Executive Summary

Plymouth Community Safety Partnership

Victim A

Year of Death 2017

Author: Paul Northcott

Date the review report was completed: 5th February 2019.

Preface

I would like to begin this report by expressing my sincere sympathies, and that of the panel, to the family and friends of Adult A. She will be remembered by those that knew her as a person who was dedicated to her family and a woman who had boundless amounts of energy. Adult A will be missed by all that knew her. Having met the family I am deeply sorry for their loss and I hope that in some way this report provides an insight to her life and a voice to her story.

I would also like to thank Adult A's family for their contribution at a time when they have had a double tragedy in their lives. Without their input, it would have been difficult to have had a full appreciation of Adult A's vibrant character and her love for her children and grandchildren.

Contents

1.0 The Review Process

1.1 This summary outlines the process undertaken by Plymouth Community Safety Partnership domestic homicide review panel in reviewing the death of Victim A who was resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, perpetrator and family to protect their identities;

- Victim – Adult A.
- Perpetrator- Adult B.
- Victim's adult daughter - Adult C.
- Perpetrators wife – Adult D.
- Child B1 – Child of perpetrator (Eldest).
- Child B2 - Child of perpetrator (Middle).
- Child B3 - Child of perpetrator (Youngest).

1.3 Both Adult A and Adult B were white British nationals and they were both heterosexual. Adult A was aged seventy-six at the time of her death and Adult B fifty-four.

1.4 On Saturday the 28th October 2017 Adult B was charged with the murder of his mother. Following a court appearance on the 30th October 2017 Adult B was remanded into custody. Adult B later took his own life.

1.5 The DHR process began with an initial meeting of the Community Safety Partnership on the 3rd January 2018 when the decision to hold the domestic homicide review was agreed. All agencies that potentially had contact with Adult A and Adult B prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.6 All of the twelve agencies that were initially contacted confirmed that they had interaction with the victim and/or perpetrator and children involved and were asked to secure their files.

2.0 Contributors to the Review

2.1 The contributors to the DHR were;

- Devon and Cornwall Police – IMR[1].
- PATH – IMR.
- Livewell Southwest - IMR.
- Children Young People and Family Services - IMR.
- National Health Service England (NHSE) – IMR.
- Plymouth City Council – Community Connections - IMR.
- Education – IMR.

[1] Independent Management Review

- University Hospitals Plymouth NHS Trust - IMR.
- Adult B's GP[2]- Letter of response.
- Family members - Information.
- Adult B's Pastor- Information.
- Friends of Adult A and Adult B.

2.2 Family members of Adult A and Adult B were invited to contribute to the review and were each sent or given a leaflet prepared by the Home Office about the DHR process. The family were also provided with the Advocacy After Fatal Domestic Abuse Leaflet and signposted to support services.

2.3 All of the IMR authors were independent and none of them had previous involvement with either Adult A or Adult B and /or their cases.

3.0 The Review Panel Members

3.1 The panel for this review were made up of the following representatives;

- Paul Northcott-Independent Chair.
- Sue Warren – Community Connections Technical Lead.
- Sara Allum - Children Young People and Family Services
- DI Steve Hambly – Senior Investigating Officer, Major crime Investigation Team, Devon and Cornwall Police.
- DS Chris Cowd – Serious Case Review Unit, Devon and Cornwall Police.
- Gillian Scoble – New Devon Clinical Commissioning Group (CCG) - Safeguarding Nurse.
- Elizabeth Cox – Integrated Safeguarding Manager for Children and Adults Livewell Southwest.
- Angela Hill – Named Nurse for safeguarding adults. University Hospitals Plymouth NHS Trust Anna Constantinou – Plymouth City Council (PCC) Community Connections.
- Katy Fisher – Plymouth Domestic Abuse Service.
- Jane Elliot - Tonic- PCC Adult Safeguarding.
- Maria Hollett – PCC Early Years.

3.2 The panel met on four occasions. Contact was also made on an individual agency basis to clarify issues raised as part of the review.

3.3 Independence and impartiality are fundamental principles of delivering Domestic Homicide Reviews and the impartiality of the Independent Chair and panel members are essential in delivering a process and report that is legitimate and credible. None of the panel members knew the relevant individuals, had direct involvement in the case, or had line management responsibility for any of those involved. This was also confirmed by agencies at the initial panel meeting.

[2] General Practitioner.

3.4 During the review the Chair and the Community Connections Technical Lead maintained an on-going dialogue with the family. Frequency and methods of contact were agreed at the initial meeting. Adult A's immediate family were invited to meet the Panel but declined to do so.

4.0 Author of the Overview Report

4.1 Safer Plymouth appointed Paul Northcott as Independent Chair and author of the Overview Report on 11th January 2018.

4.2 Paul is a safeguarding consultant specialising in undertaking reviews (critical incidents, investigations, serious case reviews and safeguarding adult reviews) and currently delivers training in all aspects of safeguarding, including domestic abuse. Paul had been a serving police officer in the Devon and Cornwall Police and had thirty-one years' experience. During that time he was the head of public protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides.

4.3 Paul had not worked in the Devon and Cornwall Police area since 2015 and retired from the service in February 2017. In that interim period he had worked in London. During that time he had no involvement with Safer Plymouth nor the policy and practices of the Devon and Cornwall Police. Prior to appointment records were checked to ensure that Paul had no involvement with those police resources involved in this case.

4.4 At regular intervals Safer Plymouth reviewed Paul's independence and the Panel were encouraged to challenge him and the Police IMR submission to ensure that it was critically reviewed. No issues were identified by those commissioning the review or by panel members which would have indicated that his independence had been compromised. Adult A's family were also aware of Pauls background and encouraged to challenge the outcomes of the report.

