# A combined Domestic Homicide Review and Safeguarding Adult Review

under section 9 of the Domestic Violence Crime and Victims Act 2004
and section 42 of the Care Act 2014

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## In respect of the death of Rita[1]

In August 2017

Report produced for Birmingham Community Safety Partnership and Birmingham Safeguarding Adult Board by
Paula Harding
Independent Chair and Author
August 2019

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[1] pseudonym

## GLOSSARY & ABBREVIATIONS

**AAFDA:** Advocacy After Fatal Domestic Abuse
**AMHP:** Approved Mental Health Practitioner
**BCC:** Birmingham City Council
**BCHC:** Birmingham Community Healthcare NHS Trust
**BCSP:** Birmingham Community Safety Partnership
**BSMHFT:** Birmingham and Solihull Mental Health Foundation Trust includes the following services:

- **Acute Inpatient Wards** are where patients re admitted when they are experiencing acute mental illness for a period of assessment and treatment. Patients may be admitted informally or under a section of the Mental Health Act 1983.
- **Community Alcohol Team** was a small team working closely with GPs, assessing referrals to ascertain if they were suitable for a home detoxification. If they were deemed suitable then the team would offer two initial appointments (possibly more if required). The team also took referrals from acute hospitals for example via Psychiatric Liaison services where a detox had been commenced and it was deemed suitable to complete the remaining detox at home. The service was decommissioned in 2011.
- **Community Mental Health Teams (CMHT)** support people living in the community who have complex or severe mental health problems. The CMHT is staffed by a multi-disciplinary team which includes psychiatrists, community psychiatric nurses, clinical psychologists and social workers. The CMHT provides assessment, specialist support, treatment and care planning for service users aged 18 years and upwards with two levels of care: the Care Programme Approach (CPA) or Care Support.
- **Criminal Liaison and Diversion Service** is a city-wide service that covers custody suites. They offer mental health assessments which can be conducted before a full Mental Health Act assessment where appropriate.
- **Home Treatment Teams (HTT)** offer crisis support at home to people with severe and enduring mental health problems or to those who are in crisis and experiencing serious mental distress. They are on call 24 hours a day, 7 days a week, and provide emergency assessment, treatment & support and are an alternative to inpatient hospital admission.
- **Psychiatric Liaison Service** offer an integrated liaison psychiatry service in Acute General Hospitals in Birmingham & Solihull. The service provides a 24 hour single point of access to mental health services for all inpatients and people who attend emergency departments in acute hospitals who are aged 16 and over. It provides comprehensive multidisciplinary assessments of people with mental health problems in the general hospital setting.
- **The Safeguarding Team** supports the delivery of safeguarding provision across the organisation ensuring that all Trust staff members are able to fulfil their safeguarding responsibilities through training, supervision and support to all staff.
- **Single Point of Access** is the single place in which GPs and some other partner agencies can refer into the Trust.

**CCG**: Clinical Commissioning Group
**CGL:** Change Grow Live
**CRC:** Community Rehabilitation Company
**CPN:** Community Psychiatric Nurse
**CPS:** Crown Prosecution Service
**DASH:** Domestic abuse, stalking and harassment risk assessment model
**DoH:** Department of Health

**DHR:** Domestic Homicide Review
**DVPO/DVPN:** Domestic Violence Protection Order/Domestic Violence Protection Notice
**General Practice:** primary care medical service
**GP**: General Practitioner
**IMR:** Individual Management Review – reports submitted to review by agencies
**IRIS:** Identification and Referral to Improve Safety - a general practice-based domestic violence and abuse training support and referral programme
**MHA: Mental Health Act 1983**

- **Section 5 (2)** is a temporary hold available for use by doctors of an informal or voluntary service user on a mental health ward in order for an assessment to be arranged under the Mental Health Act 1983. This ensures their immediate safety whilst the assessment is arranged.
- **Section 136**: where a person who, in a public place, is thought to have a mental illness and is in need of care or control, this section enables the police to hold them or transfer them to a place of safety

**Parricide:** the killing of a parent or other near relative
**SAR:** Safeguarding Adult Review
**SWMCRC:** Staffordshire and West Midlands Community Rehabilitation Company included the following interventions in this review

- **Community order:** a sentence imposed by the Court in place of a custodial sentence
- **Supervision requirement of a community order:** requires an offender to attend regular appointments with probation. During the supervision period, work will be undertaken with the offender to change attitudes and behaviour to stop them reoffending.
- **Pre-sentencing report:** Probation services are required to prepare a pre-sentence report for the court before a custodial or community sentence is imposed. The report should include an assessment of the nature and seriousness of the offence, and its impact on Rita.
- **SARA:** Spousal Assault Risk Assessment

**UHB:** University Hospitals Birmingham
**West Midlands Police** provided the following services in this review

- **Domestic abuse, stalking and harassment risk assessment model (2009).** There are three levels of risk identified by the model. Serious ham is defined as 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.
  - **Standard risk**: current evidence does not indicate a likelihood of causing serious harm
  - **Medium risk**: there are identifiable indicators of risk of serious harm. The perpetrator has the potential to cause serious harm but is unlikely to do so unless there is a change in the circumstances.
  - **High risk**: there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. All high-risk cases will be referred to the Duty Inspector for consideration of a threat to life assessment
- **Partnership Team:** part of the Neighbourhood Policing Unit which receives referrals from officers in respect of individuals who may need additional support in any way.
- **Non-crime domestic abuse report**: national recording standards require that police offices record domestic abuse incidents as crimes if there is evidence of a crime and as 'non-crime' where there is no evidence.
- **SIG' Marker:** Street Interest Gazetteer is a marker attached to a specific location in police records alerting police officers and staff to particular information of relevance, such as domestic abuse being known at an address.

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## PREFACE

Members of the review panel offer their deepest sympathy to the family and to all who have been affected by Rita's [2]death.

Rita's son agreed to provide the following impact statement.

> *"I have been asked to write a statement about my mother, Rita.*
>
> *My mother was abused for most of her life, firstly by my so-called father, then subsequently by my brother until her decomposed remains were found in August 2017.*
>
> *As a child I witnessed horrific violence and abuse to my mother, and I was also subject to this at the hands of my father. I always tried to protect my mother from this abuse, but ultimately, I failed.*
>
> *My mother was not perfect, but I do have some good memories of her. These were mostly the times when my father was not present. She had owned a local convenience store at the time she met my father, she had 2 teenage daughters from her previous marriage. They both left shortly after my father's arrival. Rita also worked as a delivery driver for an automotive company, which she really enjoyed. She did her best to be independent, as most single mothers do. We used to have days trips to Rhyl on the train with a friend of hers. At times things were 'just normal'.*
>
> *Rita was very house proud; she loved her garden. Plants and flowers were a passion she shared with her father, my grandfather who was also a massive influence on my own life. We spent a lot of time together. My mother encouraged me in my goal to be in the Army, following my grandfather into the Coldstream Guards. At an Open Day with my regiment, she won the Rifle Shooting Competition (with a little help from myself!) My mother was a complex woman who had many different aspects to her at times, strong, independent, feisty, supportive and funny.*
>
> *I have struggled so badly trying to put this together as the good bits I remember are few and far between. And I have to be honest. There are so many things and decisions she made throughout her life which I do not understand but with hindsight and an increased knowledge of domestic abuse and coercive control I am trying to.*
>
> *I would like to give this example-*
>
> *In the early 80's my father was in Prison for a violent and serious assault on Rita, and I believe a failed armed robbery attempt. We were moved in the middle of the night by West Midlands Police, on my 9th birthday. We had to change our name for protection. We moved to a house with the most up to date burglar alarms and home security at the time. I am happy. My father is in prison, we are safe. He does not know where we are!*

