding team to Together For Families, Children's Services as Lucy had been tearful and intimidated by Lee's aggressive behaviour. The Midwife additionally reported that she was struggling to have regular contact with Lucy and was concerned about the ability of both Lucy and Lee to look after two very young children. A decision was made for a social work assessment to be completed, however Lucy would not give her consent for the assessment and as there was no evidence that she met the criteria for section 47 enquiries, the case was closed to Social Care.

16.15. On 23 September 2019 Lee telephoned the hospital to ask how Lucy was as she had not texted him with the blood test results from earlier in the day. He said he felt that she was 'hiding something from him'. The Midwife informed him that she was not able to give the results as they were confidential. Shortly after this, Lucy rang the bell and asked for her blood test results. It was assumed that Lee had prompted her to get them. A DASH assessment was undertaken with Lucy, on which she scored 12. She disclosed that she had previously separated from Lee in November 2018, that she had been afraid of him in the past and that she never leaves their son alone with him. Lucy told the Midwife that he checked her bag and phone all the time. While denying any current physical abuse Lucy admitted he had choked her in the past. She confided that intercourse was consensual although she knew that currently it was not advised. Lucy also disclosed that Lee had another child who he has no contact with as there had been domestic abuse concerns respecting the mother of this child. Lucy added that she was worried about Lee's mental health as he misused drugs and had a known history of violence and arson. He had told her, he had made two suicide attempts in March and October 2018, therefore Lucy felt too scared to leave him 'for what might happen'. A Safety plan was made with Lucy and a decision was made for a referral to MARAC. However as the Midwife left the ward, Lucy was already outside with Lee, he was shouting at her but when he noticed the Midwife, they went back into the maternity unit. Due to an error by the Midwife, the referral was never sent to the MARAC.

16.16. On 27 September 2019 during Multi Agency Referral Unit (MARU) discussions regarding the family, concerns were raised about Lee's aggressive behaviour towards Lucy and Jake in the presence of hospital staff. The hospital IDVA raised these concerns with Lucy, but she declined to engage and the crime was filed by the Police with no further action.

16.17. A few days after Samuel's premature birth in October 2019, while Lucy and the baby were still on the postnatal ward, the Hospital Safeguarding Lead liaised with the Health IDVA regarding further concerns about Lucy's welfare due to Lee's aggressive behaviour while visiting her. When an opportunity arose for the IDVA to speak to Lucy alone, Lee arrived unexpectedly and could be heard outside the room they were in. Lucy became incredibly nervous and denied that there were any problems between them.

16.18. On 13 November 2019 while visiting Samuel, who had been kept in hospital due to his premature birth, Lucy was on her own and was happily talking to a nurse. She appeared animated with Jake, playing and interacting appropriately. She made good eye contact and was smiling. The nurse brought some toys in and they appeared happy. However, Lee came into the room and Lucy visibly changed, becoming quiet and making limited eye contact.

16.19. On 24 November 2019 while Lucy and Lee were visiting Samuel at the Hospital Lee was abusive towards Lucy and hospital staff and was asked to leave the ward. The Police were called as after he left, he had been constantly 'hounding' Lucy on the phone and staff could hear Jake screaming in the background. Lucy who appeared afraid of Lee informed staff that Lee had told her that Jake had been vomiting. The Police Officers telephoned Lee and being satisfied that no offence had been committed took no further action.

16.20. On 4 February 2020 Police were called by a member of the public who had seen Lucy leaning out of the window shouting for help. Lee was grabbing her and pulling her back in. Officers arrived within fifteen minutes and were able to locate the flat as they could hear the ongoing disturbance with sounds of an argument and children screaming. Lucy disclosed to officers that during the argument, Lee had slapped her twice to the face, strangled her with both hands and pushed her into a hot shower. Whilst she stated that she would be willing to make a statement and attend court, she was deemed too intoxicated to make a statement therefore a signed pocket notebook entry was made. Lee was arrested and he told the Officers he had taken Xanax and Cocaine and had been bingeing on Cocaine for the previous 48 hours. A high-risk DASH was completed and the children were taken to Lucy's mother for safeguarding purposes.

16.21. The Police bailed Lee with conditions not to contact Lucy, Officers explained safeguarding measures to Lucy and a referral was made to the Cornwall Multi Agency Risk Assessment Conference (MARAC).

16.22. On 5 February 2020 during a social worker's visit, it was noticed that Samuel had marks to his nose and face, neither Lucy nor her mother knew how the marks had come about. As Lucy had not sought medical attention for Samuel a child protection medical check was arranged for both children. Samuel was kept in hospital overnight for further tests and Children's Social Care sought legal advice. Consequently, on 7 February 2020 at an emergency Family Court hearing, Interim Care Orders were made for a parent and child placement for both children and Lucy, for their well-being and safety and to assist Lucy with her parenting skills.

16.23. The following day the MARAC IDVA contacted Lucy, who was very quiet and answered questions with single words. She said she was unsure if she wanted support but agreed to further contact. (When a further telephone call to Lucy was made by the IDVA on 11 February 2020, she was in a mother and child parenting placement and was undergoing an assessment.)

16.24. Subsequent to the Police referral, the Cornwall MARAC met on 12 February 2020, to consider Lucy's circumstances. The Police representative was asked to appraise the officer in the case, of possible breaches of bail conditions as Lee was suspected of continuing to contact Lucy and to ask the officer to prioritise taking witness statements.

16.25. On 17 February 2020 Lee attended hospital reporting a significant cocaine and ADHD medication overdose as Lucy had left him. Upon examination the only symptom found was a raised heartbeat. He was given a social worker appointment.

16.26. At a family worker direct work session on 26 February 2020 Lucy said she wanted to go home from the Foster Home. Consequently two days later she was given the opportunity to have time out of the placement and to re-join after the weekend to continue to care for her children within the safe environment.

16.27. When Lucy returned to the placement, the Foster Carer was worried about her mood and suspected she may have been taking drugs whilst out of the placement. Lucy declined for a referral to be made to 'We are With You' stating: "I am not a druggie" and she declined a referral to the Perinatal Team and CMHT. However she did agree to meet with a worker from First Light. While Lucy continued to engage with parenting work with the family worker, she admitted that she continued to send and receive texts with Lee although they both claimed they were no longer in a relationship.

16.28. On 4 March 2020 the MARAC IDVA completed a face to face meeting with Lucy. Noting that Lucy was not at ease with strangers and was not wishing to talk to her, she decided that it might help Lucy if she rearranged the meeting so that Lucy's Social Worker could be present.

16.29. On 16 March 2020, Lucy met with the Social Worker and the MARAC IDVA and they discussed available support. Lucy agreed to a referral to the 'Susie' Programme and the MARAC IDVA promised to support Lucy at the court hearing against Lee.

16.31. On 17 March 2020, Lucy was seen by the Ocean Housing Key Worker and confided that she was feeling low. She said she felt 'trapped' and that the previous week, she had self-harmed on her upper arm, The Key Worker completed a PHQ-9 Depression Test Questionnaire to see how low in mood, Lucy was. She scored 27, the highest score on the PHQ-9 which indicated severe depression.The key worker asked Lucy if she felt suicidal and she explained that she had constant thoughts of suicide but had made no plans to do it . With Lucy's consent the Key Worker alerted the Foster Carer and contacted Lucy's GP.

16.32. Later the same day Lucy presented to her GP, expressing suicidal thoughts and wanting to leave the parenting placement with her children. She told the Doctor she had felt low for about 18 months due to a history of physical, verbal and sexual abuse. It was considered that she was at high risk and an urgent referral was made to the Mental Health team via telephone and they said they would contact Lucy within 24 hours. A call was also placed to her Social Worker. Lucy was strongly advised not to leave her placement and the Foster Carer was told to phone if Lucy left the premises. The next morning the Home Treatment Team notified the GP that they had been unable to contact Lucy. The GP contacted Lucy and was told she was still in the placement but was waiting for a call from the 'Home Treatment Team' at 2pm.

16.33. At 2pm on 18 March 2020 a Community Psychiatric Nurse (CPN) spoke to Lucy on the phone. Lucy found it very difficult to talk on the telephone, but denied any current suicidal thought, claiming that: "All is fine now", saying that the previous day had been a bad day. She said the last time she hurt herself had been a month ago and this was following difficulties with her ex-partner, Lee. She told the CPN that her two children were a protective factor, nevertheless a face to face meeting was arranged for 10am the next day.

16.34. The following day Lucy did not turn up for her 10am appointment with the Assessment Lead and when contacted on the phone, Lucy said she had been in court regarding Child Protection issues which she claimed went 'pretty well'. Lucy explained that when she had seen her GP she was feeling quite desperate but this had passed and she no longer wanted to be seen by the Community Mental Health Team. The GP claimed she was not immediately notified of this.

16.35. Lucy's mother included in her statement to the Coroner, that Lucy told her that the Police had informed her, she would need to attend Court on 30 April 2020 in relation to the case against Lee for assaulting her. She told her mother that she did not want to go to Court as Lee had been breaching his bail conditions by constantly contacting her, begging her not to go to Court, claiming he was having a heart attack etc. and had been to hospital.

16.36. On the 19 March, 2020 the Police Officer in the case against Lee, spoke with Lucy who stated that she did not wish to have any special measures at court but did want a restraining order with conditions that Lee could not contact her or attend her address.

16.37. At 9.45am on the day before Lucy died, she telephoned her mother, asking her to collect her from the Foster Carer's home. Her mother told her she could not, as her husband had the car. Her mother then contacted her estranged husband, Lucy's step-father to warn him that if Lucy phoned, not to collect her as she wanted Lucy to stay with the Foster Carer. During the day Lucy phoned her mother several more times asking for transport or money for the train fare.

16.38. At 2.06pm Lucy texted her mother, asking her to put £10 into her bank account. Her mother responded 'You cannot leave". Lucy replied; 'I need Tox' [6]Her mother sent a reply; "And the kids need you.x"

16.39. Later Lucy told the Foster Carer that she wanted to leave and go home. The Foster Carer tried to persuade Lucy to reconsider and to remain in placement, but she insisted she was leaving that night. The Foster Carer transported her to the bus station to ensure she got on the bus safely, then she alerted Children's Social Care Out of Hours Service.

16.40. That evening Lucy's brother contacted his mother who was out, informing her that Lucy had turned up at their home and had gone through her mother's medicines looking for Tramedol. There were none there, but her mother later noticed that Lucy may have taken some of her Zopiclone sleeping tablets.

16.41. At about 1215 pm the next day, Lucy's step-father and her sister went to Lucy's flat to see her. On arrival they knocked on the front door but got no reply. Her step-father shouted through the letter box, then thinking she may be still asleep went around to the back of the premises and knocked on the window. Getting no response, he left his

---

[6] Lucy's mother understood 'Tox" to mean prescription drugs

daughter outside the flat and went to collect Lucy's mother who had a spare key for Lucy's flat.

16.42. On returning to Lucy's with her mother, they opened the front door and could hear water running in the bathroom. Lucy's sister went in, followed by her and step-father. They saw Lucy in her pyjamas in the bath. Her head was above the water line and . her eyes were closed. Her step-father lifted her out of the bath, placed her on the floor and after checking for a pulse tried to give her mouth to mouth resuscitation. He could not open her mouth, so gave her 'chest compressions' until paramedics arrived and took over giving CPR but without success.

Section Seventeen - Analysis

17.1. The Review Panel analysed each agency's contacts carefully from the view point of Lucy to ascertain if interventions, were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if key lessons have been identified from the chronologies and that they are being properly addressed. Consequently some agencies have added to their lessons learnt and reviewed their action plans during the course of this review. Good practice has been acknowledged where appropriate.

17.2.The Review Panel has checked that the key agencies taking part in this Review have domestic abuse policies (either stand alone or as part of a wider Safeguarding policy) and is satisfied that those policies are fit for purpose.

17.3. **Cornwall Hospital Trusts (CFT and RCHT)**

17.3.1. A comprehensive joint IMR was completed by two authors respectively from the Cornwall Foundation Trust and the Royal Cornwall Hospital Trust detailing the Trusts' interactions with Lucy and her children from 2003.

17.3.2. It was established that Lucy was referred to mental health services on 4 occasions (twice to CAMHS, once to the Special Perinatal Mental Health Team [SPMHT] and once to the Intensive Care Mental Health Team [ICMHT]). There were other occasions when advice was sought from CAMHS and SPMHT. Lucy was identified as having social anxiety and fear around talking to others and trusting others, (this was flagged by more than one professional health worker to ensure that it did not inhibit the provision or support for Lucy). She was understood to have poor emotional coping strategies and as being a risk of harm to herself. However, no severe or enduring mental health problems were identified that met the criteria for secondary mental health services in Cornwall.

17.3.3. The Panel notes that communication and information sharing between services was hampered by information being recorded on different systems. CAMHS did not have access to other childhood records and would not have had the time to routinely review 3 record systems even if there had been access. The Child Sexual Exploitation (CSE) now Multi Agency Child Exploitation (MACE) forum communication did not reach CAMHS so they were not aware that a risk from an abusive relationship with an older male (not Lee) may be current. The IMR Author highlighted several examples of this and demonstrated how each issue of inconsistent information sharing across Cornwall Foundation Trust records systems has now been resolved subsequent to this review.

17.3.4. It is acknowledged that there were missed opportunities as a Multi Agency Risk Assessment Conference (MARAC) referral was not made at an appropriate time due to human error.

17.3.5. There were barriers to seamless working between the ICMHT Assessment Team and the Home Treatment Team at the point they interface with regard to the emergency pathway.

17.3.6. Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse and available local specialist services was identified as needing to be improved as mental health teams stated not being confident that they were being kept up to date with ever changing Domestic Abuse (DA) resources to signpost to patients. Some of the interviewed Mental Health practitioners did not demonstrate a full understanding of the potential impact of controlling and coercive behaviour on Lucy. Consequently, the Safeguarding Team designed an intranet resource which will be regularly updated with any changes to domestic abuse service availability to help in this regard and promoting the NHS Safeguarding App. First Light/Safer Futures will provide an update of services into Hospital Trusts newly designed bespoke health DA training as delivered by Barnardo's (commissioned by Cornwall Safety Partnership).

17.3.7. With regards to conforming to professional standards it was noted that there were lapses on occasions such as the Home Treatment Team (HTT) attempting contact with Lucy without a prior review of their records. CAMHS staff member assessed Lucy without prior review of her record. There was no formal risk assessment recorded in the SPMHT assessment, although this was not understood to be procedure at the time. Email communication between the ICMHT assessment service and the GP was reported but was not recorded and is no longer available.

17.3.8. In relation to Domestic Abuse policy, procedures and protocols, the Cornwall Foundation Trust launched a Domestic Abuse Strategy which included the structured implementation of Routine Enquiry (RE) into domestic abuse, reflecting statutory, Department of Health and NICE guidance and was adopted by operational services in 2017. This was reflected in the Review with not all services practicing RE at the time of their contact with Lucy. RE is now the usual practice in all health services in Cornwall and is a mandatory question at every contact. All staff interviewed were now aware of how to access alert information and reported being so at the time of contact with Lucy. Staff recognised the need to see patients alone, if they attended with another person.

17.3.9. In practice, the DASH assessment carried out on the 23 September 2019 clearly identified 12 risk factors including attempted choking, harm to others and control. The comment also included that midwifery staff were worried about Lucy as she presented as being vulnerable and submissive.

17.3.10. There are instances where a lack of process, or lack of information gathering before an assessment or lack of communication after an assessment may have made the overall multi agency intervention more effective. For example, on referral to the Home Treatment Team the referral did not achieve the GP's target service and was managed instead by the assessment service, this would not have affected Lucy's immediate care but feedback to the GP should have been by telephone and included discussion of options. It is not clear if this would have altered the outcome for Lucy.

17.3.11. Lucy had two formal risk assessments completed in her contact with CFT services; both written by CAMHS and both noted the requirement for further historic information, this was not followed up as Lucy declined further input. Nor was a full risk assessment completed by ICMHT as Lucy declined a full assessment.

17.3.12. There was a lack of knowledge of the impact of previous DA on current risk of self-harm through lack of understanding of the implications of experiences of DA, and of the increased risk following relationships breaking-up, this would not have changed services as an assessment was offered and declined but may have influenced onward communication with GP.

17.3.13. Outstanding concerns raised by CAMHS that abusive relationships with an older man may be contributing to Lucy's presentation could not be explored as Lucy declined further input , these concerns were not passed on at discharge to other professionals involved.

17.3.14. A new Domestic Abuse training has been designed specifically for healthcare services, this was formulated by the Safeguarding team and provided by Safer futures (commissioned by Cornwall Safety Partnership). This includes an update of available DA services by Safer Futures. The training includes consideration of the impact of abuse experienced as a child and ACES (Adverse Childhood Experiences) on both the child and the child once an adult. It also covers the impact/increased risk of DA following leaving an abusive partner including the increased risk of suicide/homicide. The training encourages staff to be professionally curious and helps them think about RE and how to ask questions to different patient and age groups. The Integrated Safeguarding team are also designing an intranet resource which will be regularly updated with any changes to DA service availability to help in this regard and promoting the NHS Safeguarding App.

17.3.15. The DHR Panel commended the Hospital Trusts IMR Authors for their thorough and open analyses of both Trusts' contacts with Lucy and her children.. The Panel is satisfied that all key learnings have been identified and appropriate recommendations to address them will be implemented. They also thanked Safeguarding team for taking responsibility in notifying the Chair of the Community Safety Partnership of domestic abuse of Lucy's death.

17.4. **Cornwall Multi Agency Risk Assessment Conference (MARAC)**

17.4.1. The current Chair of the Cornwall MARAC confirmed that Lucy was referred to the MARAC on 5 February 2020 by a Devon and Cornwall Police Domestic Abuse Officer. The case was listed as a High Risk non-repeat referral on the grounds that Lucy had been assaulted by Lee after a domestic argument. Information was provided to the MARAC by the Police, Children's Safeguarding and First Light. The meeting took place on 12 February 2020. At the meeting it was noted that Lee had been on Police bail since 4 February 2020 until 3 March 2020 when it was anticipated that his bail would be further extended until 30 April 2020.

17.4.2. The MARAC Chair was satisfied that the case was appropriately referred to the MARAC and that Together For Families, Children's Health had provided a comprehensive update regarding the children's safety and wellbeing. However, there did not seem to be any emphasis relating to Lucy's needs, she had been identified in the MARAC research and meeting as: "her location being unconfirmed, her general wellbeing unconfirmed, as struggling emotionally, being overwhelmed by the processes happening around her

children, not engaging well with the IDVA and possibly being in drink and/or drugs when Police attended." There was no record at the meeting there had been any discussion or actions to clarify this issues.