5.0 Terms of Reference for the Review

5.1 Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Abuse, Crime and Victims Act (2004). The Act, which came into force on the 13th April 2011, states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a. A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;

b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death'.

5.2 As Adult A was the mother of Adult B, Safer Plymouth commissioned a DHR in accordance with a) above.

The purpose of the review was therefore set to;

- Establish the facts that led to the death of Adult A and whether there are lessons to be learnt from the domestic homicide regarding the way in which local professionals and organisations carried out their responsibilities and duties, and worked together to safeguard Adult A (victim), Adult B (perpetrator);

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

- Apply these lessons to service responses including changes to policies, procedures and practice of individual agencies, and inter-agency working, with the aim to better safeguard victims of domestic abuse in Plymouth;

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future and improve single agency and inter-agency responses to all domestic abuse victims and their children through improved partnership working;

- Identify, on the basis of the evidence available to the review, whether the homicide was foreseeable and avoidable, with the purpose of creating a joint strategic action plan to address the gaps and improve policy and procedures in Plymouth and across the South West Peninsula;

- Identify from both the circumstances of this case, and the homicide review process adopted in relation to it, lessons which should inform policies and procedures in respect to homicide reviews nationally and make this available to the Home Office.

5.3 In addition to the above, the following terms of reference were set by the DHR panel and there was a requirement that these needed to be addressed in each of the individual Management Reviews and the Overview Report;

1. To provide an overview report that articulates the victim's life through her eyes, and those around her, including professionals.

2. Establish the sequence of agency contact with Adult A, the perpetrator (Adult B) and the members of their household between the dates of 1st January 2005 and 23rd October 2017 (see paragraph 1.3); and constructively review the actions of those agencies or individuals involved.

3. Provide an assessment of whether the death of Adult A was an isolated incident or whether there were any warning signs that would indicate that there was any previous history of abusive behaviour towards the deceased and whether this was known to any agencies.

4. Seek to establish whether Adult A or the perpetrator were exposed to domestic abuse prior to adulthood and impact that this may have had on the individuals concerned.

5. Establish whether family or friends want to participate in the review and meet the review panel.

6. Provide an assessment of whether family, friends, neighbours, key workers were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons).

7. Review of any barriers experienced by the victim/family/friends in reporting any abuse or concerns in Plymouth or elsewhere, including whether they knew how to report domestic abuse.

8. Assess whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the relationship;

9. Establish whether improvements in any of the following would have led to a different outcome for Adult A considering:

   (a) Communication and information-sharing between services.
   (b) Communication within services.
   (c) Communication to the general public and non-specialist services in Plymouth about the role services available to victims and perpetrators of domestic abuse.

10. Evaluate the effectiveness of training or awareness raising in agencies to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city.

11. Establish whether the work undertaken by services in this case is consistent with each organisation's:

    (a) Internal policy and professional practices.
    (b) Domestic Abuse policy, procedures and protocols.

    and identify whether these policies and practices are effective to meet the needs of victims and their families.

12. Establish whether thresholds for intervention were appropriate and whether they were applied correctly in this case.

13. Review any previous concerning conduct or a history of abusive behaviour from the perpetrator, his level of risk and whether this was known to any agencies.

14. Consideration of any equality and diversity issues that appear pertinent to Adult A the perpetrator or family members e.g. age, disability, gender

reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

15. To review any other information that is found to be relevant.

16. The Review excludes consideration of how Adult B died.

6.0 Summary Chronology

6.1 Adult A was seventy-six years old at the time of her death and had been living alone in a house in Plymouth. She had been married on three occasions and had two children during her first marriage. Her children were Adult B and Adult C.

6.2 Adult A was dedicated to her family and they had become her priority, particularly after the death of her husband, whom she missed greatly. Adult A was fiercely independent and was described by those that knew her as fit, active and healthy.

6.3 Adult B was almost the opposite to his mother and over the years he found it difficult to cope with life. His family and friends describe him as a very negative person. Adult B had suffered from anxiety, depression and chronic myeloid leukemia (although this had been controlled with medication).

6.4 Adult B was extremely manipulative and could be very deceitful. He was very clever in the way in which he presented to professionals, friends and family and he constantly wanted to get his own way.

6.5 Adult B had been married on two occasions. He had married his second wife in 1999 and even at that time Adult D described her husband as appearing depressed. She had initially put this down to the fact that he missed his children from his first marriage as they had moved away. It was at this time that he had been prescribed benzodiazepines to cope with his depression. Adult B later became addicted to prescription drugs.

6.6 Adult B and Adult D had three children all of whom have been described as quiet, and unassuming. Both children lived with their parents.

6.7 During the marriage between Adult B and Adult D there were a number of difficulties in the relationship which centered around Adult B's mental and physical health, and domestic abuse. Adult D described how her husband was physically, emotionally and financially abusive and that she was trapped in the relationship due to her religious and cultural beliefs and her sense of duty.

6.8 From the information available Adult B became violent following the breakdown of his first marriage and there would appear to have been no rational explanation as to why this had occurred. Adult B's depression, his decline in mental health, and his addiction to medication, appear to have had an impact on his propensity to become violent.

6.9 Adult B exerted a consistent level of coercion and control in the relationship with his wife. Adult D was subjected to emotional abuse over a ten-year period. The level of coercion and control that was occurring within the relationship was not apparent to any agency until reported by Adult D following the breakup of her relationship with Adult B.

6.10 From the information available to the review it is difficult to know how controlling Adult B was in respect of Adult A.