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[2] pseudonym

*Normal! Until my 11th birthday, where I am presented a letter from him. And a statement from Rita that he was coming back, regardless of my protests. I can and do want to list all the violence that ensued. Social Services, West Midlands Police and the local Education Authorities were all involved until I was 16 years old. I was expelled from school and was in trouble with the Police frequently. I used to run away to avoid the violence only for Rita to report me missing and to be returned back by the Police. My father and I got into more and more violent confrontations when I was trying to intervene in his abuse of her. In one incident he tried to stab me with a large kitchen knife because I injured him while stopping him assaulting my mother. He chased me in public, to my girlfriend's house. My mother defended my father to the Police.*

*I still cannot understand the decisions that she made.*

*I had always known about the abuse from my brother as well. I had many friends and neighbours come to me and tell me what they had seen and heard. I had always questioned Rita on these matters. To which she would deny all the allegations. She made me promise that no matter what I would keep my hands off my father and brother ...... a promise I kept for over 25yrs........I have always felt that she loved and cared for them more than me.*

*I remember her last words to me, as she held my face with her hands, "Remember that you are nothing like him." At the time I did not understand or realise the relevance of that statement directly referencing my brother. Until her body was found.*

*I let her down and so did every agency involved by not acting."*

# 1. INTRODUCTION

## 1.1 Summary of the circumstances leading to the review

1. This report concerns the death of Rita (pseudonym) who was aged 81 at the time of her death in August 2017. Her youngest son, then aged 41, was convicted of her manslaughter.
2. Rita had cared for her son, who experienced mental health and substance misuse issues, for several years and she was frail and in poor health herself. Reports of domestic abuse had been made since 2014 and health, police and social care agencies had been involved at times of crisis. She commonly declined offers of help after each crisis subsided.
3. Rita was thought to have died in her bedroom several months before her body was found.

## 1.2 Aims and purposes of domestic homicide and safeguarding adult reviews

4. Domestic homicide reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act 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 she was related or with whom she was or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the death.
5. The purpose of a DHR is to:
    - Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
    - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
    - Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.
6. The Care Act 2014 determined that a Safeguarding Adult Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support if there is reasonable cause for concern about how organisations worked together to safeguard the adult, and the adult has died, and the Board knows or suspects that the death resulted from abuse or neglect. In the same way, the purpose of a safeguarding adult review is to identify the lessons to be learnt from the adult's case and apply those lessons to future cases.

7. This combined review examined agency responses and support given to Rita in the period prior to her murder. In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed in the community and whether there were any known barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

### 1.3 Timescales

8. The decision to undertake a domestic homicide review was made by the Chair of Birmingham Community Safety Partnership on 15.02.2018, following consultation with the Partnership's multi-agency, Domestic Homicide Review Steering Group. The Home Office were notified of the decision on 05.03.2018 and the review was managed in accordance with the relevant statutory guidance. The decision to combine this with a safeguarding adult review was taken later in the review process when it became clear that Rita had had care and support needs and therefore also satisfied the criteria for this type of review.

9. Although scoping and securing of files was undertaken promptly following the notification of the death in August 2017, the matter was to proceed to a criminal trial. The decision was therefore made by Birmingham Community Safety Partnership, who managed the review on behalf of the Safeguarding Adult Board, to postpone the commencement of the review until criminal proceedings had concluded in February 2018. The review panel first met in April 2018 and the review itself was concluded in August 2019 after consultation with family members.

### 1.4 Confidentiality

10. This Overview Report has been anonymised and a pseudonym for the victim was provided by her family.

## 2. Methodology

### 2.1 Terms of Reference

11. Having made the decision to undertake the review, all local agencies were notified of the death and were asked to examine their records to establish if they had been approached by or provided any services to the family and to secure records if there had been any involvement.

12. Arrangements were made to appoint an Independent Domestic Homicide Review Chair and Author, Paula Harding, and agree the make-up of the multi-agency review panel.

13. The Senior Investigating Officer in charge of the criminal investigation from West Midlands Police attended the first panel meeting and provided detail on the findings of the criminal

investigation and the conclusions of the court which have been incorporated into this review.

14. The Terms of Reference were drawn up by the Independent Chair together with the review panel incorporating key lines of enquiry and specific questions for individual agencies where necessary. Family members were consulted, and their views incorporated into the Terms of Reference. Individual Management Reviews (IMRs) were requested to be undertaken as well as information reports from agencies with less involvement. Briefings were made available for IMR authors by the Independent Chair.

15. The panel met five times during which, panel members were able to discuss the progress of the review and request further clarification and additional material, where needed. All panel meetings were minuted and all actions agreed for the panel have been tracked and signed off.

16. The panel considered and agreed the draft Overview Report and the final Overview Report was endorsed by Birmingham Community Safety Partnership on 28.10.20 and Birmingham Safeguarding Adult Board on 28.10.20 prior to submission to the Home Office.

## 2.2. Involvement of Family and Friends

17. Rita’s family were notified about the review in writing by the Independent Chair of the review. They were also provided with Home Office explanatory leaflets as well as leaflets from the support agencies Advocacy After Fatal Domestic Abuse and the Victim Support Homicide Service. As a result, Rita’s eldest son and youngest daughter engaged with the review each providing in-depth accounts of their understanding of the circumstances leading to the death, with the eldest son being helpfully supported by Advocacy After Fatal Domestic Abuse (AAFDA). Their contributions to the review have been woven into the narrative which follows.

18. Rita’s neighbours also contributed to the review and their concerns were added to the questions that were asked of services. Their testimony, which has also been included in the narrative, has provided a richer narrative of key episodes in Rita’s life and the change in her demeanour over time.

19. The perpetrator was informed by letter that the review was taking place. The letter was delivered in liaison with the prison authorities concerned but, after some initial correspondence, he declined engagement with the review.

20. All family members and contributing parties will be notified before publication of the report by the Community Safety Partnership and their concerns around publication addressed.

## 2.3. Independent Chair and Overview Author

21. The Independent Chair and Overview Author is Paula Harding, who has compiled the Overview Report. Paula Harding has over twenty-five years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For fifteen of those years she was the local authority strategic and commissioning lead for violence against women in Birmingham as well as the senior manager with responsibility for domestic homicide reviews in this area until 2016. Since this time, she has been an independent chair and author of domestic homicide and safeguarding reviews across England. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic violence and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office: *Conducting a Homicide Review*[3].