17.4.3. There was no consideration given to the impact of Lee's instability, with regards his drug and alcohol vulnerabilities and his general emotional state and how this heightened the risk to Lucy. Nor was there any focus on engaging Lee in addressing his abusive behaviour.

17.4.4. The only action that appeared to come out of the case discussion was for the Police in relation to enforcement process. The Panel concurs with the current MARAC Chair's opinion that this was insufficient and did not represent a multi-agency response.

17.4.5. To address these points the MARAC Chair identified that MARAC referrals need to be visible to all agencies when they are made, to ensure a timely and efficient response. All core agencies need to engage in the MARAC process and have designated representatives, to ensure a true multi-agency response by DASV trained area specialists. All MARAC representatives need to share information prior to the meeting and start risk reduction and safety planning from the moment the referral has been shared. MARAC meetings should focus on all impacted parties, offering support to individuals engaging to reduce the risk to people experiencing abuse.
The MARAC Chair should be looking to engage all relevant agencies, as per needs and risks identified in relation to all parties, with the aim of facilitating the delivery of a dynamic and comprehensive safety and support plan. Lucy's whereabouts should have been confirmed as a priority action, in order to deliver support and safety and evaluate actual current risk and need.
All agencies should have worked together to deliver appropriate support and outreach in a way that would have encouraged Lucy to engage in some way; to reduce her feelings of insecurity and anxiety in relation to the Domestic Abuse support process and the process regarding her children.
Actions should have been considered with regards referrals into Mental Health support, via GP or other services to ensure Lucy received adequate opportunity to receive appropriate support.

17.4.6. The Review Panel is satisfied that these issues have been addressed in the new MARAC Improvement Plan which is currently at the Pilot Evaluation Stage.

17.4.7. The DHR Panel thanked the MARAC Chair for her open and honest evaluation of the MARAC involvement in Lucy's case. The Panel is satisfied that as agencies have agreed the MARAC Improvement Plan and provided they ensure that their representatives prioritise MARAC meetings, the actions should address the lessons learnt in this case.

17.5. **Devon and Cornwall Crown Prosecution Service:**

17.5.1. The Police requested a charging decision from the CPS in relation to the alleged assault committed by Lee on Lucy on 4 February 2020. The CPS file confirmed that following his arrest and release from Police custody, Lee was on Police conditional bail not to contact Lucy and not to go to her home address. He had been on Police bail since 4 February 2020 until 3 March 2020 and his bail was being further extended until 30 April 2020.

17.5.2. On 23 March 2020 the CPS asked for further information before making any charging decision on this case. Following this request, the Police informed the CPS of Lucy's death. They received no further information from the Police. The IMR Author was therefore of the opinion that there were no lessons for the Crown Prosecution Service to learn in this case.

17.5.3. The Review Panel agreed that there are no lessons or recommendations relating to the CPS involvement in this case.

17.6. **Devon and Cornwall Police**

17.6.1. The first Police interaction, which indicated that Lee and Lucy were in a relationship was on 30 September 2018. when Lee had called Police to state that he was outside of Lucy's address and wanted to speak with her but that she was refusing. Officers attended but Lee had already left the area. The officers later spoke with him on the phone and he said that he had had a disagreement with Lucy on the phone over child contact. Officers updated the log to say that no domestic had occurred and there was no other help they could offer Lee. The log was subsequently closed. Upon analysis it is clear that it should have been noted that this was a domestic report. There was an apparent lack of professional curiosity by the attending officers.
It would have been reasonable to expect the officers to contact Lucy at the time of their attendance. This would have assisted them in more fully understanding the circumstances and would likely have led to them to record an 'Enquiry' on Police systems. This in turn would have prompted them to complete a DASH Risk Assessment, a ViST for Jake and to consider necessary referrals to partner agencies for their support and assistance.

17.6.2. This oversight was magnified by the fact that Lucy was at that time residing in a Mother and Baby Unit and therefore likely to be vulnerable. There would have been opportunities to speak with staff at the unit from whom they would have uncovered more information to help build a picture of any ongoing domestic abuse, particularly the assault from the day before that went unknown for almost another month. Officers closed the log following a brief conversation with Lee and accepted his account that no domestic had occurred despite clear indications on the incident log to the contrary. This is not considered to be in keeping with Force policy document D34 which sets out the force priorities in dealing with domestic abuse incidents. This policy is robust and fit for purpose but on this occasion, there was an individual deviation from the standards expected as laid out in this policy. Further to this oversight, the incident log was closed without any professional challenge regarding the lack of an Enquiry record being completed. The control room should act as a safety net to ensure these oversights are not made and control room staff should feel safe to make professional challenges in this regard including escalation through their own line management where they feel it is necessary.

17.6.3. The second incident that was reported to the Police was on 23 October 2018 and is set out in para 16.7. of this report. Officers recorded a non-crime Enquiry, a medium DASH risk assessment and an amber ViST. However, whilst speaking with Lucy, they uncovered a common assault crime that had happened on the 29 September and recorded this. The Enquiry for the incident on the 23 October 2018 was closed with no further actions required as any further updates would go on the crime 'freetext'. This 'freetext' stated that Lee should receive words of advice for his actions. This was not done, as it was expected that he would be interviewed under caution for the criminal matter.

17.6.4. The DASH that was submitted was correctly completed to open up the additional stalking questions. This was good practice given the circumstances of Lee hiding near to her home address and jumping out on her. The DASH evidenced fear on Lucy's part and a worry of a change in his behaviour as a result of drink and controlled drugs. The ViST that was submitted for Lucy and her baby Jake was thorough and detailed. It explained that Lucy already had a good support network from various agencies including her support worker at the Mother and Baby Unit, social care, her GP, parents and a network of friends. The officer indicated in the ViST submission that they would refer Lucy to 'First Light' and speak directly with the social worker for the family.

17.6.5. The attending officer spoke with a Support Worker at the Mother and Baby Unit, who identified that the push to Lucy was captured on CCTV. The officer requested the CCTV footage but also noted that Lucy was uncertain about making a complaint. She requested some time to consider if she wanted to make a statement or complete a video interview. The crime was updated the following day to state that the CCTV had been burned off and was ready for collection.

17.6.6. Two days after that, a dedicated Domestic Abuse Officer (DAO) reviewed the crime. The DAO acknowledged and agreed with the medium risk grading and sent a letter to Lucy. The officer also followed up with a referral to 'First Light', noting Lucy's consent to do this. Approximately a week later, the officer in the case updated the crime to state that he had spoken with Lucy, but that she was unwilling to pursue a complaint in the matter. The officer informed her that with the CCTV evidence the case presented with a realistic prospect of going to court but she still declined. The officer updated that he had given her safety advice and that if she changed her mind, she could contact the Police. The CCTV recording was never seized. A Police supervisor then filed the crime with no further action being taken. Lee was not spoken with under caution and as such did not receive the words of advice expected to be given to him as a result of the incident on the 23 October 2018.

17.6.7. This incident was alarming and undoubtedly frightening for Lucy. The attendance to her was quick and initial actions were taken to ensure all necessary crimes and enquiries were recorded on Police systems. The ViST was thorough and appropriate and the engagement with partner agencies by attending officers, the Domestic Abuse Officer and the Victim Care Unit was good. It was noted that third party agencies were aware of the earlier crime but did not report this to the Police. It is unclear if this was at Lucy's wishes. Subsequently no suspect interview took place and nor was Lee spoken to about his behaviour of hiding in the bushes and ambushing Lucy. This was a clear opportunity to address his offending behaviour at an early stage and may have helped in the development of a healthier relationship. Given the presence of CCTV that evidenced one of the assaults against her, there was an obvious opportunity to at least consider an 'Evidence Led Prosecution' on this occasion. This was not done, and the crime was filed without an update as to why this route was considered unsuitable. The rationale to file the crime was lacking in detail and gave no indication as to why a prosecution could not be considered simply stating: 'No further Police action required by the victim VNA and DASH attached Suspect updated to NFA Submitted for filing as undetected with no papers'.

17.6.8. The IMR author stated he would expect a decision to file a domestic related crime of violence to include issues surrounding perceived risk, both of pursuing the case and not pursuing the case. It is apparent that no effort to take a 'negative' statement from her was made which can be a useful tool to explore fears of repercussions and help to understand a victim's motivation not to pursue a complaint.

17.6.9. The IMR author also drew attention to the incident which occurred on 24 November 2019. (See para 16.19.) A staff nurse at the hospital had called the Police to report that she was concerned for the welfare of Jake who was believed to be at home alone with Lee.
Officers responded and spoke with Lee on the phone. They reported that all was in order and that he had just been calling the hospital to tell Lucy that Jake was ill. They reported that it had been 'crossed wires' with the hospital and the log was closed.

17.6.10. It is apparent that by accepting Lee's version of events and closing the log, without completing a DASH risk assessment, there was a missed opportunity to address his behaviour, safeguard Lucy and Jake and to work in a multi-agency arena to mitigate future risk. The lack of attendance to Lee and Jake was unacceptable as there would have been a need to see Jake, ensure his welfare and complete a ViST for him if any vulnerabilities were identified.

17.6.11. With regards the arrest of Lee on 4 February 2020 for assaulting Lucy, the review Panel noted that this crime was subject to a 'Not Proceeded With' (NPW) decision as a result of Lucy's death. There was no indication on the crime that an 'Evidence Led Prosecution' was considered.

17.6.12. The Review Panel thanks the IMR Author for his thorough, open and honest analysis. He has identified the key lessons to be learnt and the Panel is satisfied that the recommendations and action plan agreed will adequately address them.
17.6.13. The IMR Author in addition to providing the analysis of the Police responses to incidents involving Lucy and Lee also provided the DHR Panel with the following explanation regarding the Police failure to notify the Cornwall Community Safety Partnership that Lucy's death might meet the requirements for a Domestic Homicide Review.
"The Devon and Cornwall Police Public Protection Unit provides two Detective Sergeant posts and a Police staff researcher post to the Serious Case Review Team which has responsibility for identifying incidents that should be referred to various statutory reviews, including DHR's. In March 2020 only one of these post holders was in post, whilst the other two were vacancies actively being advertised and suitable candidates sought.

As a result of this the one post holder was tasked on a daily basis to review approximately 200 – 250 incident logs, enquiry records, crime entries, critical incident briefing sheets and the chief officer briefing sheet. This volume of work placed on the one officer in post, resulted in Lucy's history of domestic abuse being missed.

To ensure that such an oversight is less likely to happen in future, the Devon and Cornwall Police Public Protection Unit's Serious Case Review Team is now fully staffed with two Detective sergeants and a researcher.

In the summer of 2020, this team was amalgamated into the Criminal Case Review Team as part of the Force Crime Department and as a result now has a dedicated line manager in the review team rather than line management through other functions. This offers more focused support and leadership.

As a further failsafe, the team is provided with the spreadsheet return sent to the Home Office regarding current major crime enquires. This acts as an alert to any homicides that may have been missed.'

17.6.14. The Review Panel thanks the Report writer for his openness in identifying this lesson and accepts that the procedures now in place should ensure that cases such as Lucy's will be identified as fitting the criteria or a DHR in the future. Nevertheless the Panel whilst thanking the local Hospital NHS Trust for highlighting Lucy's death to the Chair of the Community Safety Partnership, wishes to include in the recommendations of this Review that all partner agencies should be reminded of Para 21 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews which states: 'Any professional or agency may refer such a (domestic) homicide to the CSP in writing if it is believed that there are important lessons for inter-agency working to be learned'.

17.7. **First Light**

17.7.1. The Panel found that there was good practice in multi-agency working with regular contact with agencies involved with Lucy and with joint visits arranged between the Independent Domestic Violence Adviser (IDVA) and Lucy's Social Worker. The IDVA attempted to create a safe environment for Lucy to speak about the abuse and attempted to be supportive to enable Lucy to open up about her experiences. However during First Light's contact with Lucy the IDVA personnel changed and this resulted in the IDVA not being in a position to contribute fully within the MARAC process. This has been reviewed and addressed by team leaders and through the use management system. As Lucy was treated for spinal injuries in a specialist hospital in Devon at a time of Covid restrictions the limited IDVA provision in Cornwall was not in a position to offer full IDVA service, through an increase in funding an additional IDAVA has now been appointed and this should ensure that service provision is improved in the future particularly as Covid restrictions have been lifted.

17.7.2. The Panel is satisfied that the IMR has identified the key lessons which are set out in section 20 of this report and that there is an effective action plan to address them (see section 21).

17.8. **Home Group**

17.8.1. Home Group had a contract with Cornwall Council to provide a supported accommodation scheme for single young parents (male or female) or pregnant women aged 16-30, who needed accommodation and housing related support, at Benen Chy. Each resident had an individually designed support plan to address specific areas of need.

17.8.2. The Panel noted that on 9 April 2018 Lucy moved in to Benen Chy with her new baby, Jake and she was allocated two key workers with whom she build a close rapport which enabled her confidence to grow. A risk assessment and support plan were completed, in which Lucy set appropriate goals which with the support of the key workers, she worked positively to achieve. (Lucy's mother told the Review that Lucy "really trusted and respected those key workers and blossomed while she was with them".)

17.8.3. It was noted that at a 'Core Meeting' on 23 July 2018 it was recorded that all professionals were pleased with Lucy's progress and Jake's case was to be downgraded from Child Protection to a Child in Need. By 9 August 2018 her Social Worker notified the staff at Benen Chy, that in view of Lucy's progress and as Jake and Lucy had a very good bond, she would be winding down the level of support with the intention of ending it in September 2018.

17.8.4. After receiving complaints from other residents regarding Lee's nocturnal visits to the premises and his violent behaviour towards Lucy, staff took positive action and with CCTV evidence made a referral to MARU/Safeguarding, A 'reduce risk to me goal' was carried out with Lucy. Whilst there had been a risk assessment in place from the time she moved into the service and this was reviewed every three months or more regularly as required, a new goal included safety planning and understanding risk for Lucy. Subsequently, after Lee was repeatedly found on the premises, staff did not shirk from banning him from the premises and issued a verbal warning to Lucy regarding this breach of her tenancy agreement. She was offered a referral to the domestic abuse support service 'First Light' but she declined the opportunity. Nevertheless, Jake's Social Worker did take positive action by telling Lucy that she was very concerned about her ability to keep Jake safe. She asked for Lucy to end her relationship with Lee and offered to speak to him, Lucy stated that she did not want this.

17.8.5. Attention is drawn to the close working between Jake's Social Workers and the Home Group Key Workers in exploring ways to support Lucy in her development which was so positive when Lee was not present or phoning her. They had noticed that when he was present, she regressed and lacked confidence, he appeared to intimidate her and would continuously speak on her behalf to other people. It was highlighted that in October 2018 during a MARU meeting Jake's Social Worker expressed her deep concerns and recommended a First Light referral and one of the Key Workers suggested a Claire's Law request with Lucy's agreement. This plan was agreed. The Social Worker who met with Lucy every two weeks noted that Lucy's mother was a protective influence on her.

17.8.6. On 22 October 2018 residents were notified of the closure of Benen Chy and Lucy was offered an Ocean Housing Association flat in St Austell. Good practice was evident after Lucy moved into her new flat on 3 December 2018 and the Benen Chy Key Workers continued to provide her with transitional support, assisting her with changing addresses with Housing Benefit, Council Tax, Income Support, etc. Over the following weeks they helped her sort out all aspects of her budgeting. By January 2019 the Key Workers were able to report at the completion of the transitional support session that Lucy's flat was very organised and she was starting to understand her financial situation better.

17.8.7. The Panel also highlighted that just prior to Lucy leaving Benen Chy, Lucy informed the Key Workers that the Police had attended at about 4am as Lee had tried to get into the building but she had managed to keep him out. She told them that following the incident he had telephoned her 70 times and text messaged her 50 times. Lucy had told the Police about earlier incidents including when he had put his hands around her throat. The Staff viewed the CCTV on the early hours of the 23 October 2018 and were able to confirm to the Police the accuracy of Lucy's report. While the Police spoke to Lee and returned Lucy's property to her, they never went back to Benen Chy for a copy of the CCTV evidence that the key workers had prepared for them. Nevertheless Benen Chy Staff had taken the opportunity to inform the Police Officer that Lucy would be leaving Benen Chy staff as she had been offered a flat in St Austell and that a safety package needed to be put in place as she would be very vulnerable.

17.8.8. In the IMR author's analysis it was noted that when the domestic abuse incident was reported, staff followed the organisation's Antisocial Behaviour Policy and process for managing cases. Home Group is signed up to abuse and sexual violence (DASV) information sharing agreement (ISA) with Devon and Cornwall Police. However she concluded that if the staff had been aware that Lee was Jake's father at the referral access point, it may have changed the direction of support and safety measures for Lucy and Jake

within Benen Chy. (Lucy had not disclosed that Lee was the baby's father prior to entry into Benen Chy.)

17.8.20. The Review Panel thanked the IMR Author for her comprehensive and open review. The Panel acknowledges that the Home Group staff at Benen Chy provided a supportive and caring environment for Lucy and worked positively with other agencies in dealing with the incidents involving Lee.

17.9. **GP Practice A**

17.10.1. The IMR Author reviewed all of Lucy's medical history from 2009 and identified what went well and what could be improved upon.

17.9.2. A multi-agency review relating to Lucy, who was considered to be a high risk patient was carried out on 17 March 2020 and an urgent referral for specialist help was done with a safety net plan with regards the follow-up and being unable to contact the patient. It was also requested that the other agencies involved pass on their information to help support the referral.

17.9.3. Unfortunately following the referral, the Surgery was emailed to say the Home Treatment Team were not taking the case on and it would instead be the Community Mental Health Team. during a follow-up with Lucy, she stated she was still waiting for the specialist CMHT review. The Surgery never received any follow up information from the CMHT team that Lucy had not engaged/not been taken on by their team. Consequently, at a Hub multi agency meeting, the GP Practice asked that where there is an urgent referral and the patient either does not engage with CMHT or who are not taken on, that the GP is notified immediately via phone or email so that GP follow up. This was considered to be a sound practice recommendation.

17.9.5. The DHR Panel agrees with the lessons identified by the IMR author and with the recommendation to address them.

17.10. **Ocean Housing**

17.10.1. The IMR Author in her analysis highlighted that Lucy was allocated a 'Together For Families' Support Worker. Due to the concerns relating to Lucy's welfare, the allocated officer completed a safety plan and review with Lucy and endeavoured to build up a trusted relationship. The concerns the Support Worker identified regarding the risks of Lucy self harming were promptly reported to the statutory services, foster placement and GP, in line with relevant policies and procedures. Due to her relationship with Lucy, the Support Worker was able to talk to statutory agencies, arranging appointments, chasing assessments and trying to support Lucy with harm reduction techniques as well as signposting her to support agencies when she was having suicidal thoughts.