6.11 Throughout the period covered by the review Adult B had been supported by health services including GP services, the CMHT[3] and via outpatient appointments at a local hospital.

6.12 In 2001 Adult B was diagnosed with leukemia and he was successfully treated for this condition. He had also suffered from a nervous breakdown.

6.13 In 2004 Adult B was diagnosed with chronic fatigue syndrome and at that time it was also felt that he was suffering from 'significant chronic anxiety and depression[4]. At times Adult B also suffered from paranoia, and due to his declining mental and physical health he was unable to work, which in turn had led to his family falling into debt.

6.14 During his periods of depression Adult B would rely heavily upon those around him, particularly Adult D and Adult A. He would become reclusive, fail to eat a healthy diet and he would not look after himself. He had made numerous threats to take his own life over the years, and these were generally made when he was unable to get his own way.

6.15 Adult B was treated with prescribed medication which included anti-depressants, valium and chemotherapy tablets. Adult B had become addicted to diazepam and he would often try and obtain repeat prescriptions in order to feed his habit. Information from Adult D would indicate that he was also drinking to excess.

6.16 In 2005 and 2007 Adult B had further mental breakdowns and would isolate himself in his house. During the times that he was housebound Adult A would constantly visit her son to attend to his needs.

6.17 Adult B's health severely deteriorated in 2007. He refused to eat and drink and had started to become paranoid about his wife's movements, checking her phone and demanding to know where she had been. Adult B had also become increasingly insecure about his own well-being.

6.18 During 2007 Adult B's level of violence also increased. Adult D stated that her husband would became physically abusive the more that he became depressed.

[3] Community Mental Health Team.
[4] Account provided by Adult B's GP.

6.19 Adult B and his wife regularly attended a church within the Plymouth area and both had strong religious beliefs. Adult B believed that he had been possessed by a demon.

6.20 Adult B had however become increasingly difficult to manage within the church environment and his pastor felt threatened by his attitude and confrontational behaviour. In October 2016 Adult B's pastor asked him to leave the church.

6.21 Adult B's behaviour had a huge effect on his children particularly Child B2 and Child B3 both of whom had prolonged periods of absence from school

6.22 Adult B's behaviour resulted in intervention, by children's social services, in early 2017 and in March that same year he was forced to leave the marital home. Family, friends and his GP felt that this event had a huge impact on Adult B.

6.23 Despite all of the problems that Adult B suffered during this period in his life the love and devotion shown by Adult A was unwavering and unconditional.

6.24 Following the breakup of his marriage Adult B went to live with his mother in the March of 2017. This had a huge impact on Adult A, and according to family affected her health and prevented her from doing the things that she loved. During that time his mother became increasingly concerned about Adult B's behaviour and his mental state. Adult C described her mother as being frightened of Adult B.

6.25 During the time that Adult B spent with his mother there were many occasions where he would refuse to get out of bed, wash, shave or take any responsibility for his personal care. He would refuse to leave the house and rely on his mother to meet his every need. Despite his dependence upon his mother Adult B would often treat her poorly and he could become verbally abusive.

6.26 As a result of his deteriorating mental health and the emergence of psychotic symptoms Adult B was referred to the Insight team[5], for assessment. There was some difficulty with engagement, but he was finally assessed in September 2017. The assessment concluded that there was no evidence of emerging psychosis.

6.27 Adult A's family had continued to raise concerns about his changing presentation and the mental health services had responded by offering assessment appointments. Adult B also continued to be managed by the CMHT. From the assessments completed by various clinicians, and by a number of specialist teams, there was no evidence to suggest that he posed a risk to himself or others.

6.28 In September 2017 Adult B left Adult A's address and after staying with a friend he was eventually accommodated within a multi occupancy dwelling in the Plymouth area. After Adult B had moved into temporary accommodation Adult A continued to provide him with all the care and support that he required. Adult A would visit him on a daily basis to take him food and clothing.

[5] The Insight team works with people aged 18+ who live within Plymouth, who appear to be experiencing symptoms indicating the early onset of psychosis.

6.29 As Adult B's condition continued to deteriorate he was involved in numerous incidents of harassment involving his wife, and he also appeared to become more reliant upon the support from Adult A. Despite these incidents it would appear that she never perceived herself to be under any risk of physical harm.

6.30 Adult B had become increasingly mistrusting of this relationship with his mother as the months progressed.

6.31 Adult B appeared before a court on the 19th September 2017 in relation to offences concerning Adult D. Despite this appearance it appeared that he was not deterred by the experience or the restrictions that had been placed on him via the restraining order which had been issued by the court. Adult B's behaviour towards his wife and children continued to be erratic.

6.32 On a Sunday in October 2017 Adult A went to Adult B's home address. This visit had been planned.

6.33 At 16.32hrs that same day, Adult B called the ambulance service and explained that his mother had collapsed on the floor at his address. He stated that he had commenced cardiopulmonary resuscitation (CPR). On attending the scene, the ambulance crew found Adult A lying on the floor and after commencing CPR they regained a normal heart rhythm. Adult A was then taken to a hospital in Plymouth however she never regained consciousness and later died in the intensive care unit.

6.34 On Tuesday 24th October 2017 concerns were raised by the family of Adult A that her death was not from natural causes, and that they believed that Adult B could be responsible. Police conducted further enquiries and a forensic post mortem was conducted. As a result of this examination the pathologist concluded that there was no obvious medical reason that would account for Adult A's collapse.

6.35 Following the result from the forensic post mortem a murder investigation was commenced by Devon and Cornwall Police. Adult B was already in custody having been arrested for breaching the restraining order that had been put into place to protect Adult D. Whilst he was in custody Adult B was arrested for the offence of murder.