22. Beyond undertaking reviews, Paula Harding is not employed by any of the agencies of Birmingham Community Safety Partnership and, with one exception, had not worked in any of the panel members' organisations. In the case of Birmingham City Council, she had never worked in Adult Social Care or the People Directorate affected by this review. Her work for Birmingham City Council as the Strategic Lead for Violence Against Women ended more than eighteen months prior to the commencement of this review.

## 2.4. Members of the Review Panel

23. Multi-agency membership of this review panel consisted of senior managers and/or designated professionals from the key statutory agencies. The Panel members had not had any direct contact or management involvement with the family of Rita and were independent of the chair. They were not the original authors of the Individual Management Review reports that their organisations provided but generally contributed to changes to the reports before they were finalised.

24. Wider matters of diversity and equality were considered when agreeing panel membership. Birmingham and Solihull Women's Aid provided particular expertise on domestic violence and the 'victim's perspective' to the panel. The organisation provides services for over 7000 women experiencing domestic violence and abuse each year. It delivers an older women's service and the IRIS programme in primary care, both of which provide particularly valuable experience relevant to this review

25. The review panel members were:
    - Paula Harding, Independent Chair and Overview Author
    - Cath Evans, Head of Safeguarding, Birmingham and Solihull Mental Health Trust
    - David Gray, Head of Adult Safeguarding, Birmingham City Council Adult Social Care
    - Emma Hickl, Detective Inspector, West Midlands Police
    - Kerry Clifford, Safeguarding Lead, Change Grow Live (addiction, health and behavioural services)

[3] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

- Luisa Blackwell, Deputy Designated Nurse for Safeguarding, Birmingham and Solihull Clinical Commissioning Group
- Maria Kilcoyne, Head of Safeguarding, University Hospitals Birmingham NHS Foundation Trust
- Parminder Dhaliwal, Outreach and Helpline Manager, Birmingham and Solihull Women's Aid (specialist domestic abuse service)

## 2.5. Time Period

26. The panel agreed that the review should focus on the contact that agencies had with Rita and perpetrator from January 2012, which includes the period in which the perpetrator returned to Birmingham, until the date that Rita's death was known about, on 12th August 2017. Any significant information which might come to light during the review outside the set timeframe, were to be agreed by the review panel for inclusion if determined to be of relevance.

## 2.6. Individual Management Review Reports (IMRs)

27. An IMR and comprehensive chronology was requested from the following organisations:

- Birmingham City Council Adult Social Care
- Birmingham and Solihull Clinical Commissioning Group
- Birmingham and Solihull Mental Health Foundation Trust
- Staffordshire and West Midlands Community Rehabilitation Company
- West Midlands Police

28. The IMRs were authored by professionals who had not had any direct contact or management involvement with Rita or her family.

29. Chronology and/or information reports were provided by:

- Aquarius
- Birmingham City Council Landlord Services
- Birmingham Community Healthcare NHS Foundation Trust
- Lloyds Bank regarding their subsidiary bank the Halifax
- National Probation Service
- University Hospitals Birmingham (Heartlands Hospital)
- West Midlands Ambulance Service

30. The review also sought information and engagement with the Royal Mail as the criminal trial had revealed that they were aware that Rita was experiencing abuse. Despite several attempts, no response was received and the report will therefore be shared with the communications regulator, Ofcom.

## 2.7. Key Lines of Enquiry

31. The review sought to address both the ‘circumstances of a particular concern’ set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- What decisions could have been made and action taken by agencies to prevent the homicide?
- How effective were agencies in identifying and responding to both need and risk for Rita?
- How effective were agencies in working together to prevent harm through domestic abuse?
- What lessons can be learnt to prevent harm in the future?

32. Individual Management Review Authors were therefore asked to provide a comprehensive chronology and respond to the following questions in respect of their involvement with Rita and perpetrator for the period January 2012 until Rita’s death was known about in August 2017:

- Can you provide a comprehensive chronology of your agency’s involvement within this timeframe?
- Can you provide a brief summary of the role of your organisation in responding to domestic abuse, including coercive control?
- Can your agency provide a brief pen picture of Rita and the perpetrator?
- What needs and risk did your agency identify for Rita and the perpetrator and how did your agency respond? In particular:
- Was domestic abuse, including coercive control, identified and how did your organisation respond?
- If your help and assistance was denied by Rita, how satisfied are you with your organisation’s response?
- If domestic abuse, including coercive control, was not known, how might your organisation have identified the existence of domestic abuse from other issues presented to you?
- How well equipped were staff in responding to coercive control in this case?
- How effectively was risk was assessed and acted upon in this case? How did Rita’s attitude to that risk affect decisions made or actions taken?
- How did previous history affect decisions made?
- On closure of cases, what was the analysis of risk and could anything have been done differently to act upon that risk?
- Is it expected for your organisation to adopt a Think Family approach and how was that type of approach followed in this case?
- Can you identify areas of good practice in this case?
- Are there lessons to be learnt from this case about how practice could be improved? If these lessons have been subject to any previous reviews, please provide details of actions required and progress against them.
- What recommendations are you making for your organisation and how will the changes be achieved?

33. University Hospitals Birmingham were asked to provide an information report in respect of their briefer involvement
    - Describing how their policies and processes have changed since 2014 in respect of absconding patients. What difference would these have made to their organisation's response to Rita's son had they been in effect earlier?
    - Whether it was expected for their organisation to adopt 'think family/whole family' type approach and how this type of approach was followed in this case.

34. Rita disclosed domestic abuse to her bank, the Halifax. The bank was therefore asked

    - How staff responded to Rita when it was discovered her son was mis-using her account
    - Whether financial abuse or coercive control was identified
    - Whether any support was offered, or referrals were made regarding her safeguarding?
    - Whether the Lloyds Banking Group plc, to which the Halifax belongs, provides guidance or training to staff concerning domestic abuse, financial abuse, coercive control and safeguarding

## 2.8. Agencies without contact

35. The following agencies were contacted but confirmed that the household members had not been known to them:
    - Age Concern
    - Birmingham City Council Advice and Information and Housing Options Services
    - Change Grow Live (CGL)
    - Specialist domestic abuse and sexual violence services: Anawim, Birmingham and Solihull Women's Aid, Rape and Sexual Violence Project, Gilgal, WAITS
    - MIND
    - Shelter
    - Salvation Army

## 2.9. The definition of domestic violence[4]

36. The Government's definition of domestic violence, which sets the standard for agencies nationally was applied to this review:

    *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:*
    - *psychological*
    - *physical*

[4] Since this time the Domestic Abuse Act 2021 was enacted and introduced a legal definition of domestic abusive behaviour. Economic abuse was a particular feature of this case and is now defined as any behaviour that has a substantial adverse effect on a person's ability to acquire, use, or maintain money or other property or obtain goods or services (s.3: Domestic Abuse Act 2021)

- *sexual*
- *financial*
- *emotional*

*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.*
*Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*." (HM Government, 2013)

37. The inclusion of controlling and coercive behaviour within this most recent definition is particularly relevant to this review.