17.10.2. What did not go so well was at the beginning of the tenancy, it was identified that Lucy was vulnerable under Ocean Housing's Vulnerable Person's policy, but there was a delay of one month until a 'Vulnerable Case' was opened and six weeks until the 'Neighbourhood Services Officer' (NSO) completed a visit to Lucy to complete the 2-8 week check. It is however acknowledged that the NSO had made several attempts to arrange that sooner. After this, there were a number of appointments arranged to complete property repairs and visits made to the property, but these were either recorded

as ‘no contact’ and/or contact was made but no notes were recorded on the company’s management system.

17.10.3. Due to Lucy’s circumstances ‘cause for concerns’ were raised in line with the relevant procedures but there was a lack of engagement with Lucy due to her not responding to telephone call requests. When a home visit was eventually completed, Lucy presented in a quiet manner and allowed her mother to talk on her behalf. Unfortunately after this meeting, further appointments were again cancelled by Lucy and there was a subsequent lack of engagement which was not followed up.

17.10. The DHR Panel is satisfied that the key lessons have been identified and that the action plans appropriate to address them.

17.11. **South Western Ambulance Service:**

17.11.1. The analysis of the information the Ambulance Service hold about Lucy and her children show there had been 6 calls directly relating to Lucy from March 2015 to the date of her death in 2020. They related from an incident of self-harming in 2015 to normal non-relevant illnesses and pregnancy. There were 5 calls in respect of Jake, all for minor childhood ailments.

17.11.2. It was evident that the calls were appropriately managed and safeguarding referrals submitted where appropriate.

17.11.3. The attending clinician completed a comprehensive safeguarding referral for the first incident in March 2015. This highlighted many issues including self-harm, overdoses, possible cocaine use, staying out overnight whilst in the care of her sister and her whereabouts not known. It also cited that Lucy had been referred to Social Care as there had been an incident/encounter with an older male.

17.11.4. There was good communication for the incident in October 2019 from the Hospital Midwife highlighting her concerns about domestic abuse from Lee to Lucy. Once this information was given to the attending ambulance crew, they ensured that they conveyed Lucy to hospital with Lee following behind in his own vehicle. This gave both the attending female Paramedic a chance to ask questions regarding domestic abuse as well as giving Lucy the opportunity to open up and disclose any concerns. Lucy denied any abuse and said that they (Lee and her) ‘get on at the moment’. This indicated that there may have been times when they did not get on. Lucy was quick to close the conversation down and would not discuss it further. The Paramedic, while being respectful of Lucy’s response, completed a safeguarding referral for Lucy and her child.

17.11.5. This referral was based on the information of domestic abuse given by the Midwife as well as noting that the property was cluttered and smelt of cigarette smoke. The Paramedic did try to complete a Domestic Abuse, Stalking and Harassment and Honour-Based Violence form (DASH). However, all the questions are recorded as ‘Don’t know’ due to Lucy’s lack of engagement, apart from one question ‘Is the patient very frightened?’ This is recorded as a ‘No’. Following this incident the attending Paramedic submitted a ‘Datix’, (this is the Service’s incident reporting system). The ‘Datix’ was submitted recommending placing a warning flag on the address highlighting a history of domestic abuse so that future crews would be aware of this information.

17.11.6. Warning flags are added to an address for a variety of reasons, it could be that the individual has a complex care plan, the individual is known to be violent or has weapons or it could indicate a safeguarding concern such as domestic abuse. On this occasion a warning was put on the address for a period of 6 months in line with Service current policy, after which time it would be reviewed. Due to the death of Lucy the warning flag has now been removed from the address at the request of the author of this report.

17.11.7. Following the 999 call, at the end November 2019, which related to Jake, the attending ambulance crew completed a safeguarding referral, expressing concerns of domestic abuse, this referral was sent to the GP, Children's Social Care, Named Nurse and Devon and Cornwall Police.

17.11.8. It is quite clear that those ambulance clinicians attending both Lucy and her children considered possible safeguarding concerns including domestic abuse. This resulted in safeguarding referrals being made for Lucy as a child and again when pregnant which resulted in the warning flag being placed on her address on the ambulance 999 call systems for the incident in October 2019. This warning flag which highlighted a history of domestic abuse would be available to be passed to any attending clinicians to raise their awareness. This was the last time that the Ambulance Service attended Lucy as a patient prior to attending her property when she was discovered deceased in March 2020.

17.11.9. These referrals were appropriate, following the indicators within the Trust's Safeguarding Policy for when a referral should be completed. There was no indication from reading any of the records, that practice was not sensitive to the ethnic, cultural, linguistic or religious identity of the respective individuals.

17.11.10. The Review Panel, thanks the IMR Author for his thorough review and Members are satisfied that there are no lessons for the South Western Ambulance Service in this case.

17.12. **Together For families (TFF)**

17.12.1. As Lucy had contact with three services within the remit of TFF responsibilities, i.e. Education, Child and Family Services and Health and Well Being Service, three separate senior managers who had no previous contact with Lucy, Lee or their families were appointed to conduct sections of the Internal Management Review.

17.12.2. **Education**

17.12.2.1. The review of Lucy's education commenced at the start of her attendance at secondary school on 1 September 2011. It included her pupil profile information in relation to attendance and attainment and chronological information in relation to behavioural incidents and fixed term exclusions.

17.12.2.2. In June 2015 Lucy, whilst a year 10 pupil, was permanently excluded from secondary school, after the incident when she had concealed a knife on school premises. She moved to Restormel Alternative Provision Academy until she reached the end of the statutory school age in June 2016 prior to moving to Cornwall College in September 2016.

17.12.2.3. The IMR Author found recorded on the Education Management System that Lucy had Special Educational Needs throughout primary and secondary education. Her needs were recorded as speech, language and communication difficulties and

behavioural, social and emotional difficulties. However she was never provided with an Education Health and Care Plan.

17.12.2.4. The IMR Author, acknowledged that the secondary school worked well with other agencies following a referral from Lucy's GP in December 2014 when Lucy was referred to Early Help but not into the Education Welfare Service. It was not clear what impact the Early Help referral had in supporting Lucy at school, as there appeared to have been an escalation of incidents involving Lucy during this period until she was permanently excluded in June 2015. She had 194 'behavioural incidents' reported from when she started at the school in 2011. It is not recorded if any external support was sought prior to the Early Help referral in December 2014. Her education history identifies she was at SEN (special educational needs) level support with noted behaviour, emotional and social difficulties, but there was no information available from the school about support provided to address her SEN needs. (The Government Policy Special Educational Needs and Disability (SEND) was only introduced in May 2015)

17.12.2.5. The Education IMR Author when considering what lessons could be learnt, identified that almost immediately Lucy started in secondary school in Year 7 in 2011, behaviour incidents were reported by the School. However there is no evidence that support was sought for Lucy until the referral in December 2014.Since that time the Trauma Informed Schools (TIS) programme has been rolled out across schools in Cornwall commencing in 2017/18. Had TIS training been received by those providing Lucy's education, it is possible that there would have been more insight into questioning and seeking to understand the reasons behind the behaviour incidents.

17.12.3. Cornwall Health and Wellbeing Service

17.12.3.1. This IMR Author highlighted that Lucy was initially open to the Family Nurse Partnership team. She received significant support from her Family Nurse, who would have seen her at least twice a month. When this service ended, she was handed over to a Health Visitor in her locality, but was still receiving an enhanced service. Both Practitioners found Lucy difficult to engage, they found her 'to have a flat effect, shy and quietly spoken.' She was often described as having limited 'emotional attunement' with Jake. (Her mother confirmed that this was normal behaviour as Lucy found it difficult to communicate with officials and strangers.)

17.12.3.2. Despite questioning, Lucy declined to discuss her relationship with Lee, apart from on one occasion. There was limited evidence of the Health Visitors discussing Lucy's mental health with her or considering referring for specialist support. She declined this during pregnancy, but on a number of other occasions it was recorded that it was not discussed because either Lee or Lucy's mother or both were present.

17.12.3.3. Both Practitioners who worked with Lucy, found it difficult to engage her in any kind of therapeutic relationship but continued to work with her, albeit on a more superficial level. This clearly hindered them in supporting her with the risks around domestic abuse or her mental health even though they recognised those risks. Lucy's mother confirmed that they were patient and caring with Lucy.

17.12.4. Children's Social Care

17.12.4.1. When Children and Families Services (TFF) (Children's Social Care) became involved with the family at the time of Jake's birth and there were worries about Lucy's

attunement to his needs, there was a good support plan in place including family members. When Lucy moved to supported accommodation, she worked with the Family Worker to complete the core parenting programme and showed increased confidence in her day to day care of Jake. After Jake's birth when Lucy admitted that Lee was Jake's father, the multi-agency team began to piece together a picture of controlling and coercive behaviour by Lee towards Lucy.

17.12.4.2. At the time of Samuel's birth there was appropriate contact from hospital staff with the Social Workers alerting them to Lee's behaviour whilst Samuel was an in-patient and the Ambulance staff used the opportunity of having Lucy alone in the ambulance to speak to her about possible abuse from Lee. The Local Authority, in line with its statutory duty to protect children from harm took progressive protective measures to keep the children safe in line with increasing risks.

17.12.4.3. The IMR Author set out what did not go so well. A thorough relationship based social work assessment was completed in October 2014 when concerns were raised about Lucy (when aged 14) developing an emotional attachment to an adult male aged 28 (Marcus) that indicated that she could be at risk of exploitation. The situation was discussed at the CSE Forum and the Police interviewed the 28 year old Marcus in respect of possible inappropriate contact with Lucy and her friend. Whilst there was never any suggestion that the contact had any sexual connotations and this view was supported by the respective families, there was a suspicion that there could have been an element of potential grooming. The IMR Author noted that there have been significant changes in practice and approach in relation to exploitation since 2014 and the effectiveness of multi-agency identification and disruption of exploitation has improved considerably. There is greater understanding of the signs and symptoms of exploitation and extensive work and training has been undertaken with wider partners.

17.12.4.4. When considering changes the IMR Author noted that Lucy's children's records indicated that Lucy was reluctant to communicate with the Social Worker and often said very little during a home visit. The IMR Author wondered if any attempt had been made to encourage Lucy to speak one to one with one of the involved professionals whom she trusted. However, the IMR Author acknowledged that this would have been very difficult given Lee's controlling behaviour and Lucy's continued refusal to engage. The IMR Author was not aware of the First Light involvement or if anyone else had discussed the Women's Refuge Service with Lucy. Whilst this would have offered her and the children some protection it was noted that even within the protective environment of the parent and child foster placement, Lucy left to spend time with Lee and it is unlikely, she would have been able to separate from him.

17.12.5. The DHR Panel is satisfied that the three TFF services internal management reviews have been completed thoroughly and in a professional and open manner by reviewing all of the information held and by clarifying actions by relevant discussion.

17.13. **We Are With You**

17.13.1. The IMR Author reported that Lucy had been referred by Home Group into the We Are With You, 'Positive People' employability programme as part of group delivery at Benen Chy. This was an informal project with voluntary engagement from participants. In October 2018 Lucy initially agreed to join the programme and an action plan was set. However ,Lucy never engaged and turned down support explaining that she had seen her GP as she was experiencing anxieties. Nevertheless, over the following months the

Change Coach from Positive People made attempts to contact Lucy to ascertain if she would like to join the group. After several attempts she was seen, but declined the offered appointments.

17.13.2. The IMR Author is of the opinion that as this was a voluntary programme there was nothing further Positive People could do. The DHR Panel is satisfied that there are no lessons for We Are With You to learn in this case.

Section Eighteen – Key issues

18.1. Prior to reaching their conclusions the Review Panel identified Lucy's anxieties, communication difficulties, gender and age as the reasons she was susceptible to the grooming and controlling behaviour of older predatory males, which contributed to her distress and self-harming.

18.2. Vulnerability

18.2.1. Lucy had a difficult childhood; her mother described her as displaying the characteristics of a child with autism although it was never diagnosed. She explained that Lucy would be relaxed and talkative in the home environment or with her close friends but lacked confidence in social settings or with strangers. This inhibited her ability to communicate effectively with professionals and this in turn hampered their capacity to help her. Her mother gave the example of when Lucy needed to go to the Doctor's, she would need to go with her to explain the reason for the visit as Lucy could not speak.

18.2.2. CAMHS and SPMHT assessments on Lucy, identified that she had social anxiety and fear around talking to others and trusting others. She was understood to have poor emotional coping strategies and risk of harm to herself. However, no severe or enduring mental health problems were identified that met the criteria for secondary mental health services in Cornwall.

18.2.3. It was recorded on the Capita (Education Management System) that Lucy had special educational needs at SEN support level throughout primary and secondary education. Identification of her needs were recorded as "speech, language and communication difficulties and behavioural, social and emotional difficulties".

18.2.4. Whilst Lucy had self-harmed in her early teenage years, these were considered to be more cries for help rather than being serious attempts to end her life, although it is noted that Lucy later described one as being an attempt to end her life.

18.2.5. Lucy's struggles and vulnerabilities were evident through her communication difficulties with people who she perceived as being in positions of authority and in the number of recorded incidents of her disruptive behaviour at school. Although never identified as such these were possibly the negative impact of Adverse Childhood Experiences. There is an acceptance that services through the school at that time could have been much more professional and the school was identified as not being satisfactory and has since gone under new management. This has been acknowledged by Children's Services and the learning has been taken forward in their action plan.

18.2.6. In December 2017, Lucy's midwife being aware that she had a history of self-harming, referred her to the Specialist Perinatal Mental Health Team (SPMHT) as she was presenting as extremely anxious and there were concerns about her vulnerability and risk of exploitation. The Midwife explained that Lucy found it difficult to engage with strangers

particularly by phone. However the subsequent, SPMHT assessment indicated that Lucy engaged and told them that prior to 2014; 'She had been a bubbly, happy and chatty young person but after experiencing a number of difficult social situations, she became quieter, more withdrawn, staying in more and generally seeming less social..... She did not feel depressed or low in mood and rated her mood as average, feeling: "Happy but scared" about the prospect of becoming a Mum'.

18.2.7. While she was in the safe environment of Benen Chy she had time to build a close rapport with two key workers. It was evidenced that with their support and encouragement, she grew in confidence and positively worked towards achieving set goals to the extent that Jake's Social Worker was satisfied that Lucy was able to properly look after Jake without her support. However, the Key Workers noted that Lucy 'repeatedly regressed when Lee was present, as he constantly undermined her.'

18.2.8. Lucy's mother pointed out that Lucy had always lacked confidence in social situations and was therefore easily led by others with more experience. Emotionally she was only a child, yet at the age of just 19 years of age, she had two very young children to look after on her own and had a 'boyfriend' who insidiously eroded her confidence. She suspected that after the birth of Samuel, Lucy was suffering from postnatal depression as she found it difficult to bond with the baby[7]. Lucy was afraid that the children would be taken from her, as she found having to communicate with the Foster Carer, a stranger, in the structured environment of the placement particularly traumatic. At the same time Lucy was under additional pressure as Lee had been constantly phoning, threatening to commit suicide and pleading for her not to give evidence against him.

18.3. Grooming and Controlling Behaviour

18.3.1. **Grooming** is currently defined in the UK as: 'When someone builds an emotional connection with a child to gain their trust for the purposes of sexual abuse, sexual exploitation or trafficking". (NSPCC)

18.3.2. Information provided by agencies and Lucy's family about Lucy's experiences equates with many of the common signs that a child is being groomed which have been listed by the NSPCC i.e.:

- sudden changes in behaviour
- going missing from home or school
- alcohol and/or drug misuse
- having a much older 'boyfriend'
- developing sexual health problems
- mental health problems (Rigg and Phippen, 2016)

[7] Lucy's mother expressed her opinion that Lucy was suffering from 'postnatal depression' to the Review Chair and in her statement to the Coroner, whilst acknowledging that this was never diagnosed or verified by professionals.

18.3.3. There is evidence that Lucy may have been targeted by older men from an early age. When she was three years of age a Social Worker warned her parents that Lucy and her sister should not be left alone with a male family friend who was a section 1 offender.

18.3.4. Later when she was 8 years of age, a first referral was made to Cornwall Children's Social Care following a historical allegation of sexual abuse against a male relative who after serving a prison sentence had no further contact with the family.

18.3.5. Lucy had only been about 12 years old when she first met Lee who was by then 21 years of age. Her mother told the Review that when Lucy was about 14 or 15, the family had gradually become concerned about his growing influence on her. They suspected that he had introduced her to using cocaine and cannabis. She had never been interested in drugs prior to meeting him and he was reputedly a 'drug dealer'. (Lee admitted to the DHR Chair that he had a heavy drug habit but denied being a 'pusher'.)

18.3.6. Lucy's elder sister complained that on an occasion when her mother was away and she was supposed to be looking after Lucy and her siblings, Lucy who was only 14 years of age, had been difficult to control as she would go missing and stay out all night.

18.3.7. In October 2014 after a referral from Lucy's GP, a social work assessment was completed with a subsequent multi-agency Child in Need plan until August 2015. There had been concerns Lucy was being targeted for exploitation by Marcus a 28 year old male who had 'befriended her' when she went to one of her friend's home. Lucy was 14 at this time when she witnessed an incident when Marcus was arrested following violence to her friend's mother and an attack with a machete on the Police officers, who had responded to the incident. Lucy had said whilst she had been frightened, she would miss him as she could talk to him. (The NSPCC in 2016 highlighted that, "Those who have been groomed often say their groomer was the first person who really seemed to understand and care about these issues "(NSPCC and O2, 2016).

18.3.8. **Controlling behaviour** is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. (Section 76 of the Serious Crime Act 2015)

18.3.9. Lucy's mother has told the Review that when Lucy was about 14 years of age, her husband, Lucy's step-father had banned Lee from seeing Lucy as they believed he was a bad influence on her and that he had introduced her to using controlled drugs.

18.3.10. However, it was only from the time that Lucy was at Benen Chy with baby Jake, that professionals became aware of Lee's controlling behaviour towards her and of his hold over her. He would phone her constantly and her mood would change to one of fear. He was eventually banned from entering the premises and Lucy called the Police after one belligerent incident involving Lee. Similar reports were given about his aggressive behaviour towards Lucy by the Midwife and after Samuel's birth by hospital staff, who banned him from the hospital ward after witnessing his offensive behaviour towards Lucy.

18.3.11. There were numerous occasions where agencies recorded their observations of Lee belittling Lucy, either answering her mobile phone or answering questions directed at her and making decisions on her behalf. They noted that this controlling behaviour appeared to be destroying Lucy's confidence. Although opportunities were found to speak to her alone she appeared too afraid to accept the help offered.

18.3.12. In this case, Lee's constant controlling behaviour, coercion and threats undermined Lucy's already fragile confidence to such an extent that she could not rid herself of him. Yet she tried to on more than one occasion to live without Lee, but his constant barrage of phone calls and texts (on one occasion he made over 70 telephone calls and 50 texts to her after she locked him out of Benen Chy in the middle of the night) inevitably wore her down.