6.36 On the 27th October 2017 mental health services assessed Adult B at the Police station where he was being held following the death of his mother. At that time he was assessed as not actively suicidal and there was no evidence of psychosis. He was also not deemed to be detainable under the Mental Health Act.

6.37 On Saturday the 28th October 2017 Adult B was charged with the murder of his mother.

7.0 Key Issues Arising from the Review

7.1 Evidence of Domestic Abuse in adult A and Adult B's relationship.

7.1.1 Agency records identify that Adult B had physically, mentally, emotionally and financially abused his wife due to his decline in mental health. He also subjected his children to physical and emotional abuse due to his decline in mental health. There was no evidence found by the review that he had physically abused Adult A prior to her death although it is accepted that she may not have acknowledged or disclosed abuse if she had experienced it. Adult B behaviour clearly demonstrated elements of coercion and control in respect of Adult A, Adult D and his children.

7.1.2 From the detail recorded in the IMR's and through the collective assessment of the panel it has been identified that there would appear to be good understanding of domestic abuse amongst the professionals involved in this case. There would also appear to be a good understanding of child safeguarding by the majority of agencies with the exception of one of the schools.

7.1.3 In respect of agency response to the domestic abuse the review found that all agencies and professionals were receptive to the information that they were presented with and they followed the correct procedures and practices. Thresholds for intervention in relation to domestic abuse were appropriate and correctly applied in this case. Adult D was provided with the appropriate signposting to support agencies. The decisions made by professionals were in the best interests of all parties concerned and were based on the information that was disclosed by Adult D and Adult B. Agencies appropriately used this information when completing assessments and offering support.

7.1.4 The review identified that the church where Adult B and Adult D attended had no appreciation of the services that were available to victims domestic abuse in Plymouth and it would appear that other faith groups would benefit from awareness training.

7.1.5 All agencies in Plymouth have worked hard to improve practice and knowledge in respect of domestic abuse and the professionals in this case would appear to have possessed the skills, knowledge and open mindedness to identify vulnerability, abuse and coercive and controlling behaviour. The decisions and actions of those professionals involved, from a domestic abuse perspective, were in the main proportionate and appropriate in relation to the incidents that were reported, although areas of learning in respect of risk assessments were identified.

7.1.6 In this case Adult D was unable to recall whether a DASH[6] risk assessment was completed, or that its purpose was explained at each reported incident. Officers

[6] Domestic Abuse, Stalking and Harassment and Honour Based Violence risk assessment.

must ensure that victims are fully aware of the DASH process and its relevance to them in terms of risk.

7.1.7 The review has also considered whether the death of Adult A was an isolated incident or whether there were any warning signs that would indicate that there was previous history of abusive behaviour towards her. There is no specific evidence of physical abuse between Adult A and Adult B or risks identified. There would however appear to have been a level of coercion and control in the relationship.

7.1.8 From the information known to agencies and from the information provided by family members there wouldn't appear to be any barriers to Adult A reporting abuse if she had been a victim of it.

7.1.9 This review has highlighted the need for operational staff in all agencies to improve their understanding of the behaviours and presentation of perpetrators of domestic abuse. This should include an understanding of evidence based responses and programmes to challenge perpetrators behaviours. Safer Plymouth should identify and implement appropriate pathways to allow access to perpetrator programmes.

7.1.10 In this case additional training in domestic abuse was required across GP practices to ensure that staff are aware of the impact of domestic abuse and have an understanding of perpetrators of domestic abuse.

7.1.11 Both Adult A and Adult B had made comments to Housing staff about their family arrangements and there were intimations that abuse was occurring (this is contrary to all other comments in report which indicate that there was no evidence of Adult B abusing Adult A?? . Had these comments been explored in this case then this may have led to an opportunity to intervene and offer additional protection and support and to signpost both adults to other services. Housing providers in the City need to ensure that all staff are appropriately trained and that they feel confident in managing disclosures of abuse and violence . Domestic Abuse Housing Alliance (DAHA) best practice and accreditation would enable appropriate services to work towards a 'Whole Housing Approach.

7.2 <u>Mental Health</u>

7.2.1 From the assessments that were carried out Adult B did not reach the threshold for being detained under the Mental Health Act and presented to professionals as lucid and having capacity. As a result Health services continually concluded that whilst Adult B was suffering from 'psychosis type symptoms' he was not psychotic. There has been nothing identified through the review process that would contradict this view.

7.2.2 From the information that was available to the review panel it would appear that at the time of Adult A's death appropriate mental health teams and psychiatrists were working with Adult B.

7.2.3 Health agencies followed appropriate guidelines and practice in relation to dealing with Adult B but it has become clear that he engaged with services on his own terms. There were many occasions when he personally sought help and then either rejected it or choose to ignore it. There has been nothing identified during this review that would suggest that mental health policies were inadequate or that there was a failure to follow them. There were no waiting lists that would have impacted upon a service provision as the threshold for intervention for Adult B had been met for the CMHT and Adult B was referred accordingly.

7.2.4 Evidence recorded in agency records identified that despite the demands that Adult B placed on services he was afforded the time that he required despite his non-attendance at arranged appointments. Services (Health, GP services, Children's Social Care) continually to actively try and engage with him. The commitment of certain professionals was seen as good practice.

7.3 Risk Assessment

7.3.1 Agencies including the Police and Health conducted appropriate risk assessments in terms of Adult B and there was no indication that Adult B presented a risk to any other person, other than his wife and children. In terms of these individuals intervention had taken place to reduce these risks.