## 2.10. Parallel Reviews

38. Although the review commenced as a domestic homicide review, it was combined with a safeguarding adult review as further information became available and when the criteria for both reviews was seen to have been met.

39. This change did not hinder the review process. Indeed, the domestic homicide review had already embraced the considerations of a table-top review undertaken by Birmingham Safeguarding Adult Board in this case. The table-top review had raised a series of reflective questions for practice development and these had been incorporated into the terms of reference and analysis for this review. This in turn enabled the key lines of enquiry to be capable of encompassing the requirements of a combined safeguarding adult and domestic homicide review, once Rita's care and support needs were established and the criteria for both reviews were met.

40. No inquest was held as the cause of death was deferred to the conclusions of the criminal case.

## 2.11. Equality and Diversity

41. The review gave due consideration to Rita's vulnerabilities alongside each of the protected characteristics under Section 149 of the Equality Act 2010. In particular it was considered that her sex, gender, age and disability and the perpetrator's mental health and substance misuse were relevant to this review and included in the commentary that follows.

42. In the year that Rita died, 8.5% of women killed within the context of domestic abuse[5] were killed by their sons and this was double the number of the previous year (Femicide Census, 2017, p.26)[6]. Bows (2018) examined domestic homicides involving older people in the UK and found that the majority of parricide perpetrators were adult sons and the majority of

[5] This excludes from the Femicide Census women killed by terrorism, strangers, friends or neighbours
[6] https://1q7dqy2unor827bqjls0c4rn-wpengine.netdna-ssl.com/wp-content/uploads/2018/12/Femicide-Census-of-2017.pdf

parricide victims were mothers and concluded that "the risk factors for domestic homicide in later life are gender specific" (2018:2).

43. Moreover, Dobash and Dobash (2015) went on to find that the murders of older women by men were more likely to involve five or more injuries and an inebriated perpetrator who was less likely to express remorse. These common features were also considered to be features of Rita's experience.

44. Rita's age and increasing frailty left her particularly vulnerable to fatal domestic abuse. There has been research evidence to suggest that, whilst safeguarding adult concerns may be raised, it is rarely identified or treated as domestic abuse in older women and that they are consequently often invisible to services (SafeLives, 2016; McGarry et al., 2014; Lanzebatt et al., 2013). The review proceeded with awareness of this commonly held deficit.

### 2.12. Dissemination

45. The following organisations will receive copies of this review

- Birmingham Community Safety Partnership and its agencies
- Birmingham Safeguarding Adult Board
- Lloyds Banking Group plc.
- All agencies involved in the review and beyond through publication on the Birmingham Community Safety Partnership website
- West Midlands Police and Crime Commissioner
- West Midlands Criminal Justice Board
- Ofcom

## 3. BACKGROUND

### 3.1 Persons involved in this review

46. In order to protect the identity of Rita, family and significant others, the following anonymized terms have been used throughout this report:

Persons involved:

| *Designation* | *Relationship* | *Age at the time when the death became known* | *Residing with victim at time of death* |
|---|---|---|---|
| The victim | Rita | 81 | |
| The perpetrator | Rita's younger son | 41 | Yes |
| Adult 3 | Rita's elder son | 44 | No |
| Adult 4 | Rita's elder daughter | 62 | No |
| Adult 5 | Rita's younger daughter | 59 | No |
| Adult 6 | Rita's first husband | deceased | No |

| Adult 7 | Rita’s second husband | 74 | No |
|---|---|---|---|

### 3.2. The homicide

47. West Midlands Police received a report from one of Rita’s neighbours who was concerned that they had not seen her for some time. The neighbour reported that there was an unusual smell coming from the house and that they were concerned for Rita’s safety.

48. The police found Rita deceased in her bedroom. She had been there for some time and her body was badly decomposed. At trial, her son claimed to have discovered her death only three days before the arrival of the police, although it was evident that she had been there for at least several weeks.

49. Rita had nine broken ribs but there was no evidence available of how she had come by these. In the criminal trial, the prosecution asserted that her son had thrown his mother onto the floor of the bedroom and applied pressure to her chest on both sides. They further asserted that he had knowingly concealed the death and that by leaving her in her bedroom and shutting the door, he could hamper any subsequent investigation into the causes of her death.

50. The court was made aware that the perpetrator had a history of violence towards his mother and that he took advantage of her financially. The police press statement revealed that he had sent text messages to his girlfriend showing he was "increasingly angry and frustrated with his mother" but after mid-July he did not mention her again.

51. The perpetrator was convicted of manslaughter and sentenced to twelve years’ imprisonment. At the summing up of the criminal trial, the judge acknowledged that the perpetrator’s method and reasons for killing his mother were unknown to the court but the final attack which lead to her death had been a culmination of assaults. Mr Justice Julian Knowles said, “It is a terrible crime for someone to kill their own mother, to end her life in her own bedroom where she was left to rot.”

52. The perpetrator sought to appeal his sentence without success.

## 4. CHRONOLOGY

53. The sections below have been based on information provided from agencies’ records and interviews with staff; agencies’ analysis in IMRs; verbal summaries of the criminal trial; the pre-sentence report of the perpetrator and interviews with family and neighbours of Rita. They represent the Independent Overview Author’s view of significant information and events.

### 4.1 Background

54. Rita was born in Hockley, Birmingham in 1936 and had two siblings and one step-sibling. During her working life, she mostly worked as a shop assistant.

55. In the 1950s, she met and married her first husband with whom she had two daughters. The marriage ended in divorce in the early 1970s and shortly afterwards, she met and married her second husband with whom she had two sons.

56. In her second marriage she experienced significant domestic abuse from her husband who was reported to have been an alcoholic and a gambler. Reflecting on that time, her eldest son considered that his father's violence towards his mother was so brutal that "he could easily have killed her." He recalled his father being excluded from the property for a period of time but that this did not stop him intimidating his family. For example, he would sit outside in his lorry shining the bright lights full beam into their home. He would break windows, and, on one occasion, his threats and intimidation reached such a level that the eldest son remembered armed police being required to attend. He remembered his father being convicted and imprisoned because of his violence towards his mother and that he returned to live with the family after his release.[7]

57. Rita later disclosed to a Community Psychiatric Nurse that she had taken an overdose towards the end of their marriage but had recovered without medical intervention or notifying anyone at the time. However, around this time she had started taking anti-depressants and medication to help her to sleep and continued to take these periodically thereafter for the rest of her life.