18.3.13. When Lucy did eventually agree to support a Police prosecution after Lee had assaulted her. Lee breached his bail conditions and continually pressurised her to retract her statement. Her mother told the DHR how deeply this distressed Lucy.

18.4. Mental Health and Domestic Abuse Links.

18.4.1. There is significant independent research that indicates that intimate partner violence is a common health care issue.[8] The Crime Survey for England and Wales (2017) highlights that women with a long-term illness or disability were more likely to be victims of recent domestic abuse (within the last year) than those without one; to a ratio of 15.9% compared with 5.9%.) One in four women who have died by suicide had been the victim of physical violence, one in five had suffered psychological violence and one in six had been sexually assaulted.

18.4.2. The Public Health Panel member highlighted that the Local Real Time Suicide Surveillance Programme provides insights into connections between suicide, self-harm and domestic abuse. It is important to note that the nature of real time surveillance makes it unfeasible to draw conclusive data as it includes deaths where inquests are still pending. Furthermore, the surveillance model works on the basis of voluntary contributions of information about the deceased, hence there is an understanding that the figures may not fully reflect reality (i.e. services may be unaware of self-harm; disclosures of domestic abuse may not be made until the Inquest by family members). However, important themes can still be drawn which prompt further investigation. For example, in 2020:

- 6 of 31 females who were suspected to have taken their own lives were recorded as having a history of Domestic Abuse.
- Approximately two thirds of under 25 year old females who were recorded to have self-harmed also had histories of domestic or sexual abuse.
- 3 males suspected to have taken their own lives were also suspected of being perpetrators of domestic abuse.

18.4.3. Other published research indicates that experiencing domestic violence and abuse is associated with mental health problems including anxiety and depression.

- 40% of high-risk victims report having mental health issues.[9]
- 16% of victims report that they have considered or attempted suicide as a result of the abuse, and 13% report self-harming.[10]

---

[8] Health consequences of intimate partner violence (Prof. J. C. Campbell published in Lancet 13 April 2002

[9] SafeLives (2015), Getting it right first time: policy report. Bristol: SafeLives)

[10] (SafeLives (2015), Insights IDVA National Dataset 2013-14. Bristol: SafeLives).

- Domestic abuse has significant psychological consequences for victims, including anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment. [11]

- Domestic abuse victims are at risk of post-traumatic stress disorder (PTSD), As many as two-thirds of victims of abuse (64%) developed PTSD in one study.[12]

18.4.4. A further research document stated: “These (anxiety) issues can make the abusive situation even worse, as the partner or ex-partner may make use of a diagnosis” (for example, telling them they are useless and talking for or over them in the presence of others.) It was stated in the above research that; “It can also be difficult for professionals to see beyond mental health issues and to recognise that an abusive relationship may be at the heart of the problems”.[13]

Section Nineteen - Conclusions

19.1. Many examples of individual good practice by professionals working with Lucy were identified during the Review, these include:

- The GP’s prompt referrals to appropriate mental health services.

- The consistent high standard of timely care and appropriate referrals by Ambulance personnel on the occasions they were called to attend to Lucy and/or her children.

- The bond of trust created with Lucy by the two Home Group Key Workers who endeavoured individually and together with Jake’s Social Worker to give Lucy the confidence to be able to achieve her goals and to care for Jake. They continued to support her through her transitional period of moving into her rented flat.

- The Hospital staff who were concerned about Lee’s bullying and controlling behaviour towards Lucy and took positive action by seeking ways to speak to her alone to offer help, by challenging Lee directly, later by banning him from the ward and by involving the Police.

- Ocean Housing’s positive response to the request of the First Light IDVA, in providing a safe environment and a nominated support worker for Lucy. The prompt actions of the Support Worker in identifying and notifying Lucy’s GP and Social Worker of her suicidal ideation shortly before she took her own life.

- The efforts of Lucy’s secondary school to keep her at the school, for so long in spite of 194 recorded behavioural incidents, although some Panel members were of the

---

11 CTC (2014), Website of the US Centres for Disease Control and Prevention, National Centre for Injury Prevention and Control, Division of Violence Prevention

12 Golding, J. (1999), Intimate partner violence as a risk factor for mental disorders: a meta-analysis in ‘Journal of Family Violence’, 14 (2), 99-132.

13 http://www.healthtalk.org/peoples-experiences/domestic-violence-abuse/womens-experiences-domestic-violence-and-abuse/impact-domestic-violence-and-abuse-womens-mental-health#ixzz5GbWdgJtL

opinion that more positive action could have been taken to address Lucy's behaviour needs.

19.2. There were however salient missed opportunities identified by agencies:

- The lapse in not referring Lucy to the Multi-Agency Risk Assessment Conference (MARAC) after hospital staff had identified the need to do so.

- The lack of direction at the MARAC meeting on the12 February 2020 to identify effective cross agency actions to reduce the risks to Lucy from Lee's controlling behaviour.

- The failure of the Police to consider 'evidence led prosecutions' on at least three occasions.

- The breakdown in communication by the CMHT to provide Lucy's GP with any follow up information, namely that Lucy had not engaged/not been taken on by their team.

19.3. The DHR Panel, while endorsing all of the positive action plans to address the lessons learnt by participating agencies, draws particular attention to:

- The open and decisive response from the Police to ensure officers are reminded of their Force policy to take positive action in domestic abuse cases including the use of 'evidence led prosecutions'.

- The care taken by the Hospital Trusts to address the many lessons that the IMR authors so openly identified and analysed.

- The introduction of the Cornwall MARAC Operating Protocol 2019 and MARAC Improvement Plan 2020/21 which if adhered to, should ensure appropriate and effective multi-agency actions.

- The value of expanding the real-time surveillance system within Cornwall Public Health to further collate available data on self-harm rates across the County which will better support understanding of the scale of the issue and service improvement. This has already unearthed statistics which will be of use to agencies tackling the risks of self-harming by people who have experience of domestic abuse

19.4. Whilst it is emphasised that Lee has not been convicted of any offence against Lucy and has consistently denied having assaulted her, he considers that his controlling behaviour during past relationships had been due to his diagnosed ADHD and his addiction to cocaine. It is therefore, regrettable that Lee decided not to participate in this Review as it would have provided an opportunity for him to explain his motivations and needs so that agencies could have offered him help in addressing his reliance on controlled drugs, his ADHD and controlling behaviour for the benefit of himself, his family and any future partner he might have. For the same reasons, the decision taken by the Police without discussion with the CPS, to discontinue the case against Lee for the assault on Lucy on 4 February 2020 may have been a significant missed opportunity to enable Lee to obtain help to change his abusive behaviour.

19.5. In general, the risks to Lucy from grooming and from her own propensity to self-,harm when facing difficult situations, were properly identified by practitioners from different agencies, but in the absence of any co-ordinated or structured multi-agency response being sought or delivered, their individual actions were largely unsuccessful.

19. 6. The DHR Panel is however satisfied that all of the agencies participating in the Review have been robust, open and honest in their individual management reviews and that the recommendations made will positively address lessons learnt and will make Cornwall safer for future victims of domestic abuse. This should become Lucy's legacy.

Section Twenty - Lessons Learnt

20.1. The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the Action Plan template in Section 10 of this Report.

20.2. Cornwall Multi Agency Risk Assessment Conference (MARAC)

20.2.1. The failure of some representatives to research available information relating to Lucy and Lee prior to the MARAC meeting resulted in the MARAC being unable to agree what support services were appropriate for Lucy. This reinforced the need for the Cornwall MARAC Operating Protocol and the implementation of the proposed MARAC Improvement Plan. (See Appendix C of the Overview report)

20.2.2. There was no focus on support for Lee as a person engaging in abusive behaviour, despite there being reference to his conduct during his frequent use of illegal drugs and alcohol.

20.2.3. The only action to come out of the MARAC case discussion was in relation to enforcement process, for the Police. This is insufficient and did not represent a multi-agency response.

20.3. Cornwall Hospital Trusts (CFT & RCHT)

20.3.1. **Minor Injuries Unit (MIU) learning** - The MIU practitioner who works in various MIU's across Cornwall noted concerns that there are some MIU environments where it is not possible to take a Patient to a confidential space, or make a confidential telephone call without leaving colleagues to have to work alone. This was considered by the practitioner to be an ongoing risk. MIU Matrons across Cornwall reported a safe space in each MIU to enable confidential conversations or safeguarding enquiries to be made.

20.3.2. **Governance team learning** - Staff highlighted to the review that mental health workers with significant working relationships with clients would benefit from some sensitivity when being informed of a death.

20.3.3. **Adult Community Mental Health learning** - There were difficulties ascertaining consensus across community mental health services as to the pathway of an emergency referral within working hours. Practice regarding communication back to the referrer differed depending on if the Home Treatment Team (HTT) or the Assessment Team processed the referral. Establishing agreement and uniform practice on the pathway of handling emergency referrals including timescale of feedback to referrers is essential.

20.3.4. **Adult Community Mental Health learning** - The review found that use of 16:30/16:45 cut off times for handover of incoming referrals from the Assessment Service to the out of hours Home Treatment Team service is, when used in isolation unhelpful and prohibitive of sensible and pragmatic clinical decision making. There are multiple factors that may affect the Assessment Service's ability to deal with the referral at the end of the day e.g. factors influencing anticipated assessment length such as case complexity, requirement for additional information, workloads demands and capacity.

20.3.5. **Adult Community Mental Health learning** - Clear emergency pathways need to be established for GPs on the referral management system and work is required to establish a common understanding of urgency ratings between referrer and receiving mental health service.

20.3.6. **Adult Community Mental Health learning** - There was limited knowledge and understanding of history/experience of Domestic Abuse(DA) as a risk factor including increased risk of suicide or homicide and the significance of strangulation as a high risk flag, this highlights a need for updated DA training/supervision/Learning sessions/briefings/ resources. This learning is being addressed in the work already underway with the integrated safeguarding team working with Barnardo's designing a bespoke health DA training package and augmented learning opportunities provided by the integrated safeguarding team following single agency analysis.

20.3.7. **All CFT services learning** – Records indicated and interviews found that staff who had some knowledge for example that there was a safeguarding concern/social work involvement or a history of Domestic abuse did not seek or show professional curiosity and seek to clarify specifics and current action plans. Where there are domestic abuse or safeguarding concerns staff need to be aware of/seek to clarify the nature of the specific concerns, the risks, and the action plan to mitigate these risks and which agency/agencies are responsible for these actions. Record keeping needs to reflect this, enabling known risk and current mitigating actions to be clear on all of that Patient's health records and any associated persons at risk e.g. dependents. This learning requires cultural change as well as individual practice change also service infrastructure needs to support staff to do this in their busy working days.

The individual learning aspect is being addressed in the work already underway working with Barnardo's designing a bespoke health DA training package and augmented learning opportunities provided by the Integrated SG team following single agency analysis and recommendations from Cornwall DHR 10.

20.3.8. **All agency learning** - History of adverse childhood events, abuse and safeguarding concerns are relevant holistic medical history. Key information from childhood was not available to professionals working with Lucy as an adolescent. Multiple different electronic and paper records systems run alongside each other in health. Recording systems and practice need to standardise how a summary of this information is brought forward to make it visible to all relevant professionals involved in the individual's care as the individual ages. The recent improvements include the mental health electronic records system Rio and Kits Rio providing a facility to summarise and keep a chronology of significant safeguarding events/information current and historic mental health information received will be entered onto here. This does not account for individuals whose records predate this system e.g. where paper records were held or transferred to CFT historically or the other electronic or paper record systems. Currently the onus is on the professional to review the historic records systems including scanned paper records to

access historic information and to information share appropriately across teams and services, this is unrealistic as it is time consuming and not all staff have access to all systems. Some alternative record systems including KITs are due to be migrated across to Rio electronic records although there is no date set for this.

20.3.9. The CAMHS service has grown since the CAMHS contact in this case, a historic records summary is now available at first point of contact for some CAMHS services provided by the CAMHS Access team who manage incoming referrals. Referrals going through the CAMHS access team currently have a full records search of MOSAIC, MAXIMS, KITS Rio and OCEANO made on receipt of referral and a summary entry put onto Rio for the assessing clinician. However this does not routinely apply to more urgent response CAMHS services such as Psychiatric Liaison or the CAMHS intensive team (who provide input to avoid admission) and have varied availability of information depending on referral source for example CAMHS Locality team referrals to the intensive team will have the CAMHS access teams historic summary, however other referrals routes may have minimal records. CAMHS need access to child health and social service information to enable an informed approach to first contact, this would be resolved with read only access to Mosaic.

20.3.10. **External Safeguarding information sharing** - At the time the Children's s Safeguarding Team shared external alerts with the children's records only i.e. KITS so the CAMHS workers accessing Rio were not automatically updated. Uniform sharing of MARAC, MACE and open safeguarding referrals is now in place across Rio and KITs Rio records systems relevant to the Patient and any dependents. This still does not update staff using other records systems or paper records.

20.3.11. **CAMHS learning -** Prior to face to face contact with Lucy the CAMHS worker did not seek further information about childhood abuse, existing and historic safeguarding concerns, why the case was open to social services, dysfunctional relationship patterns, or current and historic risk. As a result, the CAMHS worker was not able to use appropriate selective enquiry or account for any of this unknown information in assessing a presentation/making a formulation and communicating risk or pertinent monitoring information onwards. Instead routine enquiry was relied on as the only source of this information. This relies on a child recognising their own abuse. This individual practice has been highlighted to the team lead who was not able to comment on the context at the time. Trauma informed practice and the resource of the CAMHS service have both developed significantly since 2015; the equivalent CAMHS service is now a 24 hour 7 days a week psychiatric liaison service sited within RCHT, an assessment pro-forma requires review of hospital records and Rio records as a minimum. Weekly safeguarding supervision drop-in sessions are available to all CAMHS intensive and psychiatric liaison staff creating a forum to discuss individual cases and through this opportunity to develop safer and more trauma informed practice. Trauma informed practice is one of the 4 Trust quality improvement priorities.

20.3.12. **CAMHS learning** - At the point Lucy declined CAMHS input, School Nursing was not considered as an option to continue this piece of work as had previously been considered by the MDT. School Nursing commented that their working relationship and communication was significantly improved with CAMHS since the team had increased staff resource

20.3.13. **SPMHT learning** - SPMHT emergency 4 hour pathway is a new service and not a well-known resource within other CFT mental health services. Training and awareness raising is required to ensure appropriate referral into this service.

20.3.14. **Safeguarding learning** - Staff found keeping up to date with changing DA services difficult and rely on a person as a touchpoint usually a safeguarding link worker for information. A format which enables busy staff to have 24 hour convenient access to up to date information enabling effective signposting is required Bespoke health DA training and resource packages are underway as part of DHR 10 CFT single agency action plan

20.3.15. **CFT Information governance and Cornwall Council** - School nursing continue to have restricted access to their own historical records pre April 2019 held on KITS by CFT, Current access is by an information sharing request and a previous plan to enable several named Cornwall Council workers to have access on behalf of the team has not resulted in functioning access for individual workers looking to compile case histories. This was not direct learning from the case but was raised by delays in the review process where previous CFT School Nursing, now Cornwall Council staff were not able to view their own records from the period. It was also raised by staff at interview.

20.3.16. **Multi-agency learning** - School Nursing which is now part of Cornwall Council are not confident that they are receiving relevant information from MACE at present. This concern was raised by School Nursing but not by CFT staff.

20.4.1. Devon & Cornwall Police

20.4.1. Devon and Cornwall Police's Domestic Abuse policy is robust and withstands scrutiny well. It is regularly reviewed by a Domestic Abuse Steering Group and changes are made when identifiable opportunities to provide a better service are presented.

20.4.2. On all occasions throughout the Police dealings with Lucy and Lee, there were instances of individual deviations from this policy. It is considered that this should be dealt with on an individual basis through targeted training and management advice. It is not believed that this is indicative of a systemic, organisation wide learning opportunity. The most recent reviews of Devon and Cornwall Police carried out by external regulatory bodies in relation to recorded crime data are published and available online. These include the Crime Data Integrity Re-inspection 2018 and the Devon and Cornwall Police PEEL Assessment 2018/19. In these, Devon and Cornwall Police were described as 'GOOD' with 93.4% of reported crimes being recorded and all previous recommendations fully implemented. They also noted that Devon and Cornwall Police had 'improved substantially it's recording of violent and sexual crimes, including rape and domestic abuse.' As a result of the 2018 Re-inspection and to ensure future performance, Devon and Cornwall Police Crime Standards Unit undertake an internal Crime Data Integrity Review twice a year with each review covering a three month period. This process is scrutinised by the Deputy Chief Constable and so far, has provided consistent results with the external review above. These reviews are expected to continue with no planned cessation at this stage. sAs a result, no specific recommendation to organisational practice is made in this respect.

20.4.3. It is a consistent theme throughout Police engagement with Lucy and Lee that an Evidence Led Prosecution was never properly considered and there was an over acceptance on Officers' parts to believe Lee.

20.4.4. Devon and Cornwall Police policies for dealing with domestic abuse are up to date and in line with ACPO guidelines. That is: The Devon and Cornwall Police policy and procedure on tackling domestic abuse gives guidelines to officers on taking positive action:

- Positive action includes arresting the suspected perpetrator for any offence disclosed. It is the decision of the attending officer whether or not to arrest a suspect and therefore victims should not be asked whether they require an arrest to be made.

- The requirement for 'positive action' means that in all domestic abuse cases, officers should consider the incident as a whole, not just the oral or written evidence of the victim.

- Officers must focus efforts from the outset on gathering alternative evidence in order to charge and build a prosecution case that does not rely entirely on the victim's statement. This is particularly important where at any stage the victim appears not to support a prosecution.

- The victim's views are always to be considered but the decision to arrest remains with the officer even if the victim does not wish to pursue a complaint. All actions will be taken in the interests of the victim in order to take the pressure and responsibility away from the victim.

- It is acknowledged that on occasion, the victim may not agree with the actions taken, however the overriding concern is to keep the victim safe. Only by protecting the victim can we be truly focused on the survivors of domestic abuse.

- Previous withdrawals of support for a prosecution should not adversely influence the decision making in whether to arrest for an offence.

- The Domestic violence definition does not require 'violence' to have been used and 'abuse' is much wider than any criminal allegations.

20.4.5. This was not an easy case for the Police to resolve, having to balance the need to take positive action with Lucy's wishes. The reports of domestic abuse on Lucy came primarily to the Police through other agencies. Had there been more direct evidence or had the officers been more enquiring, officers could have considered either the specific offence of stalking or the offence of controlling or coercive behaviour in an intimate or family relationship.