7.3.2 Adult A's family have raised concerns that their mother was not informed of the risk that Adult B posed when he was asked to leave his home address. In this case all the presenting evidence pointed to the fact that Adult B was a risk to his wife. Adult B hadn't made threats, nor had he been violent to any other adult person. Adult A was a calming influence in Adult B's life and had willingly taken him into her home at that time and there was no previous history of abuse between them. As a result of the information available to agencies there would have been no apparent reason to inform Adult A that her son was a specific risk to her, or to inform her of the abuse that Adult D had disclosed. Agencies were however cognisant that where risks are clearly identified then risk to all relevant parties should be considered.

7.4 Drug Abuse

7.4.1 Adult B had been placed on a programme by his GP which was designed to reduce his dependency on prescription drugs. The prescription regime adopted in this case has been reviewed by an independent GP. In their view the approach taken by Adult B's GP was entirely appropriate.

7.4.2 Whilst acknowledging that GP's work in extremely pressurised environments the panel felt that additional care was required when dealing with patients such as Adult B in relation to the continued prescribing of drugs. The prescribing of benzodiazepines should be closely monitored. Records maintained by primary care services must ensure that they contain clear and unambiguous information to prevent patients from circumventing the system.

7.4.3 Whilst there is clear evidence of the affect that these substances had on Adult B

and his relationship with Adult D the impact is less evident in terms of his relationship with his mother. There has been nothing found to suggest that drugs or alcohol was a factor in the homicide of Adult A.

7.5 Operational Practice

7.5.1 The Education IMR identified that one particular school failed to follow practice and policy in relation to safeguarding. On occasions the behaviour of Adult B towards his children was not recognised as being inappropriate and consequently was not challenged or the appropriate referrals made. There were also incidents identified by the review which indicated that the Designated Safeguarding Lead (DSL) in one of the schools was dissatisfied with the decisions and operational practice of Children's Social Care. On these occasions there was no evidence of escalation in line with local policy. There was nothing to suggest that the failure to follow established policy and practice came from poor training or a lack of knowledge, however those involved would benefit from refresher training.

7.5.2 Despite the issues raised in respect of safeguarding practices in the school and escalation processes there was clear documentary evidence recorded in the IMR submitted by Education of good interaction between the schools and the children within the family.

7.5.3 In this case no one organisation was party to all of the information in relation to Adult B's decline or the totality of his vulnerability. Much of the information was only known to family and friends and to his GP. What was clear is that Adult A and other family members were frustrated with regards to the services that were available to help them support Adult B at the time when they considered him to be most vulnerable. As a consequence it was identified that Health and Adult Care services in Plymouth therefore need to review their communications strategies in order to ensure that there is increased awareness amongst staff and the general public in relation to the mental health services that are available in the City.

7.6 Information Sharing and Communication

7.6.1 The Education IMR identified evidence of poor communication between schools and children social care.

7.6.2 In their IMR, PATH identified that prior to them housing Adult B there was no exchange of information relating to any risk assessments that Bournemouth Churches Housing Association (BCHA)[7] and Plymouth Temporary Accommodation (PTA) had completed. PATH have stated that had they known this information then they may have refused to house Adult B or asked that support or monitoring was put into place by the relevant service. They concluded that information sharing between partner agencies and professionals should be implicit and that any assessments from the referrer should be referred to PATH and vice versa.

[7] BCHA are a major provider of a diverse range of housing, support and learning services for socially excluded people.

7.6.3 In the earlier years covered by this review, there were examples where ineffective information sharing procedures were in place. It was clear in more recent years that information sharing within the City has improved through the use of the 'Plymouth Gateway'[8]. Agencies report that they are now sharing information at an earlier stage. There were clear examples of good information sharing practice between multiple agencies identified as part of the review.

7.6.4 There was evidence of good practice regarding interagency communication between the DSL and the GP for Child B2. Conversely there would appear to have been poor communication between the GP and children's social care as on this occasion the GP stated that they were not aware of any safeguarding concerns and that they had not been contacted by any social worker. The GP has also stated that they had not received the minutes from the case conference held in respect of Adult B's children.

7.6.5 An additional area where practice could be improved was the relationship and information sharing between the three schools. The Education IMR identified that neither Child B2 nor Child B1 were subject to anything other than a standard transition into secondary school. The IMR concluded that this was most likely correct in relation to Child B1 given the limited information about them. In relation to Child B2 however significant issues had been identified at the primary school and yet no safeguarding concerns or other information was initially shared between schools. The IMR identified that historical information (including the nationality and religious beliefs of parents and children) is crucial, particularly in cases where there are indicators of domestic abuse.

7.6.6 A better use of chronologies within the schools would have been beneficial. The Education IMR identified that a wider consideration should be given to developing combined family chronologies across the education system where siblings are enrolled in different schools. Two of the schools in this review, for example, used the CPOMS[9] online system and the third was considering it.

7.6.7 As a result of this review consideration has been given to the tracking of siblings more effectively throughout a single school. This would provide a comprehensive and accessible record to safeguard children. Although there is evidence of the schools communicating with each other at certain points, formalising this process would make it more effective and ensure consistent communication through the critical points of a child's journey within the education system.

7.6.8 There was also evidence of good practice relating to information sharing through the use of the ViST[10] by the Police. This process, which has not been adopted nationally, offers the ability to consider the vulnerability of adults and children. Often these concerns didn't meet the statutory threshold for intervention. Such incidents

[8] The Gateway can be used for any general information and advice question that relates to a child pre-birth through to 18 years of age (or 25 in relation to SEND matters).