58. Although the couple divorced in 1986, Rita continued to have problems with her ex-husband and they continued to have contact for many years afterwards, at one-point co-habiting again. After the divorce, she relocated to Sutton Coldfield where she remained until her death, moving into her last home in September 2003. Rita never talked with family about the violence that she had experienced during these years and went so far as to deny the history of abuse when confronted by her eldest son. However, in 2000 she did tell a mental health practitioner about the abuse when she was in a low mood. She further reported that her low mood had been affected by the unexpected death of her father four years earlier, with whom she was extremely close. By this time, Rita had been seeing her GP and been provided with anti-depressants and medication to help her sleep for around eighteen years.

59. A family member remembers that Rita was subject to abuse from her youngest son, the perpetrator, when he reached the age of 16 and that he had already been drinking heavily for a couple of years by this time.

60. Although the perpetrator had moved with his mother into her new home in 2003, he moved away a few years later to live with his girlfriend in Cardiff where he lived off and on until 2012. He had been working as a security guard until leaving Wales and revealed later

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[7] These allegations have not been put to Rita's second husband.

to mental health practitioners that he had often been sacked from previous jobs due to his drinking.

61. A family member recalled that this period of her living on her own, and her being free from violence and abuse, was the most content that she had ever been seen. Likewise, the neighbours recalled that when the perpetrator was away, Rita would chat to the neighbours but when he returned, she would not come out of her house.

## 4.2 March to August 2014: Rita was pushed through a window

62. In March 2014, the City Council Landlord Services made a routine visit to Rita's home to check on the tenancy. Rita's rent account was balanced and, as no concerns were noted, no further routine visits were made to the property.

63. On the evening of the 23rd April 2014, the police received a call from a member of the public reporting that the perpetrator, who was unknown to them, had come to their door saying that someone was following him and he was refusing to leave. He had told the caller that he had been threatened over accusations that he was mentally, verbally and sexually abusing his mother. He also disclosed that he had depression but was no longer taking his medication and was instead, self-medicating with cannabis. He said that he was an alcoholic and was continuing to feel suicidal.

64. Police and ambulance services were called, and the perpetrator told them that he had tried to commit suicide earlier that day. He was taken to the Emergency Department of Good Hope Hospital under section 136 of the Mental Health Act 1983 and the police stayed with him due to his threat of absconding. He was seen by Psychiatric Liaison Service practitioners and disclosed that he had tried to hang himself with a belt over the Easter period and was experiencing auditory hallucinations. As well as reporting his heavy drinking and cannabis use, he was described as being paranoid and thought that he was being followed and spied upon. He disclosed having arguments with his partner around this time, but no further details of the argument were recorded.

65. The Psychiatric Liaison Service psychiatrist was under the impression that the perpetrator was experiencing alcohol dependency and withdrawal with chronic hallucinations, depression and a serious suicide attempt. An assessment was undertaken under the Mental Health Act (1983) where he was deemed not to be medically fit, psychotic, suicidal and with an unpredictable risk. He agreed to be admitted as voluntary patient and was put on the bed list for a psychiatric hospital.

66. Rita was visited by police officers to confirm that she was safe and well and having done so and receiving no disclosures of abuse, they closed the case.

67. The following day, the perpetrator was reported missing from hospital. As he was there voluntarily, he was entitled to leave the hospital without having to inform medical staff. Nonetheless, an internal, security and police emergency response was undertaken. West Midlands Police treated him as a high-risk missing person due to his risk of self-harm,

visited and searched his mother's home eventually locating him at Birmingham Children's Hospital and they returned him to Good Hope Hospital six hours later, where he was held temporarily under section 5.2 of the Mental Health Act 1983, pending a formal assessment.

68. On 27th April 2014, the perpetrator left the ward again, pushing past patients and staff. A police helicopter was deployed to help find him and he was returned to the psychiatric ward unharmed and held temporarily again under section 5.2 of the Mental Health Act 1983. On returning to the ward, 1:1 supervision put in place. As his psychotic and suicidal condition was seen to be caused by alcohol misuse, he was being held temporarily to manage his withdrawal from alcohol and at this point, he stated that he was motivated to accept help with his alcohol issues.

69. The following day, Rita phoned her GP upset that the perpetrator was wanting to come home but saying that she was not able to cope with him. The GP advised that he was unlikely to be discharged.

70. The perpetrator remained on the acute ward for six days during which time he disclosed his concerns that neighbours and his ex-girlfriend had accused him of abusing both children and his mother and that they were conspiring against him. He believed that he could hear the neighbours talking about him through the walls. He handed in his Security Industry Authority badge for safekeeping, although he had not worked as a security guard since leaving Wales two years earlier.

71. Medical opinion determined that he was having alcohol induced hallucinations. As he was considered to be motivated to seek help with alcohol issues and had stopped reporting hallucinations, he was discharged to the Home Treatment Team and returned to his mother's home.

72. Six days later, on 13th May 2014, he was taken to hospital again where he was assessed by the Psychiatric Liaison Service and the case reviewed by a psychiatrist and community psychiatric nurse the following day. The perpetrator accepted a referral to Aquarius addiction service, was discharged from the Home Treatment Team and advised to register with a GP. He did not register with a GP and went on to cancel his appointment with Aquarius.

73. Within two days, Rita contacted the police as her son had stormed out of the house and had threatened to kill himself. The perpetrator was located near to a public house in the town centre. The Street Triage Team attended. 'Street Triage' is a mobile vehicle staffed by a community psychiatric nurse (CPN), police and ambulance. The perpetrator was assessed by the CPN where he stated that he wanted to be out of the area for "fear of the voices"

74. The CPN agreed that he was to be referred to the Community Mental Health Team and, as he did not want to return to his mother's home, he was taken to a bed and breakfast

establishment in the south of the city. The next day, on 18th May 2014, he was taken to an acute hospital by the police after he had entered another unknown person's home.

75. At hospital he told the Psychiatric Liaison Service nurse that he had been hearing derogatory voices for two days and that he had experienced "two-way" domestic violence with his partner. Marks of self-harm were observed on his arm, although it is not known whether these were historical or new. There was no record of the identity of this partner and he was to be returned to his mother's home and Home Treatment Team followed up his engagement with Aquarius. Again, he was asked to register with a GP.

76. The practice nurse visited Rita the next day, who stated that she was coping with her son back home.

77. On 27th May 2014, the perpetrator was discharged from Home Treatment Team as he had consistently avoided contact and appointments with them. When they had seen him over recent weeks, he appeared largely well with no imminent risks beyond that related to his alcohol abuse. He had continued to fail to register with a GP but was discharged to the Community Alcohol Team.

78. On 23rd June 2014, Rita phoned 999 and spoke to the Ambulance Service who noted that she sounded both anxious and scared. Both Ambulance and Police attended, and the perpetrator was arrested for having pushed his mother out of an open ground floor window. When the police had arrived at the scene, both Rita and her son were sitting in the front garden and it was noted by officers that Rita had a visible injury to her forehead and her right wrist was swollen. On arrest, the perpetrator was found to be carrying four kitchen knives in his rear trouser pocket and he told the police that he was trying to get his mother out of the house but could not find his keys. This version of events was also offered by Rita when she was later interviewed by a Police Response Officer at hospital. She said that he had been talking to himself and then took a knife from the drawer and began repeatedly telling her that she needed to get out of the house. When he couldn't find the front door keys, he opened the window and pushed her out. She stated that he climbed out of the window after her and explained that he needed to get her out of the house, and she felt that he was trying to protect her. She also told the officers how her son's mental health had been worsening in recent months. After returning home from the psychiatric hospital three months previously, he seemed well but his mental health had been worsening since: he had become reclusive; was hearing voices in his head and talking to himself; had stopped eating and sleeping and was having daydreams.