20.4.6. The Devon and Cornwall Police Public Protection Unit provided two Detective Sergeant posts and a Police staff researcher post to the Serious Case Review Team which has responsibility for identifying incidents that should be referred to various statutory reviews, including DHR's. In March 2020 only one of these post holder was in post, whilst the other two were vacancies actively being advertised and suitable candidates sought. As a result of this the one post holder was tasked on a daily basis to review approximately 200 – 250 incident logs, enquiry records, crime entries, critical incident briefing sheets and the chief officer briefing sheet. This volume of work placed on the one officer in post, resulted in Lucy's history of domestic abuse being missed.

20.5. First Light.

20.5.1. One of the learning outcomes established was that the helpline was under resourced at the time, First Light has subsequently applied for additional funding and has uplifted the helpline team and is currently recruiting to extend the helpline opening hours – Monday-Friday 9am-9pm and Saturday 9am-5pm.

20.5.2. Record keeping needs to reflect not only risks identified but clarification of historical abuse, taking into consideration multiple complex needs, additional factors and a requirement to be professionally curious. This learning requires a cultural change as well as an individual practice change. In-house training is currently under way to ensure comprehensive note taking, is maintained and reviewed regularly on our case management system.

20.5.3. Safeguarding concerns and actions were not being documented effectively and consistently on the case management system. First Light has introduced weekly dip sampling and monthly auditing on all case recordings and has implemented a process to ensure safeguarding is documented and considered in all cases.

20.5.4. A clear lesson learnt whilst reviewing this case is for the domestic abuse team to be more creative at opening up opportunities to access support, to look outside the box and be dynamic in the support First Light offers, developing and implementing multi-agency support plans and assertive outreach approaches.

20.6. Home Group:

20.6.1. Lucy's mother wanted the DHR to highlight the positive impact on Lucy through the support she received from the two dedicated Home Group key workers at Benen Chy.

20.6.2. Benen Chy gave Lucy her first experience of independent living in a safe supported environment. The stable system of having two key workers allocated to her, created an atmosphere of trust which enabled her to grow in confidence in looking after her son and interacting with people.

20.7. GP Practice A

20.7.1. That all urgent referrals who either do not engage with CMHT or who are not taken on, their GP should be immediately alerted via phone or email so that prompt follow up can occur from the GP Practice.

20.7.2. Effective communication between agencies should be encouraged and welcomed.

20.8. Ocean Housing

20.8.1. As a whole looking at the tenant and their tenancy history, in particular ASB, damage to the property, repeated' cause for concern' and rent arrears, could be an indicator of domestic abuse. In isolation, they may not be a concerning factor, however, looked at collectively may warrant further investigation.

20.8.2. Neighbourhood Services Managers currently complete monthly case supervision with their team members. Moving forwards these will focus more on complex vulnerability cases as well as legal enforcement matters. The case supervision template and reporting are being reviewed to give greater emphasis on such cases.

20.8.2. Staff to ensure full and comprehensive notes are maintained and reviewed on the Ocean Housing QL management system**.**

20.9. South Western Ambulance Service:

20.9.1. The IMR Author was satisfied that on each of the occasions Ambulance personnel responded to calls relating to Lucy and Jake, they were appropriately managed and safeguarding referrals submitted where appropriate. In line with policy a domestic abuse warning notice was put on the address for a period of 6 months. The Review Panel highlights the consistent high standard of service provided by ambulance personnel and the excellent communication with other services.

20.10. Together For Families (TFF):

20.10.1. Much of the learning for TFF from this DHR links to ongoing learning across theSafeguarding Children Partnership for Cornwall and the Isles of Scilly in relation to recent Rapid Reviews and other Domestic Homicide Reviews.

20.10.2. Education The roll out of the Trauma Informed Schools (TIS) approach across schools in Cornwall is aimed at building schools' response to support children and teenagers who suffer with trauma or mental health problems and whose troubled behaviour acts as a barrier to learning. This has involved the implementation of Mental Health training for teachers in every school in Cornwall. TIS continues to be key to ensure staff in schools are able to recognise the signs of trauma in children and see that behaviour is communication. Work continues to ensure schools are also aware of the impact adverse childhood experiences have on children and how they affect a child's ability to fully access and participate in education.

20.10.3. X School had been a school in RI category (requires improvement) for a number of years and as a result an order was placed on it to become an academy within a Multi Academy Trust (MAT). The school has been under new leadership since September 2019 and part of the CELT MAT since that time. There is now a reduction in fixed term exclusions. There is still work for the school to do in respect of support for some of its most vulnerable children and this is acknowledged by senior leaders in the MAT. The Head of School Effectiveness continues to discuss the school (and Trust's) performance and support for its pupils through regular contact with the SLT at the school and with the wider MAT and the Regional Schools' Commissioner's office.

20.10.4. Health There is now a multi-agency young parents' pathway in place, this ensures that additional support is in place for our most vulnerable families from pre-birth.

20.10.5. Children and Family Services

20.10.6. Services to children who are at risk of exploitation are significantly improved since 2016 with co-ordinated multi-agency meetings and plans, legal disruption meetings that lead to consideration of civil orders, and local support and disruption meetings targeting area based 'on the ground' contextual safeguarding approaches to protect children and prevent exploitation.

20.10.7. In the October 2019 inspection of Local Authority Children's Services OFSTED reported the following 'Children at risk of exploitation benefit from effective multi-agency information sharing. Action plans developed through theMulti-agency Criminal and Exploitation Panel (MACE) are comprehensive and well targeted'. This is significantly

improved from the report in June 2016 which said, 'Services for children vulnerable to sexual exploitation are at an early stage of development' and this was in line with the national picture in relation to multi-agency work to tackle exploitation of children'.

20.11.1National and/or Cross Agency Lessons Learnt

20.11.1. The family of the deceased were initially concerned that the title 'Domestic Homicide Review' indicated that there was a suspicion that Lucy was murdered. Lucy's ex-partner Lee initially agreed to participate in the Review but later, after a family discussion, changed his mind after reading the statutory Guidance and leaflets, because he is worried that people may believe he had been responsible for Lucy's death. He was also concerned that the Police might decide to prosecute him for offences in relation to domestic abuse and/or Lucy's death. It was explained to him and his family that was not the case and that by participating in the review his contacts with agencies would be reviewed to ascertain if any lessons could be learnt from the services he had received or not received, however he refused to change his mind and asked the Review Chair not to contact him again.

Whilst Lee was never prosecuted for any domestic abuse related offence on either Lucy or his previous partner, if he had participated in the Review, he may have been receptive to engaging in a behavioural change programme as he has attempted to justify his abusive behaviour to his use of controlled drugs and to ADHD

20.11.2. That nationally, there is a need to ensure that agencies whose personnel may work with the victims of domestic abuse embed within their Domestic Abuse Strategies that their staff receive training on legislation and practice relating to grooming, stalking and coercive control .

20.11.3. To avoid duplication of work for agencies that have provided statements to the Coroner for the purpose of the Inquest rather than them having to produce an IMR for the DHR, the Cornwall Coroner shared the Inquest statements with the Review. The Coroner was of the opinion that by doing so agencies would not need to provide IMRs for the DHR, believing that this would be in accordance with the judgment in the case R (Sec of State for Transport v HM Senior Coroner for Norfolk. 2016 which states : "It is important to emphasise that there is no public interest in having unnecessary duplication of investigation or inquiry."mThe issue this causes for DHRs is that Inquest statements are focused on the cause of death rather than to all of the relevant contacts agencies have had with a deceased, their partner and children, so that lessons can be learnt to improve services in the future for the benefit of future victims of domestic abuse.

20.12. The DHR Panel's recommendations and up to date action plan at the time of concluding the review on 20 July 2021 are detailed in the template below. After publication of this report, Safer Cornwall will discuss with partner agencies how other existing cross agency strategies can build on these recommendations.

Section Twenty One - Recommendations

National

21.1. The Review recommends that the Home Office takes action to amend the wording of information leaflets and statutory Guidance relating to Domestic Homicide Reviews to reflect the increasing number of domestic abuse related suicides.

21.2. As this review is not unique in finding that the families of the deceased and her partner were confused by the title of this review “Domestic Homicide Review” resulting in missed opportunities for the safety of future partners; it is recommended that consideration should also be given to changing the title to ‘Domestic Abuse related Death Reviews

21.3. That the Home Office seeks clarity from the Dept. of Justice and/or Lord Chancellor’s Office if the judgement in the R (Sec of State for Transport v HM Senior Coroner for Norfolk includes DHRs. That is whether Domestic Homicide Reviews are considered to be a statutory Review within the meaning of the judgement which states that to avoid duplication agencies need only to respond to the Inquest and the information will be shared with other statutory reviews. This issue is likely to come up again in Suicide DHRs so Legal clarity would be beneficial.

National & Local

21. 4. That Community Safety Partnerships embed within their Domestic Abuse Strategies that practitioners receive training on legislation and practice relating to stalking and coercive control .This training should encompass grooming

LOCAL

21.5. Safer Cornwall Community Safety Partnership

21.5.1. For agencies to be aware of all available civil and criminal justice options to tackle perpetrators of domestic abuse.

21.5.2. Commissioned Cornwall Domestic Abuse Services should have clearly defined processes for supporting victims who may want to stay in a relationship and pass referrals to other support services

21.5.3. Community Safety Partner agencies should be reminded of Para 21 of the **Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews** which states: ’Any professional or agency may refer such a (*domestic)* homicide to the CSP in writing if it is believed that there are important lessons for inter-agency working to be learned’

21.5.4. After publication of this Domestic Homicide Review’s reports, relevant Safer Cornwall cross agencies strategies and action plans should be reviewed to ascertain how they can build on the recommendations and action plans of individual agencies set out in this DHR.

21.5.5. Safer Cornwall should remind partner agencies that perpetrators of domestic abuse can self refer into Cornwall based Community Behaviour Change Programme. This is to be expanded to have an out of court IOM/MARAC pathway and a programme for families impacted by child on parent abuse.

21.6. Cornwall Foundation Trust and Royal Cornwall Hospital Trust

21.6.1. Mental Health services to develop an integrated emergency referral pathway and ensure that this is reflected consistently across all policy, process and practice.

21.7. Cornwall Foundation Trust (CFT)

21.7.1. CFT should continue to commit to a trauma informed approach to patient care, being one of its 4 quality priorities.

21.7.2. CFT should ensure that all midwives receive operational Safeguarding and Domestic Abuse training.

21.8. Cornwall Foundation Trust and Cornwall Council

21.8.1. The Cornwall Foundation Trust and Cornwall Council should review and agree a safer information sharing process to enable previous CFT services to access their own historic

records where required. That is an Information governance and named nurse to review and agree a safer process for information sharing across the two agencies.

21.9. MARAC

21.9.1. As the success of the MARAC and associated reduction in risk and increased positive outcomes for all impacted parties is entirely dependent on service engagement and prioritisation of the MARAC; Cornwall MARAC management & members have developed an improved MARAC process in Cornwall. To maximise its potential, all services and agencies must continue to resource MARAC representatives and support the delivery of the MARAC, ensuring information is shared in a timely fashion and multi-agency working initiates as soon as referrals to MARAC are made.

21.9.2. As part of the MARAC pilot review to continue MARAC awareness raising process, to move away from DASH scoring as a sole referral criteria to MARAC and focus more on risk of escalation and professional judgement

21.10. Cornwall & Isles of Scilly (IoS) Public Health

21.10.1. Public Health will target the need for a better understanding of the links between self-harm and suicide. Self-harm is a way of communicating distress and may be used as a coping strategy. However, for some people it can be a risk factor in suicide. Self-harm in itself is not an indicator of suicidal intent.

21.10.2. That key agencies gain a deeper understanding of the risk factors and their prevalence in deaths by suicide.

21.11. Devon and Cornwall Police

21.11.1. Devon & Cornwall Police should issue a Force wide Policy reminder of D34 to all officers and staff to include the definition of a domestic incident, the need to promptly record the relevant crime or enquiry and the necessity for a DASH and any necessary 'ViSTs' to be included in all cases.

21.11.2. Devon and Cornwall Police should remind all trained gatekeepers of the importance of evidence led prosecutions. The Gatekeeper training module should be modified to emphasise the importance of evidence led prosecutions where the victim has declined to support a prosecution or has since died.

21.11.3. It is recommended that the officers who dealt with incidents involving Lucy and Lee without fully following relevant Force policies would benefit from advice on the need to follow Force policy for the benefit of future victims of DA.

21.11.4. An 'Evidence Led Prosecutions' audit should be conducted to assess knowledge and implementation.

21.11.5. The Devon and Cornwall Police Public Protection Unit's Serious Case Review Team should consistently be fully staffed to ensure that incidents warranting a statutory review are correctly identified and referred to the specific authorities responsible for initiating statutory reviews.

21.12. First Light

21.12.1. First Light are encouraging the expansion of multi-agency working and sharing of information. This will promote the development and implementation of multi-agency support plans, assertive outreach approaches to work more effectively with families with multiple support needs.

21.12.2. First Light to commit to updating the Trauma informed practice, training, knowledge and culture within the service – and recognising the signs of CSE, CSA and exploitation and the impact this has on current presentation and behaviour incorporating ACE's into current assessment processes.

21.12.3. First Light are committed to the improvement of recording and reporting all information onto the current data base to include and evidence professional curiosity within the recording.

21.13. GP Practice and Cornwall Integrated Care Partnership

21.13.1. For GPs to be informed at the time an urgent referral assessment to CMHT is either declined or passed to another agency. For all patients to be receptive to confidential information sharing of concerns.

21.14. Ocean Housing

21.14.1. The Company will revise its Case Supervision Template and one to one process.

21.14.2. The Company will reaffirm the Domestic Abuse Policy and the Cause For Concern Procedure to all staff within Ocean Housing.

21.14.3. There will be a review of the Domestic Abuse Policy and Housing Management System to identify any triggers / contacts that could identify domestic abuse.

21.14.4. DASH training to be provided as a refresher to all staff.

21.15. Cornwall Children's Services - Together For Families (TFF)

21.15.1. That the recently introduced Trauma Informed Programme be continued within schools for children and young people.

21.15.2. The significant issues identified in the TFF Education IMR which relate to Lucy's time at secondary school should be discussed in detail with the current management team at the school (which is under new management) and more generally with other Cornwall secondary school head teachers.

21.15.3. Learning from this review has identified the need for practitioners working with victims of domestic abuse to find ways of engaging parents where there are challenges in exploring domestic abuse where the perpetrator is close by.

21.15.4. Recognising signs of CSE and exploitation: Significant progress has been made within the workforce about signs and understanding of exploitation, this review highlights the progress that has been made and need for continual focus and systemic work in this area of practice

Appendix A: Glossary of Terms

Devon and Cornwall Police

CARA: Child at Risk Alert

CONTROLLING or COERCIVE BEHAVIOUR: The offence came into force on 29 December 2015.

An offence is committed by A if:

- A repeatedly or continuously engages in behaviour towards another person, B, that is controlling or coercive; and
- At time of the behaviour, A and B are personally connected; and
- The behaviour has a serious effect on B; and
- A knows or ought to know that the behaviour will have a serious effect on B.

There are two ways in which it can be proved that A's behaviour has a 'serious effect' on B:

- If it causes B to fear, on at least two occasions, that violence will be used against them - s.76 (4)(a); or
- If it causes B serious alarm or distress which has a substantial adverse effect on their day-to-day activities - s.76 (4) (b).

CPS: Crown Prosecution Service

CST: Central Safeguarding Team

D34: Devon and Cornwall Police store their policy documents under 'D' numbers for ease of reference. D34 is the force policy relating to Domestic Abuse and our response to it. this policy is reviewed at least annually and is overseen by a force lead at Detective Superintendent level along with a DA steering group.

DA: Domestic Abuse

DAO: Domestic Abuse Officer

DASH: Domestic Abuse Stalking and Harassment Risk Assessment model

DVDS: Domestic Abuse Disclosure Scheme

DVPN: Domestic Violence Protection Notice

Evidence Led Prosecution: If the victim of domestic abuse decides not to support a prosecution, Police and prosecutors should consider whether it is possible to bring a prosecution without that support.

Freetext: Unifi (the force crime and intelligence system) allows for both Crimes and Enquiries to be recorded. Enquiries are recorded when no crime has been identified but we need to record something or undertake some form of Police investigation or action. On each of these record types, there is a facility to record information relating to the investigation in a freetext form. It is expected that officers will use this area for

investigation plans, the recording of decisions, victim contact plans and frequency of contact. It is also a space for supervisors to record their workload management discussions and provide direction and control of the investigation.

Grooming: The NSPCC definition is: Grooming is "a process by which a person prepares a child, significant adults and the environment for the abuse of the child" (Craven, 2006).

HMP: Her Majesty's Prison

ICPC: Initial Child Protection Conference

Maru (Cornwall & Isle of Scilly): Multi-Agency Safeguarding Hub

Stalking : The Protection of Freedoms Act 2012 amended the 1997 Act and created two new offences of stalking:

- Stalking (section 2A) which is pursuing a course of conduct which amounts to harassment and which also amounts to stalking

- Stalking (section 4A) involving fear of violence or serious alarm or distress

The offences came into force on 25 November 2012.

SIO: Senior Investigating Officer

VCU: Victim Care Unit

ViST: A vulnerability screening tool used by Devon and Cornwall Police officers and staff whenever they encounter somebody they deem vulnerable. They are graded on a red, amber, green basis and then submitted for assessment by the Central Safeguarding Team. The CST will then make decisions regarding the sharing of this information with partner agencies. These decisions are influenced by the degree of vulnerability identified and whether the subject of the ViST consents to their details being shared. This consent can be overridden if the risk is such that it justifies a disclosure for their own immediate safeguarding and welfare.

The ViST comprises of five questions as follows:

1. ViST circumstances
2. Concerns and vulnerability identified by officer and what additional support is required for each.
3. Provide full details of any support that each vulnerable person has (include family/ friends/key worker/care worker/ or other agencies involved).
4. What initial action have you taken to reduce the identified risks and what support do you feel is required.
5. Child/adult's voice – record on the thoughts/feelings of each person and what intervention or help they would like.

VNA: Victim Needs Assessment

Cornwall Multi Agency Risk Assessment Conference

MARAC: Multi-agency Risk Assessment Conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local Police, probation, health, child protection, housing practitioners, Independent Domestic Violence

Advisors (IDVAs) and other specialists.

Surgery A

GP: General Practitioner acts as first point of contact for physical and mental health concerns.

First Light

CC: Case Coordinator

CiN: Child in Need: children under 18 who need local authority services to achieve or maintain a reasonable standard of health or development, prevent significant or further harm to health or development or who are disabled.

CP: Child Protection: The protection of individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect

CP Conference: Child Protection Conference: brings together family members, the child (where appropriate), supporters/advocates and those practitioners most involved with the child and family to share information, assess risks and formulate a Child Protection Plan.