[9] Child Protection online Management System- Safeguarding and Child Protection IT system for Children.

[10] Vulnerability Screening Tool used by Devo n and Cornwall Police.

would previously have resulted in no action being taken and safeguarding issues left unresolved.

7.6.9 There was good evidence of the use of the Child at Risk Alert (CARA) process by the Police to ensure that the schools attended by the children were notified of incidents of abuse in the household. That said there were also occasions that these reports were not received (School 2), although the review has not been able to ascertain why this occurred. This would appear to have been an omission and not a reoccurring issue requiring a recommendation in this case. Quality assurance practices are in place to prevent a repetition of this from occurring in the future.

7.6.10 In respect of information sharing regarding domestic abuse the work undertaken by services in this case was consistent with each organisations policy and professional practices and their policies. These policies have been found to be effective.

7.7 Agencies Policy and Practice

7.7.1 Whilst the majority of agency policies at the time (in respect of domestic abuse) would appear to have been robust (many have since either been refreshed to reflect changes in National policy) there were some discrepancies identified as part of the review.

7.7.2 In respect of domestic abuse, the review identified two compliance issues relating to the recording of domestic abuse incidents against the National Crime Recording Standards. These were human errors and ultimately had no bearing on the outcome of this case. From an organisational perspective similar issues were raised during a HMIC Inspection (2016) [11] . In response the Force has delivered a training programme in May/June 2017 to all relevant staff and has initiated a quality assurance and compliance regime to improve practice.

7.7.3 In order to improve efficiency and effectiveness the Police are now starting to utilise mobile data technology to record the DASH assessment. At present frontline officers are experiencing some technical problems researching the subjects of DASH assessments as the devices used do not allow them to access the police intelligence system. There is also an issue regarding the time that it takes for the DASH assessment to be entered onto the Force IT system. At present work is taking place to overcome these issues.

7.7.4 All of the three schools that were involved with the children of Adult A and Adult B had safeguarding and child protection policies which also consider the impact of domestic abuse. Neither School 2 or School 3 however had written procedures in place regarding staff who make disclosures regarding domestic abuse. Such a policy would ensure a co-ordinated and risk managed multi agency response with management oversight should such disclosures occur.

[11] Devon and Cornwall Police: Crime Data Integrity inspection 2016

7.7.5 In this case schools failed to undertake and document effective risk assessment processes in relation to Adult B and his access to their premises, Adult D, and his children.

7.7.6 The Education IMR identified that there would appear to be a lack of clarity about how schools use the CARA, its purpose, how it is monitored, and how concerns are escalated.

7.7.7 Within their IMR PATH identified that they do not have a specific domestic abuse policy.

7.7.8 The family of Adult A had raised concerns as to why the Police had not been contacted when paramedics attended Adult B's address. The Panel were able to establish that when the paramedics attended the scene their primary concern was the welfare and treatment of Adult A. No concerns were raised that a criminal offence had been committed and the priority was to transport Adult A to hospital. The operational practice in this case adhered to policy and there has been nothing found as part of the review to suggest that police should have been contacted.

7.7.9 In this case Children's Services asked Adult B to leave the family address on a voluntary basis due to the safeguarding concerns that had been raised in respect to his children. Once Adult B had agreed to do this Children's Social Care left the address. Adult B remained at the address despite him being a risk to his children. This practice would appear to be poor practice and requires review.

7.8 Supervision

7.8.1 Effective supervision was demonstrated by the majority of agencies involved with the family and was evidenced within IMR's. There was evidence that records were reviewed and that staff had supervisory input and support when making decisions.

7.8.2 In respect of the DSL involvement with the family and the issues raised with respect of child protection referrals there would appear to have been a lack of supervisory support and oversight.

7.9 Training

7.9.1 All agencies involved in this review have demonstrated their commitment to training in relation to domestic abuse, however additional refresher training (as identified in the Education IMR) should be considered by the schools involved for their DSL's. All other staff that were involved with both Adult A and Adult B would appear to have been trained to the standards expected, and all were equipped to identify safeguarding issues.

8.0 Conclusions

8.1 The content of this section seeks to bring together an overview of main issues identified, and conclusions drawn from them which will translate into the detailing of lessons learned in the next section.

8.2 From the information gathered from agencies, family and friends Adult B would appear to have exhibited elements of controlling behaviour over Adult A, however the review did not identify any direct evidence of physical abuse in the relationship.

8.3 Although Adult B presented a risk (due to his previous violent behaviour) there was insufficient information available to agencies to suggest that Adult B posed any specific threat to Adult A on the days prior to her homicide. Adult B had not made any direct/indirect threats or intimated violence towards his mother. Adult B's violence was perpetrated against Adult D and there was no evidence from the risk assessments conducted that he posed any additional risk outside of his immediate family setting. He had never demonstrated any intent to commit such a crime and had never threatened to kill anyone.

8.4 Adult A was unaware of the level of violence that Adult B had inflicted on Adult D. Her family have on reflection concluded that she may have been more concerned about the risks that Adult B posed had she known all of the facts in relation to his abuse of his wife. Whilst Adult A was concerned about Adult A's behaviour, whilst he had lived with her, there is no indication that she was scared of him or concerned about her own welfare at the time that the homicide occurred.

8.5 Adult B was addicted to prescription medication and his mental health was in decline. He had been receiving support from the CMHT which on review was considered to be appropriate for the symptoms that he was exhibiting. The ability for professionals to accurately and continually assess Adult B's mental health status was frustrated by the fact that he failed to take medication and often would fail to turn up for appointments. Adult B also presented with capacity and whilst Health professionals describe him as displaying psychotic tendencies he was never diagnosed with psychosis.