79. An assessment under the Mental Health Act was undertaken overnight by two doctors and an Approved Mental Health Practitioner (AMHP) during which he disclosed hearing voices telling him to kill his mother. His mental and behavioural disorder was judged in this assessment, by both mental health services and the local authority, to be a result of substance misuse and not of a nature or degree which would warrant detention in hospital. Although he was found fit to be detained and interviewed, the custody sergeant queried the assessment, stating that they were of the opinion that he would be a danger to himself and his mother on release. The custody sergeant further queried the notes of

the assessment which on police records said that ‘he had no current mental health issues’ and was ‘sobering up’, whereas the officer noted that he had shown no sign of intoxication, either on booking or since. Health practitioners had responded saying that they were aware of his history of mental health assessment and the fact that he had been discharged from Home Treatment services as he had no current mental health issues. There was no evidence that the police sergeant had escalated concerns and the Home Treatment Team had closed the case without a multi-agency risk plan having been put in place.

80. The perpetrator was subsequently charged with assault and possession of offensive weapons and bailed to a bed and breakfast hotel with the condition not to have direct or indirect contact with his mother or enter the road in which she lived. Mental health services encouraged him to self-refer to addiction services and to register with a GP.

81. Rita was taken to Good Hope Hospital and treated for a fractured wrist, a head injury and bruising. She disclosed that her son was becoming increasingly abusive and so hospital staff raised a Safeguarding Multi-Agency Alert and sent it to Adult Social Care who visited her the following day. At this point, Rita advised social workers that she feared not surviving another incident but had been told that as a result of an injunction, her son would not be returning to her home. After the social worker had made various safeguarding enquiries, Rita asked for the safeguarding matter to be closed saying that she just wished for her son to receive the help that he needed. The review found no evidence of an injunction having been sought in this case.

82. In the meantime, the police Custody Sergeant made contact with the duty mental health team in the area to progress a mental health assessment and recommended that the matter be filed. It is unclear whether the Custody Sergeant was aware that the perpetrator was not open to mental health services and would have needed a referral from a GP. Nonetheless, the police Safeguarding Team Sergeant reviewed the case and requested that further enquiries were completed in order to address the long-term safeguarding of an elderly victim.

83. The day after the incident, a police safeguarding officer from the Domestic Abuse Team phoned Rita who said that her son’s actions had been a ‘cry for help’ and that she wanted him to come home. However, after being told that the perpetrator had heard voices telling him to kill his mother and that he had bail conditions, she agreed that he should not return to her home. Rita declined assistance from other agencies and the police attached a ‘SIG’ marker to her address in order to alert future police responders about domestic abuse in the household.

84. Rita was then visited by her GP who had received a letter from the Ambulance Service. The GP talked with her about the assault that had taken place and Rita was clear that she did not want her son back into her home. The GP advised her to call the police if her son attempted to return.

85. On 25th June 2014, a police officer from the Investigation Team visited Rita at home and updated her on the progress of the criminal case. The officer noted that her injuries "looked horrendous" but that she would not allow them to be photographed. However, Rita did agree that she would be willing to engage with support services and the officer referred the matter to the police Partnership Team with the suggestion that an organisation such as Help the Aged be notified in order to offer support. The Partnerships Team attempted to contact Rita to gain her explicit consent to the referral to no avail. Meanwhile, Rita was given the officer's contact details as well as those of the Custody Sergeant.

86. That week, the perpetrator pleaded guilty to the offence of common assault against his mother. The judge ordered a pre-sentence report to be undertaken for him and a social care assessment to be undertaken for Rita. His bail conditions continued whilst these assessments were undertaken.

87. In response to Court directions, on the 2nd July 2014, Adult Social Care phoned Rita offering a care needs assessment, but she declined saying that she was managing with all her tasks of daily living.

88. That afternoon, an officer from the police Domestic Abuse Team visited Rita to discuss safety planning. Rita refused them entry and they suspected that the perpetrator was at the address in breach of his bail conditions although she denied it. They arranged for the police officer from the Investigation Team, who had visited the week before and had built a rapport with the victim, to visit. Finding the perpetrator there, he was arrested. He was later released as the Police believed that the Crown Prosecution Service had not listed his case for hearing by the Court.[8] However, the police attended Rita's home again two days later to check that the perpetrator had not returned and, finding him there, arrested him again and the perpetrator was remanded in custody until his court appearance three weeks later. The police also contacted Adult Social Care to ask them to try to contact Rita once more and make an assessment of her needs.

89. When the social worker contacted her by phone on 9th July 2014, Rita again declined an assessment but said that she intended to have her son back home after his court appearance. The next day the police Custody Sergeant phoned Rita who said that she required no further help from agencies. She felt safer now that her son was in custody but would probably allow him to come home as she felt responsible for him.

## 4.3 September to October 2014: the courts were involved

90. In advance of the hearing, probation services visited the perpetrator in prison. He presented as being isolated with no meaningful relationship besides that with his mother. The probation officer completed a Spousal Assault Risk Assessment and assessed the perpetrator as being of medium risk of causing serious further harm to his mother if he

[8] The CPS were asked to confirm the accuracy of this statement provided by West Midlands Police but did not respond.

continued to live with her, consume alcohol and if there was a deterioration in his mental health. His financial dependency upon his mother was also identified. The probation officer contacted Rita by phone. She displayed clear concern for her son and recognised a deterioration is his mental health since he left the psychiatric hospital. She believed him to be in need of psychiatric help and said that she was his main source of support. There was no indication that the probation officer contacted Adult Social Care or advised others outside of the court process of the perceived risk that Rita faced.

91. The pre-sentence report presented the risk and needs assessment and recommended a two-year supervised community order and recommended that a Mental Health Act assessment be undertaken to inform the conditions of his sentencing. The risk and needs assessment stated that his psychological well-being made him un-suitable for a community order, community supervision or a curfew. In order to have an Alcohol Treatment Order recommended, he would have needed to be assessed as alcohol dependent. As the probation officer's assessment was completed in prison, his alcohol dependency may not have been so evident as he will have already undergone medically assisted detoxification. Without contacting other agencies, the officer would neither have been aware of the antecedents in this case nor the diagnosis that his mental state had been caused by alcohol misuse.