CP Plan: Child Protection Plan: a child who has suffered, or is likely to suffer Significant Harm must have a Child Protection Plan, which has clear actions, timescales, how much improvement is needed, and by when. Formulated in CP Conference.

DAO: Domestic Abuse Officer

DASH: Domestic Abuse Risk Identification and Assessment Management Tool

IDVA: Independent Domestic Violence Adviser

ISSP: Individualised Safety and Support Plan

MARU: Multi Agency Referral Unit

OIC: Officer in Case

RO: Retraining Order

RIC: Risk Identification Checklist

SOAG: Severity of Abuse Grid

SUSIE: Recovery programme group work

WAVES: Therapy Service

Ocean Housing

ASB: Anti Social Behaviour

CFC: Cause for Concern

DASH:Domestic Abuse Risk Identification and Assessment Management Tool

Documotive: Ocean Housing repository for storing documents

GAD-7: Anxiety Disorder Questionnaire - 7 Questions

HTT: Home Treatment Team

MAPPA: Multi Agency Public Protection Arrangements

NSO: Neighourhood Services Officer

NSM: Neighbourhood Services Manager

PHQ-9: Safety Planning Tool - Depression Test Questionnaire

QL : Ocean Housing management system

Smart Worker: DWP funded post working with new tenants to access training

VT: Vulnerable Tenant

South Western Ambulance Service

SWAST – South Western Ambulance Service

BASIC – British Association for Immediate Care

DGH – District General Hospital

GP – General Practitioner

CPR – Cardio pulmonary resuscitation

Together For Families (TFF)

SEN: Special Educational Needs

Trauma Informed Schools: A trauma informed school is one that is able to support children and teenagers who suffer with trauma or mental health problems and whose troubled behaviour acts as a barrier to learning.Training programmes were born out of a response to major public health studies that have shown that when children who have suffered several painful life experiences, are not helped, there is a very high chance of them going on to suffer severe mental and physical ill-health. TFF therefore support schools, communities and other organisations in providing relationships for these children that heal minds, brains and bodies. Key conversational skills in addressing and making sense of what has happened are central to our work as is a major shift in whole school/ organisation/community culture.

'Rising numbers of children are presenting with mental health difficulties in schools and current teaching environments are struggling to keep up. Many children have a high ACE score (meaning multiple adverse childhood experiences) known to leave children at risk of mental and physical ill-health later in life and even early death' (The ACE study Felitti and Anda, a study involving over 17,000 people). With the cuts in CAMHS and with over 1 million children in the UK with a mental health problem, schools are often left holding the baby. Children spend 190 days a year at school so schools are very well placed to pick up the baton and help these children.

Training to schools is offered to empower and enable key staff to be able to respond effectively to mild to moderate mental health problems. The government Green Paper 'Transforming Children and Young People's Mental Health Provision' (December 2017) wants a Mental Health Lead in every school (trained member of school staff). Their research found that appropriately trained teachers /teaching assistants can achieve results comparable to those of trained therapists. To quote, "There is evidence that appropriately-

trained and supported staff such as teachers, school nurses, counsellors, and teaching assistants can achieve results comparable to those achieved by trained therapists in delivering a number of interventions addressing mild to moderate mental health problems (such as anxiety, conduct disorder, substance use disorders and post-traumatic stress disorder)"
From the ACE study to practical implementation, interventions are informed by over 1000 cutting edge up to date research studies from neuroscience, medicine and psychology. Offered are whole school inductions (whole or half a day) Senior Leads training (two days) and a Practitioner training leading to the award of Diploma in Trauma and Mental health Informed schools (University award route 12 weekend days, non- University route 10 days).

A trauma informed school is one that is able to support children and teenagers who suffer with trauma or mental health problems and whose troubled behaviour acts as a barrier to learning. Our training programmes were born out of a response to major public health studies that have shown that when children who have suffered several painful life experiences, are not helped, there is a very high chance of them going on to suffer severe mental and physical ill-health. We therefore support schools, communities and other organisations in providing relationships for these children that heal minds, brains and bodies. Key conversational skills in addressing and making sense of what has happened are central to our work as is a major shift in whole school/organisation/community culture.

'Rising numbers of children are presenting with mental health difficulties in schools and current teaching environments are struggling to keep up. Many children have a high ACE score (meaning multiple adverse childhood experiences) known to leave children at risk of mental and physical ill-health later in life and even early death' (The ACE study Felitti and Anda, a study involving over 17,000 people). With the cuts in CAMHS and with over 1 million children in the UK with a mental health problem, schools are often left holding the baby. Children spend 190 days a year at school so we believe that schools are very well placed to pick up the baton and help these children.
We offer training to schools to empower and enable key staff to be able to respond effectively to mild to moderate mental health problems. The government Green Paper 'Transforming Children and Young People's Mental Health Provision' (December 2017) wants a Mental Health Lead in every school (trained member of school staff). Their research found that appropriately trained teachers /teaching assistants can achieve results comparable to those of trained therapists. To quote, "There is evidence that appropriately-trained and supported staff such as teachers, school nurses, counsellors, and teaching assistants can achieve results comparable to those achieved by trained therapists in delivering a number of interventions addressing mild to moderate mental health problems (such as anxiety, conduct disorder, substance use disorders and post-traumatic stress disorder)"
From the ACE study to practical implementation, our interventions are informed by over 1000 cutting edge up to date research studies from neuroscience, medicine and psychology. We offer whole school inductions (whole or half a day) Senior Leads training (two days) and a Practitioner training leading to the award of Diploma in Trauma and Mental health Informed schools (University award route 12 weekend days, non- University route 10 days). We offer training in London and throughout the UK

This has involved the implementation of Mental Health training for teachers in every school in Cornwall, which is over 270 schools involving over 44,000 children. We are also working to 'trauma inform' communities and other organisations in the area. This is part of a £9.8million programme to develop resilience and mental wellbeing in young people aged

10-16 years. The programme was launched in response to evidence that clearly demonstrates that half of cases of diagnosed mental illness begins before the age of 14, and 75% before the age of 18. Mental Health in schools and communities training programme is entirely evidence based. It is informed by over 1,000 psychology and neuroscience research studies on relationships that harm and relationships that heal. All trainings are delivered by a qualified psychologist and a Senior Lead from education who collectively share over 100 years' experience of working with vulnerable children in a school setting. This has involved the implementation of Mental Health training for teachers in every school in Cornwall, which is over 270 schools involving over 44,000 children. TFF is also working to 'trauma inform' communities and other organisations in the area. This is part of a £9.8million programme to develop resilience and mental wellbeing in young people aged 10-16 years. The programme was launched in response to evidence that clearly demonstrates that half of cases of diagnosed mental illness begins before the age of 14, and 75% before the age of 18. The Mental Health in schools and communities training programme is entirely evidence based. It is informed by over 1,000 psychology and neuroscience research studies on relationships that harm and relationships that heal. All trainings are delivered by a qualified psychologist and a Senior Lead from education who collectively share over 100 years experience of working with vulnerable children in a school setting.

Appendix B: Bibliography

CAADA Responding to Domestic Abuse: Guidance for General Practice.

Care Act 2014

Children and Domestic Homicide
By Nicky Stanley, Khatidja Chantler and Rachel Robbins

Children and Young People's Vulnerabilities to Grooming
By Jane Reeves, Emma Soutar, Sally Green and Tracy Crowther Published: December 20th 2017

Code of Practice for Victims of Crime (October 2015)

Crime Survey for England and Wales for year ending March 2017

Domestic Abuse Act 2021

Domestic Homicide Review Toolkit.

Domestic Abuse: findings from the Crime Survey for England and Wales: year ending March 2017

Domestic Violence, Crime and Victims Act 2004.

Equality Act 2010

Factors Associated With Child Sexual Abuse - stacks.cdc.gov

2008; Kaufman & Widom, 1999; Trickett, Noll, & Putnam .Child Abuse & Neglect 2000 24 10 1257 1273 11075694 Trickett PK Noll JG

Guidance on Safeguarding and investigating abuse of vulnerable adults NPIA (2012)

Health consequences of intimate partner violence :Prof Jacquelyn C CampbellPhD

HM Government Information Sharing: Guidance for practitioners and managers.

In Control: Dangerous Relationships and How They End in Murder. Bloomsbury Publishing. (2021) Monckton-Smith, Jane

Intimate Partner Violence as a risk factor for mental disorders: A Meta-Analysis. Jacqueline M. Golding

Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse' Cathy Humphreys Ravi Thiara (2003).

Mental Health Homicide Review: NHS England https://www.england.nhs.uk/south/publications/ind-invest-reports/south-central/avon-wiltshire/

Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse' (2003).

Mental health, sexual identity, and interpersonal violence: Findings from the Australian longitudinal Women's health study,

Mortality statistics in England and Wales by sex and age range (ONS) Dec 2015: Laura A. Szalacha, Tonda L. Hughes, Ruth McNair and Deborah Loxton. (BMC Women's Health, 17, 1, 2017).

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2013)

Nice Guidance on "Domestic Violence and Abuse: How Health Services Social Care and the Organisations they work with can respond effectively". (February 2014)

NICE guideline - depression in adults - recognition and management. (2009)

Office of National Statistics

Police Response to Domestic Violence: Carolyn Hoyle Andrew Sanders

Perceptions of Domestic Violence: The Effects of Domestic Violence Myths, Victim's Relationship With Her Abuser, and the Decision to Return to Her Abuser: Niwako Yamawaki, Monica Ochoa-Shipp, Craig Pulsipher, Andrew Harlos, Scott Swindler: Journal of Interpersonal Violence 27, iss. 16, 2012, 3195 – 3212.

Practice guideline for the Assessment and Treatment of Patients With suicidal Behaviours: D.G. Jacobs, et al. (Originally published in November 2003).

Protecting adults at Risk: Good Practice Guide (Social Care Institute for Excellence

Reasons for Reporting and Not Reporting Domestic Violence to the Police: Criminology March 2006

Safeguarding Vulnerable People in the NHS; Accountability and Assurance Framework (NHS England July 2015)

Serious Incident Framework (NHS England Patient Safety Domain March 2015)

Standards of Conduct, Performance and Ethics - Health and Care Professions Council 2016

The Association Between Exposure to Interpersonal Violence and Suicide Among Women: a Systematic Review: Michael B. MacIsaac Lyndal C. Bugeja George A. Jelinek. (23 October 2016).

The Mental Capacity Act 2005

The Homicide Timeline by Dr Jane Monckton Smith Gloucester University 2020

The Evolution of *Grooming*: Concept and Term
Kenneth Lanning, MS Journal of Interpersonal Violence, vol. 33, 1: pp. 5-16. , First Published December 13, 2017.

Violence, Alcohol, and Completed Suicide: A Case-Control Study Kenneth R. Conner, Psy.D., Christopher Cox, Ph.D., Paul R. Duberstein, Ph.D., Lili Tian, M.A., Paul A. Nisbet, Ph.D., and Yeates Conwell, M.D. (2001)

Women's Aid, National Survey 2015

Working Together to Safeguard Children, Department for Education (2010)

Why Domestic Violence Victims Don't "Just Leave": Wendy L. Patrick PH.D. Psychology Today April 2018

"'Why Doesn't She Just Leave?': A Descriptive Study of Victim Reported Impediments to Her Safety.": Michael A. Anderson, Paulette Marie Gillig, Marilyn Sitaker, Kathy McCloskey, Kathleen Malloy, and Nancy Grimsby,
Journal Of Family Violence 18, no. 3, 2003, 151-155.

WHY DON'T VICTIMS OF DOMESTIC VIOLENCE LEAVE THE RELATIONSHIP? The National Office for the Prevention of Domestic, Sexual and Gender-based Violence.

Appendix C: Cornwall MARAC Operating Protocol 2019 and MARAC Improvement Plan 2020/21

CORNWALL
MULTI AGENCY RISK ASSESSMENT CONFERENCE
(MARAC)
OPERATIONAL WORKING PRACTICES DOCUMENT

LIST OF CONTENTS:

INTRODUCTION

1. The purpose of this working practices document is to establish accountability, responsibility and reporting structures for the Multi Agency Risk Assessment Conference (MARAC) within Cornwall and to outline the MARAC process.
2. Multi Agency working is key to tackling the complex issues associated with domestic abuse, and in particular, cases that are perceived as “high risk” (please see the definition of high risk later in the document). The MARAC is a person centred method of providing a proportionate response to individuals considered to be at high risk of harm, by focussing on their safety and the safety of their children/ family members and associates.
3. MARAC meetings will combine up-to-date risk assessment information, together with a comprehensive assessment of the individual’s needs, linking this information directly to the provision of appropriate support services. The interventions and actions that come out of the MARAC will take into consideration the needs and safety of all those directly associated with, or impacted by, the individual in an abusive relationship, for example their children/family members and close friends
4. The sharing of information gained through the Domestic Abuse MARAC meetings can only be used for official MARAC purposes, and cannot be used for any other purposes without prior and authorised approval from the MARAC Chair, and the appropriate Lead Agency providing the specific information.
5. The sharing of personal information will be managed under the guidelines of the Crime and Disorder Act, GDPR, Data Protection Act 2018, Care Act 2014 and Child Safeguarding Legislation.
6. The principals of these working practices will be applied fairly, regardless of gender, disability, nationality, ethnic origin, age, religion and sexual orientation.

2. PURPOSE

2.1. The purpose of the MARAC is to provide a confidential forum where agencies are able to share information which will increase the safety, health and wellbeing of individuals and children related to the case. This will take place through the sharing of information, expertise and resources, and the development of multi-agency plans which identify appropriate interventions or other actions to safeguard individuals and their children.

2.2. The MARAC will seek to reduce the threat of further harm and repeated domestic abuse to the individual and their family members, through the agreed actions of the partner agencies.

2.3. The MARAC has no authority or responsibility in statute and is intended to enhance existing arrangements rather than replace them. As the MARAC is not an official body it does not own the risk associated with any particular case, but, by discussing cases at a MARAC, all the constituent agencies assume some responsibility for that ongoing risk.

2.4. The MARAC will utilise advocacy and support services within Devon & Cornwall to support the individual, reducing the level of risk to said individual and maximising their safety and general wellbeing.

2.5. The MARAC will identify, where possible, whether the individual engaging in abusive behaviours poses a continuing significant threat to the individual in relation to the MARAC or the wider community; making referrals where appropriate, for example to the MAPPA (Multi Agency Public Protection Arrangements) or Local Policing teams.

2.6. Neither the individual experiencing, nor the individual engaging, in DASV will attend MARAC meetings. The agreed lead agency representative will inform the individual experiencing the abuse regarding the MARAC meeting recommendations, the individual engaging in abusive behaviour will not be informed as to the MARAC process, as this could increase the risk of the individual experiencing the abuse.The MARAC will attempt to identify any child contact concerns between children and individuals engaged in abusive behaviour.

3. DOMESTIC ABUSE DEFINITION

3.1. The Home Office definition of Domestic Abuse is – “Any incident of a threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.”

3.2. ACPO Definition of Domestic Abuse is – “any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between Partners (16 years and over) who are or have been in an intimate relationship or between family members (18 years and over) regardless of gender and sexuality.

3.3. Family members are defined as mother, father, son, daughter, sister and grandparents, whether directly related, in-laws, common-law or step-family.

3.3.1. Child on Child under 18 within the family - Not a domestic abuse incident

3.3.2. Adult on child under 18 within the family - Child Abuse Investigation

3.3.3. Adult on Adult over 18 within the family - Domestic Abuse Incident

3.3.4. Partner on Partner both aged 13 years and over - Domestic Abuse Incident

3.3.5. Adolescent on Parent within the family – Domestic Abuse Incident

4. PARTNER AGENCIES

4.1. Appendix A details all the agencies who are partners to the MARAC process and consequently signatories to the declaration specified in Appendix B.

4.2. The list in Appendix A is not exhaustive. Consideration will also be given to requesting additional professional support from other specialist Agencies, as appropriate to MARAC needs i.e. – Cornwall Fire & Rescue Service (where there is a risk/threat of arson, fire or chemicals), YOT, Benefits & Pensions, BME specialist Agencies, Disabilities Agencies, and any Advisory and Voluntary Service which will benefit the effectiveness of the MARAC.

4.3. Each Partner Agency will identify a MARAC representative in their agency.

4.4. Partner agencies will have clearly defined roles and responsibilities and will be accountable to the MARAC Review Group for ensuring that these agreed responsibilities and actions are carried out.

4.5. Partner agencies will support the principals and purpose of the MARAC, which is to promote the safeguarding of the individual experiencing domestic abuse, and their immediate family members.

4.6. All agencies must refer to DASV Integrated Service in the event of making a MARAC referral; providing as much detail as possible.

4.7. Partner agencies are responsible for providing relevant and up-to-date information regarding individuals experiencing domestic abuse, as per the agenda. All MARAC representatives must then coordinate and communicate with their counter parts, across agencies, to facilitate an action plan to reduce risk immediately and feed back to the relevant MARAC.

4.8. The MARAC will set further actions where necessary, with a specific time frame attached, and all representatives must ensure that agreed actions are completed, with the status of agreed actions being communicated to all MARAC reps and the MARAC administrator by their deadline.

4.9. Any outstanding actions must be clearly communicated at the next MARAC, allowing the Chair to open up the conversation to other possible actions, if the risk has not

yet been reduced.

4.10. Where the risk has not yet been reduced and all partner agencies have attempted contact, where appropriate, the Chair will refer the case to the High Risk Behaviour Unit.

5. GOVERNANCE AND PERFORMANCE MANAGEMENT

5.1. The MARAC is a multi-agency meeting which has the safety of individuals at high risk of domestic abuse as its focus. It involves the active participation of all of the key statutory and voluntary agencies who might be involved in supporting a person experiencing domestic abuse.

5.2. The MARAC Review Team will monitor the MARAC: It will :

5.2.1. Meet Quarterly

5.2.2. Ensure its membership includes senior representatives from each of the key agencies Appendix C

5.2.3. Address the practical and resource implications of the MARAC

5.2.4. Monitor and review data and performance of the MARAC, including the attendance and participation of partner agencies.

5.2.5. Address any operational issues.

5.2.6. Report to the Safety Partnership Group

6. **IDENTIFICATION OF MARAC CASES** All MARAC representatives will attend MARAC Training; pertaining to Routine enquiry, Risk Identification, Risk Categorisation, Safety Planning and Referral Pathways

6.1. It is expected that all agencies participating in the MARAC will routinely screen for domestic abuse and will have a process/written guidance for doing so or will be actively working towards this. MARAC representatives will be tasked with gathering all and any relevant information they hold, in relation to any person referred to the MARAC, working closely with all frontline workers engaged with the individual in question.

6.2. The first formal risk assessment should be carried out by the lead agency that identifies or recognises a potential case of domestic abuse, or by the Integrated DASV Service. All referrals to MARAC should be referred to the DASV Service.