8.6 In this case there were no identifiable gaps in practice or service provision that would have prevented the death of Adult A. From the information presented by agencies operational policy was in the main adhered too, although the review has identified a number of areas where practice can be improved.

8.7 All agencies in the City continue to strive towards the delivery of comprehensive services for those experiencing domestic abuse. Whilst the majority of agencies taking part in this review have comprehensive policies in place in relation to domestic abuse there were others identified (Schools 2 and 3, PATH) who should update current guidance or introduce a specific policy.

8.8 In the main agencies are confident that should an individual present themselves then their staff are trained to identify the signs of domestic abuse or coercive and controlling behaviour. There was evidence presented at panel documenting that

all agencies continue to train their staff in this area of safeguarding and progress in relation to this should be continually monitored.

9.0 Lessons to be Learned

9.1 The learning opportunities identified in this case are listed by number and these correspond with the recommendations in section 10.0. The learning and the recommendations also relate to issues specific to the education and welfare of children. These have been included in the report as they were identified as part of the DHR process and the Panel did not want these issues to be lost as they will benefit the lives of children living with parents with complex needs in the future.

Single Agency Learning

- **Learning Opportunity 1 (xref: Recommendation 1)**

  There is a need to identify and evaluate appropriate perpetrator programmes in the city.

- **Learning Opportunity 2 (xref: Recommendation 2)**

  Housing providers in Plymouth should review and amend policy and practice to ensure appropriate responses to domestic abuse.

- **Learning Opportunity 3 (xref: Recommendation 3)**

  Housing providers in the Plymouth should review and amend policy and practice to ensure appropriate responses to domestic abuse. Safer Plymouth will promote DAHA accreditation and a 'Whole Housing Approach'.

- **Learning Opportunity 4 (xref: Recommendation 4)**

  PATH identified that they do not have a specific domestic abuse policy.

- **Learning Opportunity 5 (xref: Recommendation 5/6)**

  PATH identified that in order to make informed placements all available information, including needs and safety information, is needed and that they need to promote the service that they provide.

- **Learning Opportunity 6 (xref: Recommendation 7)**

  Whilst mobile data technology is being utilised to improve the effectiveness of the DASH submissions the current system prevents active scrutiny of Police intelligence systems.

- **Learning Opportunity 7 (xref: Recommendation 8)**

  In this case Adult D was unable to recall whether a DASH risk assessment was completed, or that its purpose was explained at each reported incident. Officers must ensure that victims are fully aware of the DASH process and its relevance to them in terms of risk.

- **Learning Opportunity 8 (xref: Recommendation 9)**

  Neither School 2 or School 3 had written policies in place regarding staff making disclosures about abuse. In this case such policies would have provided a point of reference for staff and would promote best practice within those organisations.

- **Learning Opportunity 9 (xref: Recommendation 10)**

  In this case schools failed to undertake and document effective risk assessment processes in relation to Adult B and his access to the school, Adult D, and his children. Such risk assessments would assist in protecting staff, pupils and parents from threat risk and harm.

- **Learning Opportunity 10 (xref: Recommendation 11)**

  There were occasions when the DSL's failed to follow appropriate safeguarding procedures and practice. Child abuse should never be seen as acceptable and parental behaviour towards their children cannot be excused due to external influences.

- **Learning Opportunity 11 (xref: Recommendation 12)**

  In this case those working within the schools failed to utilise the LSCB escalation policy. The Education IMR identified a number of incidents where professionals did not agree with decisions that were made regarding the children in the family. Even where escalation was apparently used it was not recorded.

- **Learning Opportunity 12 (xref: Recommendation 13)**

  School 2 and 3 should review supervisory policies and practice in relation to DSL management.

- **Learning Opportunity 13 (xref: Recommendation 14)**

  Whilst there was evidence of information sharing between schools, the review identified that schools need to make more effective use of historical information, particularly in relation to siblings. Schools should also consider ways of maintaining an up to date live chronology where siblings attend different schools.

- **Learning Opportunity 14 (xref: Recommendation 15)**

The Education IMR identified that in many instances schools had failed to capture details regarding the nationality and religious beliefs of parents and children**.** This information would have been useful in having a holistic overview of the needs of the family in this case.

- **Learning Opportunity 15 (xref: Recommendation 16/17)**

  This review identified that Adult D did not appreciate that she was the victim of abuse and that the church that she engaged with had no appreciation of domestic abuse services available in the City. Safer Plymouth should promote current domestic abuse services to all faith groups.

- **Learning Opportunity 16 (xref: Recommendation18)**

  Adult A and other family members were frustrated and confused with regards to how to access the services that were available to them to support Adult B. Health services in Plymouth need to raise awareness amongst the general public of the mental health services that are available to them.

- **Learning Opportunity 17 (Not subject of a recommendation)**

  The Haematology Research Nurse who had contact with Adult B has stated that on reflection she would now formalise concerns that she may have for any patient suffering from mental health decline and open communications with the primary care/community services providing care in this field. This information sharing pathway is in place and its use is encouraged by Health services.

- **Learning Opportunity 18 (Recommendation 19)**

  Following Child Protection concerns being raised Children's Services asked Adult B to leave the family address on a voluntary basis. Once Adult B had agreed to do this, Children's Social Care left the address. Adult B remained at the address despite him being a risk to his children.

- **Learning Opportunity 19 (Recommendation 20)**

  The review has identified that there were occasions missed in relation to the effective sharing of information between children's social care and Adult B's GP.