92. The Magistrates Court sentenced the perpetrator to a two-year community order without requiring a Mental Health Act assessment to be undertaken. The sole requirement of the community order was for supervision by probation services and he returned home to his mother's address. One week later, the social worker contacted Rita by phone, who reported that all was well. She was advised to contact the police should there be a need to and gave her contact details in case she changed her mind about wanting an assessment herself in the future.

93. On 31st July 2014, the perpetrator failed to attend his initial appointment with the Community Rehabilitation Company and was sent a first warning letter concerning his breach of the conditions of his community order. Rita responded by telephone to say that her son had been unwell, had not been eating or talking, had left home and she didn't know where he was. She said that he needed psychiatric help and was concerned that he would self-harm. The case manager advised her to report him as a missing person to the police, which she did, and withdrew the warning letter. The perpetrator returned home two days after he had been reported to the police.

94. Over the next six weeks, the perpetrator failed to attend all six appointments, each time phoning up with an explanation of staying with friends. Statutory warning letters were issued, and the Community Rehabilitation Company prepared a 'breach pack' recommending to the court that the order be revoked, and he be resentenced. It also highlighted the risk issues to his mother stemming from his pre-sentence report. His breach of the court order was referred back to the Magistrates Court who issued a warrant for his arrest without bail.

95. On 10th September 2014, the National Probation Service presented the perpetrator's breach to the Magistrates Court.[9] He pleaded guilty to the breach and, despite the identified risk, the order was amended to include a two-week curfew between 9pm to 7am to his mother's address.

96. For the rest of the month, the perpetrator continued to miss all appointments and he continued to telephone his case manager with excuses. He was breached again and failed to attend Court in October 2014 and a warrant for his arrest was issued without bail. The Community Rehabilitation Company were unable to complete a fresh assessment as they had not been able to interview him by this time.

97. On 28th October 2014, the Magistrates Court revoked his community order and sentenced him to two months' imprisonment suspended for six months. This suspended sentence had no requirements for ongoing supervision by probation services.

### 4.4 January to June 2016: Rita's deteriorating health

98. Over the following two years, the only service having any contact with the household is Rita's GP practice regarding her various health issues including asthma and diabetes. On occasions she stopped taking her medications as she did not believe that she had these conditions and regularly declined services, failed to attend specialist appointments and declined routine home visits that were offered to her because of her age (25.09.15).

99. Rita notified her doctor that her son was back home and that there were no problems. However, in January 2015, the GP noted that she had lost a lot of weight and when questioned she described herself having a poor appetite.

100. In August 2015, Rita told the GP that she was worried about having spare medicines in the house and asked for monthly supplies instead.

101. The GP first became aware of Rita potentially having some confusion in April 2016, after she had stopped eating or drinking for four days. She continued to refuse medication for several months, complained of problems swallowing and continued to lose weight. A diabetic review and follow-up blood tests showed that her diabetes was nevertheless under control and was to be reviewed again three months later.

102. In June 2016, Rita reported having slipped on the ice during a cold spell two months earlier, which had left her feeling 'off balance'. She continued to report feeling very unsteady and confused and complained about painful knees at the end of the summer. The GP called at her home twice and each time the perpetrator said that she was out shopping but had been having hallucinations and was very confused. The GP followed this up with telephone calls, eventually talking to Rita and convincing her to restart her medication.

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[9] Under Government changes to probation services introduced in June 2014, the National Probation Service present Community Rehabilitation Company breaches to court.

## 4.5 October 2016 onwards: disclosure of the extent of the abuse

103. On the morning of 31st October 2016, Rita approached the local branch of her bank, the Halifax, concerned that her account balance was lower than it should have been. Staff blocked her son's online access to her account with her agreement. Whilst they attempted to discuss matters further, Rita had a taxi waiting so needed to leave. It was suggested to her that she return soon to discuss matters further.

104. Later that morning, a neighbour called the police after Rita had come to their address complaining that her son had assaulted her as well as claiming off her pension and running up bills. She broke down in tears and told the police officer that she was 'frightened to death' of her son and wanted him out. She stated that he assaulted her on a daily basis, took money from her, made her stay in her room and that day had bent the fingers of her hand back. She alleged that the bank had told her that he had taken £400 out of her account but also showed the officer that she had £400 in her purse. It was noted that Rita was shaken and confused and at times incoherent and for this reason a DASH was not undertaken. However, the officer recognised that she was at high risk because of her age, demeanour, fear and the history of assault and raised a safeguarding alert with adult social care. The neighbours also heard Rita say that the perpetrator had never claimed welfare benefits.

105. The perpetrator was arrested and a police officer from the Domestic Abuse Investigation Team visited Rita that afternoon. By this time Rita was reported to be calm and lucid. She did not want to support a prosecution, did not want to attend Court and was reluctant to provide any information beyond confirming that her son had bent her fingers back.

106. The perpetrator was interviewed about the allegation whilst in custody. He stated that he believed that his mother was suffering with dementia as she kept having visual hallucinations and shouting in the middle of the night. He also thought that she had had a stroke in April and that he had tried to encourage her to see the GP but she refused, although there was no evidence that he had called an ambulance in response to these concerns. He recognised that he had become an alcoholic and wanted to stop drinking as he did not feel that it helped the situation.

107. The investigation was filed on the basis that Rita had not provided detail of the assault and did not support a prosecution; her son had denied assaulting her and no other evidence had been sought. Appearing to be convinced that Rita was confused, there was no indication that the police investigated the allegations of theft with the bank. She was recorded as being at medium risk but without a rationale or DASH undertaken to support this judgement. The neighbours noted that by the evening, he had returned home.

108. Later that day, Rita called the GP as she was fed up with knee pain and wanted to stop taking her medication. She said that she was worried that she might forget the GP's home visit scheduled for the next day.

109. West Midlands Police made a referral to Adult Social Care summarising the events and stating that the perpetrator was struggling to cope with his mother's behaviour and did not know how to respond to her not having any other family to support her. Adult Social Care contacted Rita who denied that her son was stealing from her and stated that her wind-up had caused his assault.

110. The next day the GP made a home visit and undertook a cognitive impairment test with Rita who was found to have normal cognitive functioning. She declined attending the memory clinic. No mention was made of the incident the day before and it was not until some days later that the GP was contacted by a social worker and told of the allegations. The GP advised that he had visited the home when both Rita and her son were present and that Rita did not appear frightened of her son and had no obvious bruising.

111. On 3 November 2016, Rita returned to the Halifax Bank and disclosed that her son had assaulted her in the past. She said on previous occasions he had bent her fingers back and hit her. She said that her neighbour had contacted the police who attended the property but as she declined to press charges, the police would take no further action. As the police were known to be involved, bank officials did not take any further action but encouraged her to contact the police should anything similar happen in the future.

112. When social workers visited her the next day, Rita advised that she did not want to take matters any further and had 'had words' with her son. The social workers also spoke with the perpetrator who said that his mother was becoming increasingly confused and that he was not taking money from her. The social workers subsequently advised the GP of what had been said and questioned the GP on Rita's apparently deteriorating mental health. The GP confirmed that the perpetrator had reported his mother's short- term memory loss for which she had been referred to the memory clinic. He posited that Rita had recently started anti-depressants and that this may have caused disorientation.