6.3. In most cases this would be the Police, given that they attend many domestic abuse incidents. However, it is known that many victims access other services without reporting to the Police, particularly health services including health visitors, A&E hospital staff and Mental Health Services. Thus staff within these settings should

ensure that they are aware of the signs and symptoms of domestic abuse and have access to risk assessment and domestic abuse advice and information. All agencies should, therefore, ensure that their staff attend the 3 Tier DASV Training.

6.4. In order for the MARAC to work effectively all MARAC representatives need to have a common understanding of risk levels which can be achieved by use of the Domestic Abuse, Stalking & Harassment (DASH) risk assessment tool and undertaking the available training.

6.5. The completed ACPO/DASH, will identify the level of risk to the individual experiencing DASV, and highlight high risk indicators.

6.6. The cases which should be referred to the MARAC are those which have been identified as **HIGH RISK.** The definition of High Risk is '***that there are very clear and identifiable indicators of further risk of serious harm. The potential event could happen at any time, and the impact would be serious'***.

6.6.1. The definition of SERIOUS HARM is a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

7. THE REFERRAL PROCESS

7.1. MARAC referrals are based on a comprehensive assessment of the perceived risk of further harm to a person experiencing domestic abuse and professional judgement. Each partner agency has the authority to refer cases to the MARAC based on the appropriate actuarial assessment, **on professional judgement** or as a result of an **escalation of incidents** or the **professional judgement of the likely escalation of harm.**

7.2. The threshold for referral to a MARAC will be set by the MARAC Review Team and will be consistent across Cornwall. The current threshold for the actuarial assessment is 14+ positive responses to the DASH Risk Assessment Checklist. It is, however, **best practice to prioritise professional judgement.**

7.3. Referral of repeat cases into the MARAC is essential and all agencies must develop processes whereby they can identify repeat victims.

7.3.1. A repeat incident is an incident that has occurred within the 12 months following an individual's case being heard at the MARAC.

7.3.1.1. If this incident is categorised as high risk, then the 12 month window will start afresh. An incident that would trigger a repeat referral would be one that constitutes Domestic Abuse, under the aforementioned definition (to include, but not limited to: an act of violence, threat of violence, sexual

violence/assault, coercive control, harassment or stalking).

7.4. Agencies will make a referral to the MARAC via HALO. This will be done by their in-agency MARAC representative.

8. IMMEDIATE INFORMATION SHARING PROCESS

8.1. Each referral, including MARAC to MARAC referrals, received will be quality assured by the MARAC chair (or other authorised person) to ensure that the HIGH RISK threshold is met and sufficient detail of parties involved is provided. Where the threshold does not appear to be met, the MARAC Chair will refer back to the referrer to gather further information and have a discussion around the case.

8.2. Following the Q.A. check, the referral will be immediately circulated, electronically, by the MARAC Administrator to the identified MARAC representatives within partner agencies, via HALO. This will enable all partner agencies to be aware of the potential for serious harm, at the earliest opportunity, and will allow agencies to appropriately flag their records, gather information, coordinate and communicate an action plan with their counterparts and begin reducing risk, immediately. These referral papers will be shared with those agencies who are signatories to the information sharing agreement.

8.3. The relevant MARAC representatives will then share their action plan and relevant information within 3 working days, electronically via HALO. Reporting back at the MARAC what they have achieved and whether the risk has been reduced. In the event that the risk has not been reduced, the MARAC will discuss further options to address the risk and set actions accordingly.

8.4. All information will be marked and handled in accordance with the Government Protective Marking Scheme. This is likely to be either as RESTRICTED or CONFIDENTIAL material.

9. MARAC PROCESS AND MEETING

9.1. Meetings will be held on a weekly basis. In the event of exceptional risk posed to an individual the option of an emergency MARAC is available. This is to be organised by the relevant worker and the MARAC Chair.

9.2. A confidentiality statement will be read out at the beginning of each MARAC and where appropriate, attendees may be required to sign a confidentiality statement.

9.3. Partner agencies will endeavour to achieve consistency in representation at the MARAC. As such, we recommend 2 members of staff, as a minimum, attending the MARAC training, to ensure all representatives are fully informed and able to make

commitments on behalf of the agency.

9.4. The MARAC Chair will rotate on a 6 monthly basis, between the relevant Police representative and the relevant DASV Service representative; both representatives will be of appropriate seniority and qualification.

9.5. The Chair's role will be to structure the MARAC and ensure agency representatives understand their agreed responsibilities for undertaking actions. In addition, the Chair will ensure that agency representatives new to the process receive a satisfactory induction to the process and responsibilities.

9.6. MARAC representatives will be responsible for offering actions which will assist in securing greater safety for the individual experiencing abuse and their children/ family/associates.

9.7. The Chair must make sure that safeguarding concerns regarding any child or young person living in the household are considered and appropriate actions are recorded, including any specific referrals to Children Services or Police CAIT teams.

9.8. The MARAC will operate as a referral portal; no referral will need to go through any additional pathway. This will ensure a timely response to serious risk of harm.

9.9. The Chair will be responsible that all actions offered by the MARAC representatives are recorded, specific, measurable, achievable, realistic and have a completion date.

10. The MARAC actions and meeting will be recorded in audio form, for the purpose of audit trails, DHRs, freedom of Information requests and best practice.

10. EMERGENCY & CLOSED MARAC MEETINGS.

10.1. **An emergency MARAC** meeting is an exceptional event and is only called when an individual is assessed as being at a "High Risk" level, and the risk of harm is so imminent that statutory agencies have a duty of care to act at once, rather than wait for the next MARAC meeting.

10.2. It is expected that the referral agency will have in place an interim safety plan agreed with the individual at risk, prior to the emergency MARAC meeting, to ensure that immediate safety issues have been addressed.

10.3. All Administrative updates can be completed afterwards, unless the MARAC Administrator is available, and forwarded to the MARAC administrator for recording purposes at the earliest opportunity.

10.4. The process for calling an emergency MARAC Meeting is as follows –

10.4.1. An initial phone call referral by any Agency to the lead Agency.

10.4.2. The lead Agency is to contact other relevant statutory agencies and make them fully aware of the current situation, and to arrange the emergency meeting as soon as possible and this could be via conference call.

10.4.3. The referral agency must attend the meeting, to confirm (and update where appropriate) the accuracy of information being provided.

10.4.4. Urgent actions should be agreed and executed immediately to safeguard the individual.

10.4.5. As in every case, basic target hardening, appropriate home security measures, a SIG marker and an individual safety plan should be carried out as soon as possible to ensure the continued safety of the individual.

10.4.6. The case details and agreed actions of the emergency MARAC meeting should be recorded, so that it can be further reviewed at the next MARAC meeting, and brought to the attention of all other agencies.

10.4.7. **Closed MARACs** may also be called where the case is a very sensitive one. For example:

- any party involved in the case is employed by one of the MARAC participating agencies
- in some cases of Honour Based Violence, where by the referring agency of the Chair deem it to be inappropriate to discuss said case in an open MARAC meeting
- any case that has links to Organised Crime Groups
- any case that either the referring agency or the Chair deem to be inappropriate to discuss in an open MARAC meeting

The MARAC chair will make the decision to hold a closed MARAC and invite the agencies required to participate.

In such cases, referral information will not be sent out with the other MARAC referrals.

11. ACTIONS BEFORE THE MARAC

11.1. All MARAC representatives will appropriately flag their records, gather information, coordinate and communicate an action plan with their counterparts and begin reducing risk, immediately. These referral papers will be shared with those agencies who are signatories to the information sharing agreement.

11.2. All agencies will seek to systematically flag case files when heard at the MARAC, facilitating the identification of repeat incidents/escalation and referral to the

conference.

11.3. The IDVA service will be advised of all referrals into the MARAC

11.4. All agencies which initially identify a MARAC case are responsible for taking appropriate immediate actions to safeguard any person at risk from serious harm and should not wait until the MARAC to put such procedures in place.

12. CONTACT WITH PERSON AT RISK OF HARM

12.1. Generally the MARAC IDVA will have responsibility to bring the views of the person experiencing abuse, including family members and children impacted, to the meeting and notify the victim of the conference and feedback relevant actions. In some cases, however, this role may be undertaken by another agency, if the service user has a better relationship with another agency worker.

12.2. Wherever possible the person experiencing abuse should be informed that their case is being discussed at MARAC, however in exceptional cases where the views of the person experiencing abuse are not available or the person experiencing abuse is unaware of the conference, then the referring agency will provide information as to why this is the case which must be recorded in the MARAC meeting minutes.

12.3. Any contact with the person experiencing abuse should be done via the agreed safe contact details and no letter or other communication should be made unless it is safe to do so.

13. MINUTES AND ADMINISTRATION

13.1. The MARAC will be supported by an administrator who will circulate the MARAC actions within 24 hours of the meeting.

13.2. The administrator will maintain data in respect of the cases heard at the MARAC and ensure repeat incidents, within a 12 month period, are noted as such.

13.3. The administrator will inform MARAC reps of cases that are out of their 12 month repeat window and de-flag via Electronic Case Management System, or advise MARAC rep to de-flag

13.4. In the event of an individual experiencing abuse moving out of the jurisdiction of the local MARAC, a MARAC to MARAC referral will be made by the administrator. The administrator will ensure that all relevant information is shared with the appropriate MARAC, pertaining to the individuals involved in the case.

13.5. In the event of an external MARAC referring into the local MARAC, the administrator will receive the MARAC to MARAC referral; ensuring that they have received all

relevant information pertaining to individuals involved in the case. The administrator will also ensure that a referral has been made to the local IDVA service.

13.6. In the event of a Domestic Homicide Review, the MARAC administrator will be responsible for gathering any and all relevant information held within the MARAC and assist in the preparation of evidential reports.

14. INFORMATION SHARING AT THE CONFERENCE

14.1. Proportionate information sharing is essential for a successful MARAC, facilitating effective safety planning while protecting the rights of the individual. Safer Cornwall will review the Information Sharing Agreement and signatory process.

14.2. All key agencies will be signatories of the Information sharing agreement which will be reviewed annually. Information that is shared must be proportionate, up to date, accurate and relevant to the case.

14.3. Fears about sharing information cannot be allowed to stand in the way of the need to safeguard and promote the welfare of children or adults at risk of abuse or neglect. All MARAC cases that identify any additional risks of harm to adults or children will be referred to adults safeguarding or the MARU, respectively, with all the relevant information from the MARAC discussion and any other relevant information held by any agency.

14.4. The Government (Home Office) legislation that guides these agreements are – GDPR, Data Protection Act 2018, Care Act 2014 and all up to date Child Protection Legislation.

14.5. MARAC representatives will attend meetings to discuss only relevant and current matters relating to individuals experiencing high risk domestic abuse. The shared information gained through these MARAC meetings can only be used for official MARAC purposes, and cannot be used for any other purpose without prior and authorised approval from the appropriate Agency providing the specific information.

14.6. The Human Rights Act requires public agencies to act within their powers only, and to respect the individual's right to privacy. Any disclosure of appropriate information must be seen as being both legal and fair.

15. ACTION PLANNING

15.1. A tailored action plan will be developed prior to the MARAC, to immediately increase the safety of the individual at risk of harm, their children and any other vulnerable parties, this action plan will be discussed, added to and escalated, when necessary at the MARAC. There will be clarity of agency responsibility in respect of each action

and its time frame for completion.

15.2. Each MARAC representative with responsibility for an action will advise the MARAC when it is completed or provide reasons why it could not be completed. Actions will also be updated via HALO. These updates should be within the specified timescale agreed at the meeting.

15.3. The Administrator will maintain a record of actions planned and completed.

15.4. In the event of failure to notify of a completed action, the administrator will contact the MARAC representative concerned and ensure completion as appropriate. Continued failure to update a specified action will be raised with the MARAC Chair who, if unable to resolve, will refer it to the MARAC Review Meeting.

16. OWNERSHIP OF RISK

16.1. A MARAC is not a corporate body and does not own risk associated with any case. The risk remains with individual agencies in accordance with the scope of their service. The MARAC does not make a person safer, it is the actions and efforts of the individuals and agencies involved.

16.2. MARACs will not hold a caseload under review or undertake monitoring of specific cases. The principle of a MARAC is that cases are discussed & action plans developed to promote the safety of individuals at risk of harm and any associated children. The 'repeat referral' process is the safety net which ensures that victims at continuing risk are returned to the MARAC.

16.3. If a person is not engaging with any agency or services, despite repeated and vigorous efforts to initiate/maintain contact, then the Chair will refer said person to the High Risk Behaviour Unit.

17. EQUALITY

17.1. The MARACs will recognise the need to adequately address the needs of all individuals at risk of harm from domestic abuse, including those from minority communities and where English is not their first language. Conferences will seek to include information on the ethnicity, age, religion or belief, sexual orientation, disability or gender of individuals referred to the conference. Specialist organisations and interpreters will be engaged as appropriate by the conference to ensure an effective response to all individuals at risk of harm can be offered.

18. EVALUATION

18.1. Data from the MARAC will be collated and maintained by the MARAC Administrator

for onward provision to the MARAC Review Group and the Safer Cornwall Outcomes Framework.

19. COMPLAINTS & DISCLOSURE

19.1. Where a complaint arises against another signatory agency, this will first be brought to the attention of the MARAC Chair, if appropriate, and then raised formally with the agency concerned. In the event that the complaint is not satisfactorily resolved, or it is not appropriate to refer to the Chair, the matter will be referred to the MARAC Review Group.

19.2. Where a complaint is received from a member of the public, regarding the MARAC process or these working processes, then the complaint will be initially forwarded to the MARAC Review Group to allocate an appropriate Investigating Officer.

19.3. Where any request for disclosure of information discussed at a MARAC is received by a signatory to these working practices, it should, in the first place, be forwarded to the MARAC chair.

20. BREACHES OF THE WORKING PRACTICES

20.1. It is recognised that breaches of these Working Practices may increase the risk posed to an individual at risk of harm, the wider public and any professional working with said person. All partner agencies will seek to work within the principles outlined.

21. WITHDRAWAL

21.1. Should any partner agency decide to withdraw from this 'Working Practices Agreement' they will advise the MARAC Review Group, in writing.

22. REVIEW

22.1. This Working Practices document will be reviewed after 6 months of operation and annually thereafter through the MARAC Review Group.

Cornwall MARAC Improvement Plan 2020/21

Priority 1. Facilitate a working group to determine priority improvement areas, develop a process and complementary ECMs

Objectives	Delivery	Lead	Progress and Actions	RAG	Deadline
1.1 Evaluate and determine the improvements needed in reference to the MARAC Review by Safe Lives, Devon and Cornwall Police and safer Cornwall.	Establish a working group	Anna MacGregor	There have been 4 MARAC Task & Finish Groups.		Complete
	Develop an effective and timely response to risk, against the recommendations for improvement	Anna MacGregor	Agreed areas of improvement, against the recommendations: 1. Expand risk categorisation to prioritise profession al judgement and potential escalation 2. Increase understanding of complex/ multiple vulnerabilities, as additional risks 3. Improve meeting location and attendance of all agencies 4. Improve multi- agency working to		**Complete**
	Develop a MARAC Operating Protocol to reflect the new MARAC process	Anna MacGregor	MARAC Operating Protocol has been written and signed Update 2022/23		Complete
1.2 Establish a secure and accessible multi-agency working platform	Develop a case management system that can facilitate the proposed improved process	Anna MacGregor, James Butler, Rob Beaton	Bespoke Electronic Case Management system has been developed to facilitate the MARAC process		Complete
1.3 Improve attendance of all relevant agencies	Engage all relevant partners by establishing a collaborative commitment to the MARAC, in the form of consistent attendance and improved	Anna MacGregor	Improvements and new MARAC process have been agreed and signed off by the Community Safety Board MARAC meetings held virtually on a weekly basis		Complete

Objectives	Delivery	Lead	Progress and Actions	RAG	Deadline
	accessibility				
1.4 Ensure best practice and effective MARACs, with improved multi-agency working	Develop and deliver MARAC training to all allocated MARAC Reps to cover: DASV Identification, Awareness and Referral Pathway MARAC process ECMS (HALO)	Anna MacGregor, James Butler, Rob Beaton	Training has been developed and venue and dates are booked		Complete
	Monitor and evaluate: • Improved outcomes for all impacted parties • MARAC referrals (source) • Type of risk categorisation • MARAC Repeats • MARAC Rep feedback • Complex needs/ multiple vulnerabilities	Anna MacGregor, James Butler, Erika Sorensen, Mairead Munro	Electronic Case Management system has been developed to capture and report against this data. Amethyst commenced formal review. MARAC review panel presented with the proposed review process /model 10/12/20.ES chaired MARAC review panel with focus on evaluation of the improvement plan, in line with the end of the pilot. MARAC Survey completed and findings presented to MARAC review panel. Case studies from services to demonstrate outcomes. April 2021		Complete
2.4 Provide feedback to partners and Community Safety Board	Present findings at the end of the MARAC Pilot	Anna MacGregor, James Butler, Erika Sorensen, Mairead Munro	Initial presentation of findings by end of the financial year – allowing for further updates in relation to system improvements that go beyond the original Improvement plan		Complete

Appendix D: Review Action Plan

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
The Review recommends that the Home Office takes action to amend the wording of information leaflets and statutory Guidance relating to Domestic Homicide Reviews to reflect the increasing number of domestic abuse related suicides. Consideration should also be given to changing the title 'Domestic Homicide Review' to 'Domestic Abuse related Death Reviews." This review is not unique in finding that the families of the deceased and her partner were confused by the title resulting in missed opportunities for the safety of future partners.	National	The Home Office is aware that some of the language used in leaflets and guidance does not necessarily apply to cases where the death was by suicide and is working to update this where appropriate. The Home Office however cannot commit to changing the title of DHR	**Home Office**	The Home Office is currently working on revising the Statutory Guidance and rewording leaflets.		**ongoing**

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
That the Home Office seeks clarity from the Dept. of Justice and/or Lord Chancellor's Office if the judgement in the R (Sec of State for Transport v HM Senior Coroner for Norfolk includes DHRs. That is whether Domestic Homicide Reviews are considered to be a statutory Review within the meaning of the judgement which states that to avoid duplication agencies need only to respond to the Inquest and the in- formation will be shared with other statutory re- views. This issue is likely to come up again in Suicide DHRs so Legal clarity would be beneficial.	National	The DHR Chair has discussed this issue with the Home Office who after taking internal legal advice Home Office is of the opinion that Domestic Homicide Review's statutory responsibilities are essentially different from that of a Coroner's Inquest. That is, a DHR is about agencies reviewing their contacts with the deceased and his/her partner, to ascertain if there are lessons to be learnt and addressed for the benefit of individuals in similar situations in the future, whereas the role of the Coroner is to decide on the cause of death. Any agency listed in the statutory guidance which does not participate in a DHR would therefore be in breach of their statutory duty.	Home Office Dept of Justice			**Ongoing**