- **Learning Opportunity 20 (Recommendation 21)**

  Adult B was able to manipulate GP's into prescribing benzodiazepines at times of alleged crisis. More robust systems are required to prevent poor practice in relation to those patients that are addicted to prescription medicines.

Multi Agency Learning

- **Learning Opportunity 22 (xref: Recommendation 22)**

  Community Connections identified that the communication processes that currently exist across Plymouth commissioned partners and Plymouth City Council with regards to clients need to be adhered to.

- **Learning Opportunity 23 (xref: Recommendation 23/24)**

  The use of the CARA and its central role in safeguarding children has perhaps been lost and may require some additional training and guidance from the Police and the Local Authority to ensure it reaches its full potential.

- **Learning Opportunity 24 (no recommendation)**

  The review identified that whilst the GP for Adult B had been trained in relation to domestic abuse further awareness was required. At the time of the review Safer Plymouth had been working on a concurrent DHR set of recommendations where actions were wholly focussed on work with GP surgeries. DA awareness raising training was undertaken with all local GP surgeries by the local CCG during the timeframe of this DHR. There is also a business case being developed with Devon CCG to look at rolling out IRIS[12] to all local primary care networks. As a consequence this recommendation was not duplicated in this review.

10.0 Recommendations

10.1 This section sets out the recommendations made by the DHR panel and the recommendations made in each of the IMR reports.

10.2 The DHR panel therefore offers the following overarching recommendations for local action:

<u>Single Agency Recommendations</u>

- Recommendation 1

Safer Plymouth to provide opportunities for the workforce to improve understanding around DA perpetration. This should include identifying pathways to access to appropriate perpetrator programmes.

- Recommendation 2

Staff within Plymouth GP Practices should receive updated training with regards to Domestic Abuse. This should include understanding DA perpetration.

[12] IRIS is a national project which works with GPs to combat domestic abuse and make the most of their opportunities to reach vulnerable victims.

- Recommendation 3

  Housing providers in the Plymouth should review and amend policy and practice to ensure best practice around domestic abuse is adhered to across the City. This will include promotion of DAHA accreditation and working towards a 'Whole Housing Approach'.

- Recommendation 4

  PATH to implement a domestic abuse policy within the organisation.

- Recommendation 5

  PATH to review their referral forms and include a section requiring referrers to declare that they have provided all relevant Needs and Safety Assessments and the copy of the homeless application.

- Recommendation 6

  PATH to review the information that promotes the service that they deliver and implement a communications strategy.

- Recommendation 7

  Devon and Cornwall Police to review the current mobile data technology to ensure frontline officers access to research subjects on their devices and to ensure a timely upload of DASH information onto force systems.

- Recommendation 8

  Devon and Cornwall Police to remind all officers and appropriate staff of the need to inform victims of the purpose of the DASH risk assessment and its relevance in terms of risk to their situation at each recorded incident.

- Recommendation 9

  School 2 and School 3 must review their domestic violence policy to ensure that it includes advice a guidance regarding staff making disclosures of domestic abuse.

- Recommendation 10

  School 2 and School 3 must ensure that there is an effective risk assessment process in place where there are perceived or actual risks to staff, pupils or parents.

- Recommendation 11

School 2 and School 3 must ensure that their DSL's receive child abuse/ safeguarding update training.

- Recommendation 12

Staff in School 2 and School 3 must be reminded of the LSCB escalation policy.

- Recommendation 13

School 2 and 3 should review supervisory policies and practice in relation to DSL management.

- Recommendation 14

Education to undertake a review to establish the feasibility and implementation of live chronologies across the school's network in Plymouth.

- Recommendation 15.

Schools to ensure they review existing data collection systems to ensure that they detail the nationality and religious beliefs of parents and children**.**

- Recommendation 16

Safer Plymouth must review the current domestic abuse communications strategy to ensure that it reaches all victims.

- Recommendation 17

Safer Plymouth to arrange domestic abuse training to appropriate people within the church attended by Adult B and Adult D.

- Recommendation 18

Health to review the existing communications strategy in relation to informing members of the public regarding mental health service access and gateways.

- Recommendation 19

Children's social services to ensure staff are trained in risk assessment in relation to domestic abuse in the home and the management of situations where high risk offenders refuse to leave premises.

- Recommendation 20

Children's Social Care to review their information exchange policy with GP's in line with multi-agency safeguarding procedures.

- Recommendation 21

  Adult B's GP to review its prescription policy to ensure it meets national recommendations.

  Multi agency recommendations

- Recommendation 22

  Safer Plymouth partner agencies should implement a quality assurance practice to ensure that information sharing processes between agencies are being adhered too.

- Recommendation 23

  Police, Education and the Local Authority must review the current CARA training strategy in the City and provide update training where appropriate.

- Recommendation 24

  Police, Education and the Local Authority must review exiting policy in relation to CARA, to ensure that there is clarity regarding who the information is shared with; whether victims and children are spoken with; how risk is managed; and that there are effective monitoring and escalation procedures in place.

Glossary

BCHA - Bournemouth Churches Housing Association.
CARA - Child at risk alert.
CCG - Clinical Commissioning Group.
CMHT - Community Mental Health Trust.
CPR - Cardiopulmonary resuscitation
CYPS - Children and Young Person Services.
DASH - Domestic Abuse, Stalking and Harassment and Honour Based Violence risk assessment.
DHR - Domestic Homicide Review.
DSL - Designated Safeguarding Lead.
GP - General Practitioner.
IMR - Independent Management Review.
IRIS - Identification and referral to Improve Safety.
NHSE - National Health Service England.
PATH - Plymouth Access to Housing.
PCC - Plymouth City Council.
PTA - Plymouth Temporary Accommodation.