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
That Community Safety Partnerships embed within their Domestic Abuse Strategies that practitioners receive training on legislation and practice relating to stalking and coercive control. This training should encompass grooming	National & Local	Safer Cornwall's DASV Strategy to include DA professionals training within their next strategy 2022-27 Safer Cornwall to update the currently commissioned DA professionals training to include grooming and the legislation around stalking and coercive control	Safer Cornwall Community Safety Partnership Home Office	Strategy go live – March 22 Amended training – Sept 21	March 22 Sept 21	1. Completed in Cornwall 2. complete
For agencies to be aware of all available civil and criminal justice options to tackle perpetrators of domestic abuse	Local	1. Cornwall CSP to prepare a practitioner's guide to using civil powers under the ASB, Crime and Policing Act 2014, as a supplement to Police and CPS powers, to tackle domestic abuse. 2. There is a Community Behaviour Change Programme which is part of the Cornwall Family Domestic Abuse Programme which includes self-referrals which is being expanded to include out of court IOM/ MARAC pathway and a programme for families impacted by child on parent abuse.	Safer Cornwall Community Safety Partnership	Practitioner's guide developed – Oct 22 Webinar planned for June 2023	Oct 2022	Complete Ongoing

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
		CSP to develop a webinar on behaviour change programmes within Cornwall – to cover BBR, Change 4 You and other civil and CJ options.				
Commissioned Cornwall Domestic Abuse Services should have clearly defined processes for supporting victims who may want to stay in relationship and pass referrals to other support services	Local	1.Cornwall CSP to draft contract variation for approval by Law and Democratic ser- vices. 2.Varied contract finalised by Com- missioner	Safer Cornwall Community Safety Partnership	Contract already includes provision for those who want to stay in a relationship. The following list is the Safer Futures interventions that support people who are experiencing domestic abuse, whether they are in a relationship, about to leave the relationship or have already left the relationship – this is for current abuse or historical. • Helpline • Domestic Abuse Support Advisors (DASA) • Family DASAs • Outreach DASAs • GP DASAs • IDVAs • Change 4U	Sept 2022	Complete

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
				• Healthy foundations Programme Safer futures carry out an assessment on an individual basis to ensure they are in a safe place and able to look at recovery from Domestic Abuse, potentially Safer Futures may not be able to offer support if in a current DA situation. Therefore, the only intervention with the specific criteria of not being able to support people in current abusive relationships is SUsie.		
Community Safety Partner agencies should be reminded of Para 21 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews which states: 'Any professional or agency may refer such a (domestic) homicide to the CSP in writing if it is believed that there are	Local	CSP to draft briefing around DHR guidance para 21	Safer Cornwall Community Safety Partnership	Briefing draft and distributed – July 21	July 21	Complete – Feb 2022

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
important lessons for inter-agency working to be learned'.						
After publication of the DHR's reports relevant Safer Cornwall cross agencies strategies and action plans should be reviewed to ascertain how they can build on the recommendations and action plans of individual agencies set out in this DHR.	Local	The Domestic Abuse and Sexual Violence Strategy Lead will request relevant cross-agency working groups and Panel Chairs (e.g. Missing and Child Exploitation Panel)	Safer Cornwall Community Safety Partnership	After publication of this DHR, relevant cross agency groups will be invited to review their strategies and action plans to build on recommendations and actions of individual agencies as listed in this report.	Dec 21	Complete
The Community safety Partnership should remind partner agencies that perpetrators of domestic abuse can self-refer into Cornwall based Community Behaviour Change Programme. This is to be expanded to have an out of court IOM/MARAC pathway and a programme for families impacted by child on parent abuse.	Local	To be discussed and cascaded through Safer Cornwall CSP Change 4 You information to be distributed throughout CSP, including referral mechanisms Webinar (as above rec)	All Community Partners Agencies	Change 4 You info distributed- July 21 Lunch and Learn networking event held in Truro 2022	July 21 Oct 22	Complete Complete

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
Mental Health to develop an integrated emergency referral pathway and ensure that this is reflected consistently across all policy, process and practice.	Local Cornwall wide	Working group to be established to develop, implement and evaluate an integrated emergency referral pathway and associated work. Cornwall Public Health and Kernow CCG will be invited to have representation on the Working Group.	Deputy director of Mental Health Cornwall Foundation Trust (CFT) and Royal Cornwall Hospital Trust (RCHT)	June 22 – CFT Governance Business Partners for mental health to meet with key senior leaders in acute/emergency mental health services to ensure this action is progressed	Oct 2022	
CFT should continue to commit to trauma informed practice being one of its 4 quality priorities.	Local	CFT to evidence practitioners are using a trauma informed approach to patient care	CFT	June 22 – trauma-informed care programme has been continued as part of the quality priorities for 2022-2023. Governance business managers to establish lead for this priority to link them in with this action.	Oct2022	Completed
CFT should ensure that all midwives should receive operational Safeguarding and Domestic Abuse training.		The Trust has already commissioned Barnardo's to provide Safeguarding and Domestic Abuse training to all midwives		All midwives have sign up for the course and all will have completed the training by December 2022	December 2022	On target
CFT and Cornwall Council re- view and agree a safer information sharing process to enable previous CFT services to	Local	CFT Information governance and named nurse from the Council to review and agree a safer process for information	CFT & Cornwall Council	Completed	September 2022	Completed

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
access their own historic records where required. i.e. Information governance and named nurse from the Council to review and agree a safer process for information sharing across the two agencies.		sharing across the two agencies				
As the success of the MARAC, and associated reduction in risk and in-creased positive outcomes for all impacted parties, is entirely dependent on service engagement and prioritisation of the MARAC; Cornwall MARAC management & members have developed an improved MARAC process in Cornwall. To maximise its potential, all services and agencies must continue to resource MARAC representatives and support the delivery of the MARAC, ensuring in-formation is shared in a	Local & national	All agencies in- volved in MARACs have: 1)Committed their representatives to prioritise the preparation and attendance of MARAC meetings. 2)Agreed to the implementation of the Cornwall Improvement Plan which was drafted in January 2019	Cornwall Multi Agency Risk Assessment Conference (MARAC)	1. MARAC Improvement Plan agreed 2. Introduction of Pilot Evaluation Stage 3. Cascade the MARAC Operating Protocol and Implementation Plan to other areas	January 2019 July 2020 Ongoing	1. Completed 2. Completed 3. Completed

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
timely fashion and multi-agency working initiates as soon as referrals to MARAC are made.						
As part of the MARAC pilot review to continue MARAC awareness raising process, to move away from DASH scoring as a sole referral criteria to MARAC and focus more on risk of escalation and professional judgement	Local	MARAC refresher training is being scheduled, following the MARAC Pilot review. The training will be focusing on the MARAC process, generally, with an emphasis on identifying additional high-risk indicators relating to multiple vulnerabilities and complexities and taking these in to account to encourage referral to MARAC and DA services.	Cornwall & IOS MARAC	A continuous programme of MARAC training has been developed. This includes MARAC rep training and a wider awareness raising training session for profressionals.	May 2022	Complete
Need to have a better understanding of the links between self- harm and suicide. Self- harm is a way of communicating distress and may be used as a coping strategy. However, for some people it can be a risk factor in suicide. Self- harm in itself is not an indicator of suicidal intent.	Local Cornwall and Isles of Scilly	Cornwall and Isles of Scilly Public Health Suicide Prevention has started to develop a real-time surveillance system to collate available data on self-harm rates across the county to support understanding of the scale of the problem and service improvement.	Cornwall & IoS Public Health	A short audit of Cornwall and the Isles of Scilly (CIoS) data on children and young people (under 25) who have died by suicide (or suspected suicide prior to inquest) has been conducted which indicates that over 2018-2020, around 70% of those had previously self-harmed.	1. Completed 2. Initial meetings started early 2021	Complete

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
				A real-time surveillance system to be instigated to collate available data on self-harm rates across the county to support understanding of the scale of the problem and service improvement.		
That key agencies gain a deeper understanding of the risk factors and their prevalence in deaths by suicide	Local (CIoS)	Deep-dive into Coroner inquests of deaths by suicide during the period of the COVID-19 pandemic Working with multi agency partners to reduce the risks of domestic abuse related self harming and suicides	Cornwall & IoS Public Health	Deeper understanding of the risk factors and their prevalence in deaths by suicide. Finalized report and recommendations due February 2023	Starting May 2021	Ongoing
Devon & Cornwall Police should issue a Force wide Policy reminder of D34 to all officers and staff to include the definition of a domestic incident, the need to promptly record the relevant crime or enquiry and the necessity for a DASH and any necessary ViSTs to be included in all cases.	Local: Devon and Cornwall wide	This recommendation will be considered by the Devon & Cornwall Police Safeguarding Business Board and allocated for action.	Devon and Cornwall Police	The D34 DA Policy has been incorporated into a larger recommendation relating to training Evidence Review Officers (Gatekeepers) for cascade dissemination.	16/3/21	Completed

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
Devon and Cornwall Police should remind all trained gatekeepers of the importance of evidence led prosecutions. The Gatekeeper training module should be modified to emphasise the importance of evidence led prosecutions where the victim has declined to support a prosecution or has since died.	Local: Devon and Cornwall wide	This recommendation will be considered by the Devon & Cornwall Police Safeguarding Business Board and allocated for action.	Devon and Cornwall Police	A three-day CPD event being held starting 16/3/21 with specific training inputs, delivered by a CPS lawyer, on the topic of evidence led prosecutions. It is also being recorded and made available on our intranet for those who cannot attend. The training package for new Evidence Review Officers now incorporates an input into Evidence led prosecutions for cases where there is no support from a victim or where they have since died. This is already in place and the most recent cohorts to go through this training have already received this input (February). The force has also established an Evidence Led Prosecutions working group which sat for the first time w/c 15/3/21 and is made up of key stakeholders from across the force	16/3/21	Completed

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
				area in order to maximise learning and opportunities.		
It is recommended that the officers who dealt with incidents involving Lucy and Lee without fully following relevant Force policies would benefit from advice on the need to follow Force policy for the benefit of future victims of DA.	Local	The informal management advice is underway and subject to review by the relevant line managers of the necessary departments. It is anticipated that this will be completed by mid-March.	Devon and Cornwall Police	Completed	31/03/21	Completed
Evidence led prosecutions audit to take place.	Devon and Cornwall wide	Devon & Cornwall Police should review victimless prosecutions to ensure 3rd party material is utilised effectively in the absence of victim testimony.	Devon and Cornwall Police	A number of audits have taken place, mainly around domestic abuse to benchmark our current investigative standard and to identify areas for improvement. Audits have recently led to a force wide campaign to raise awareness of why victims may not engage with a prosecution and how we can build evidence led prosecutions, another audit finding has led to the change in Policy that all DA offences where no interview is to take place	01/07/2021	Completed

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
				must be authorised by an Inspector. All ERO's have had additional training delivered by a former CPS crown prosecutor in relation to evidence led prosecutions, this includes the importance of first response such as utilising BW camera footage, 999 calls, previous history etc, capturing the evidence in terms of witnesses, House to House, CCTV, Digital media etc. understanding Res Gestae, the significance of section 78 of PACE and how documentation a victim's fear can help avoid hearsay evidence being excluded. Audits complete – August 2021 A three-day CPD event held 16/3/21 with specific training inputs, delivered by a CPS lawyer, on the topic of evidence led prosecutions. It is also being recorded and made available on our intranet for those who cannot attend. The training package for		

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
				new Evidence Review Officers now incorporates an input into Evidence led prosecutions for cases where there is no support from a victim or where they have since died. This is already in place and the most recent cohorts to go through this training have already received this input (February 2021). The Force has also established an Evidence led prosecutions working group which sat for the first time w/c 15/3/21 and is made up of key stakeholders from across the force area to maximise learning and opportunities. A further CPD event held 2021 for Evidence Review Officers. The training package still emphasises the importance of Evidence Led Prosecutions. The working group still sits and is still well represented including CPS partners. A joint agency Reflective		

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
				Learning Panel has been carried out with the CPS in October 2021 focussing specifically on Evidence Led Prosecution. The learning points are being shared across both organisations to raise awareness generally and to highlight good practice i.e. “What works well”.		
The Devon and Cornwall Police Public Protection Unit’s Serious Case Review Team should consistently be fully staffed to ensure that incidents warranting a statutory review are correctly identified and referred to the specific authorities responsible for initiating statutory reviews.	Local: Devon and Cornwall wide	Action was taken immediately to recruit the correct complement of staff to address the duties of the Unit.	Devon and Cornwall Police	By the summer of 2020 the Public Protection Unit’s Serious Case Review Team was fully staffed and amalgamated into the Criminal Case Review Team with a dedicated line manager, providing focused support and leadership.	August 2020	Completed
First Light are encouraging the expansion of multi-agency working and sharing of information. We would promote the development and implementation of multi-agency support plans, assertive outreach approaches to work more	Local	Action already being taken with the induction of an assertive outreach IDVA working alongside We Are With You and a Health IDVA based at Royal Cornwall Hospital- The new service of Primary care (IRP) workers being based in GP practices and the	First Light	Actions being taken on Multi-Agency basis	June 2023	Complete

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
effectively with families with multiple support needs.		commitment to the improvement plan at MARAC, attendance at MACE meetings, High risk behaviour panel, daily safeguarding triage meetings, co-location with MARU, YMCA and Harbour Housing.				
First Light to commit to updating the Trauma informed practice, training, knowledge and culture within the service- and recognizing the signs of CSE, CSA and exploitation and the impact this has on current presentation and behaviour incorporating ACE's into current assessment processes	Local	ACE being incorporated into assessment processes	First Light		September 2022	Complete
First Light are committed to the improvement of recording and reporting all information onto the current database to include and evidence professional curiosity within the recording.	Local	Action taken immediately- with weekly auditing put in place of the case management of all new referrals in line with Safer Lives processes. Dip sampling of all current cases monthly. Case Discussion within line	First Light	Completed	January 2022	1 Completed 2 Ongoing 3 Completed

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
		management and regular team meetings.				
For GPs to be informed at the time an urgent referral assessment to CMHT is either declined or passed to another agency. For all patients to be receptive to confidential information sharing of concerns	Local	Discussion at Significant Events meeting.	GP Practice and Cornwall CCG	Following a review of this incident with CMHT during a Significant Events Meeting in the summer of 2020 this has been actioned and GPs are now receiving emails or phone calls to inform them.	July 2020	Completed
Revise Case Supervision Template and one to one process.	Local and Companywide.	Case supervision template and one to one supervision to be amended to ensure that the process captures complex vulnerable cases, so these can be monitored, and appropriate actions completed. Include sampling QL notes to make sure they are clear and helpful.	Ocean Housing	31/05/2021- one to one template reviewed 31/05/2021- procedure note issued to staff regarding 1-2-1 covers all domestic abuse case now. Case discussion section at team meetings each month too	01/07/2021	Complete

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
Reaffirm- the Domestic Abuse Policy and the Cause for Concern Procedure to all staff within Ocean Housing	Local and Companywide.	Staff to be receive refresher training and or team brief on the Domestic Abuse Policy, Cause for Concern Procedure including the identification of warning signals. This is to be delivered across all teams.	Ocean Housing	30/06/2021- Team brief disseminated 30/08/2021- Relevant staff received fresher training within Neighbourhood services Tailored training for each work group planned in - ongoing	01/07/2021	Complete
Review the Domestic Abuse Policy and Housing Management System to identify any triggers/contacts that could identify domestic abuse.	Local and Companywide.	Amend the procedure that underpins Open Housing Domestic Abuse Policy to ensure that it more clearly prompts the team to look for patterns that could be triggers to escalate a case more rapidly e.g. Multiple missed appointments.	Ocean Housing	Included in the new procedure currently in draft form	30/08/2021	Complete
DASH training to be provided as a refresher to all staff.	Local and Companywide.	DASH training to be provided as a refresher to all staff.	Ocean Housing	As above, part of training roll out	31/03/2022	Completed
That the recently introduced Trauma Informed Programme be continued within schools for children and young people.	Local	There is a wealth of research that shows that children who experience stressful or traumatic childhoods are more likely to develop health-harming and/or anti-social	TFF	Programme currently being continuously implemented with schools in Cornwall.		Ongoing

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
		behaviours and perform poorly in school. There is an increased risk of poor mental and physical health, learning difficulties and early death. There is already an ongoing programme of training in Cornwall through the roll out of the Trauma Informed and response approach.				
The significant issues identified in the TFF Education IMR which relate to Lucy's time at secondary school should be discussed in detail with the current management team at the school (which is under new management) and more. Generally with other Cornwall secondary school headteachers.	Local	The Head of Education Access and Sufficiency will cascade as leaning points, the salient issues identified in the TFF Education IMR with Cornwall Secondary school managers.	TFF Education	Completed	September 2022	Completed
Learning from this review has identified the need for practitioners working with victims of domestic abuse to find ways of engaging parents where there are challengers in exploring domestic abuse where the	Local	OSCP learning lessons workshop to take place in June 2021 on the impact of domestic abuse of families and children. There is ongoing training offered in TFF and through	TFF	QAPM Audits, themed audits, and the PQS undertaken by Children's Rights Advocate's will include the needs of parents, identifying gaps in practice.	September 2021	Ongoing

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
perpetrator is close by.		the OSCP that practitioners can access. A further review of the training programme to consider specific inclusion of coercive control. TFF/Children and Family Services will undertake a thematic audit as part of the audit processes. CFS will continue to take a whole family approach to assessments and planning for children. New guidance written in May 2020 coinciding with assessment and planning workflow emphasises the need to consider the parental support and capacity to meet the needs of the child, and to ensure that any actions are proportionate and realistic.				
Recognising signs of CSE and exploitation: Significant progress has been made within the workforce about signs and understanding of exploitation, this review highlights the progress that has been made and	Local	The OSCP have a Contextual Safeguarding subgroup who are reviewing the strategic response to practice in this area of practice. There is ongoing training available to the workforce through the	TFF	OSCP scrutiny panel on vulnerable adolescents agreed areas for multi-agency focus. OSCP contextual safeguarding sub-group is currently being formed and will report to	September 2021	Complete

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
need for continual focus and systemic work in this area of practice.		OSCP on exploitation. Contextual safeguarding is understood in respect of older children. This is to be considered in conjunction with OSCP Exploitation sub-group. Exploitation work is developed in a partnership way acknowledging that no one agency has sole responsibility, and that each has a role to play.		OSCP board. MACE panel TOR have been refreshed We have introduced Local Disruption Meetings to further strengthen disruption, building on existing MACE meetings. CFS has invested in a specialist legal officer to support disruption.		