113. On 7th November 2016 Rita returned to the bank and said that she wanted the online access to be reinstated for herself. The bank customer advisor had concerns and so referred the matter to the manager who discussed the matter with Rita, but she was adamant that her son had not influenced her and that she wanted the online access reinstated.

114. On 10th November 2016, the practice nurse undertook a planned home visit to find that Rita felt that her memory was improved and that she was taking her medication. The next day, adult social care closed the case.

115. On 17th November 2016, the Mental Health Trust contacted Rita by phone after receiving a referral from her GP for assessments of her mental capacity and memory, although it is unclear why the GP referred Rita as she had been found to have normal cognitive functioning and had just started anti-depressants which plausibly could have caused some disorientation. Moreover, if the GP had concerns about Rita's mental capacity, it is not clear why the GP would not assess those at the time of contact rather than passing the

decision to another agency. Nevertheless, the GP had provided a brief medical history and details of recent fractures but not how these injuries had occurred. The GP's referral also referred to the social worker's assessment that Rita's relationship with her son was good and that "he doesn't assault her". Whilst she disclosed her memory problems, Rita continued to minimise the recent assault. The triage nurse reinforced that it was unacceptable for her son to assault her and Rita agreed but declined an assessment and therefore the case was closed and the GP notified.

116. By the winter in 2016, the neighbours noticed that the gardener and window cleaner no longer called and found out that the window cleaner had not been paid. They were aware that Rita had always invested in her home but was no longer even putting the bins out. She had stopped going to the shops and the only deliveries to the house appeared to be alcohol for the perpetrator, delivered by the local shopkeeper.

117. Late in the evening of 11th March 2017, Rita contacted the police saying that her son was intoxicated, knocking over furniture and that she wanted him to leave. As it had been too late in the evening, after arresting the perpetrator, to return to take a DASH with Rita, the officer completed intelligence checks and found two previous reports of assault with the perpetrator having mental health and alcohol concerns. The perpetrator was kept in custody overnight to prevent a breach of the peace and appeared in Court where he was bound over for the sum of £100 for a period of twelve months.

118. The DASH was completed without speaking with Rita, recorded as medium risk, reviewed by the Sergeant on the Domestic Abuse Team and a safeguarding plan prepared. Officers made several attempts to contact her, eventually talking to her on 31st March on the doorstep as she wouldn't let them in. She appeared well and uninjured, but officers noticed the perpetrator leaving the property shortly after them. There were no orders in place at the time that prevented him being there.

119. Police made a referral to Adult Social Care who were also refused entry and spoke with Rita through the window. She declined all offers of help including the local Women's Aid helpline and they closed the case.

120. Two months later, the neighbours saw Rita in an upstairs window and called to her, asking if she was alright. She nodded to say that she was, but they noticed that she had become very thin. A few weeks later on 15th June 2017, the neighbours phoned Adult Social Care as they were concerned that they had not seen her for 6 days. They said that they gave a history of Rita and the perpetrator but were advised to call the police if they were worried as they could force entry into the house. On speaking with the neighbours afterwards, they said that they were reluctant to phone the police directly as Rita would undoubtedly be very angry with them if they did.

121. Rita went on to miss a further appointment for diabetic screening and no further contact was had with agencies until another neighbour alerted authorities and Rita's body was discovered on 12th August 2017.

## 5. OVERVIEW

122. This section considers the Individual Management Reviews (IMRs) and Information Reports completed by the individual agencies and the panel's contribution to their analysis.

### 5.1 West Midlands Police

123. West Midlands Police investigated three incidents of domestic abuse involving Rita and the perpetrator between June 2014 and March 2017. They also dealt with four incidents of him being reported missing between April and August 2014 when he was having a mental health crisis.

124. The earliest incident in April 2014 concerned the perpetrator's mental health, his voluntary admission to hospital, his subsequent absconding from hospital and his risk of self-harm. As he was believed to be in immediate danger, he was treated as a high-risk missing person. Significant resources were deployed to locate him and return him to hospital as well as to undertake a check on the safety and well-being of his mother.

125. This first incident, however, also involved his disclosure that he was being accused of sexually, verbally and mentally abusing his mother. Officers visited Rita who did not disclose any abuse and his disclosure was thereafter treated as a symptom of his mental illness, substantiated by his being admitted to the psychiatric ward of the hospital.

126. The Police actively responded to each domestic abuse incident and made clear attempts to engage, discuss and arrange safeguarding of Rita. It was clear that one police officer in particular had built a rapport with her, visiting her after her son had been remanded in custody in June 2014. The officer enabled Rita to agree to engage with agencies and requested the police Partnerships Team to make a referral to a local charity supporting older people. Ultimately this request was unsuccessful as the Partnerships Team were unable to contact Rita to re-confirm her consent for the referral. This was a missed opportunity to enable her access to services at a critical time. Since this time, West Midlands Police have introduced electronic hand-held devices which would enable the referral to be made, with the victim's consent, directly at the scene.

127. Having built a rapport, the same officer was brought in to safeguard Rita at a later point when her son was breaching his bail conditions by staying at his mother's house. This led to her son's arrest and remand into custody for almost three weeks. There was also evidence that safeguarding referrals were made to Adult Social Care on every incident of domestic abuse as well as documented signposting for the perpetrator to substance misuse services.

128. There were indicators that the police had taken a pro-active approach to managing the perpetrator's threat when, suspecting that he was at his mother's home, they returned specifically to locate him there and arrested him for breach of bail conditions.

129. Further good practice could be evidenced by the decision of the Custody Sergeant to query and challenge the Mental Health Act assessment conducted when the perpetrator was in custody in April 2014. Although the Custody Sergeant made clinicians aware of concerns, unfortunately, there were no records available to show whether the matter was escalated, or should have been escalated, when clinicians did not respond to the challenge.

130. The Police were called from Rita's neighbour's home in October 2016 after Rita had discovered the alleged theft of money from her bank account. Rita made several disclosures of abuse to the police in front of her neighbours recounting her experiences of daily assaults, economic abuse and being imprisoned in her bedroom. Unfortunately, the next day she went on to minimise her experiences and withdraw all complaints. The IMR author recognised that, whilst a charge would have been unlikely without medical evidence, consideration could have been given to building an evidence-based prosecution against the perpetrator, based on the evidence provided to the police at the scene and through interviewing the neighbours. There was also no indication that further enquiries had been made to the Halifax Bank and the issue of potential financial abuse investigated.

131. The IMR author also recognised that it was not documented whether a Domestic Violence Protection Order/Notice (DVPO/DVPN) had been considered in respect of the perpetrator's assault of his mother in 2016. Authorised professional practice says that "Officers should consider DVPOs at an early stage following a domestic abuse incident to provide short term protection to a victim, in this case, where an arrest has not been made but positive action is nonetheless required to protect the victim" (West Midlands Police IMR).

132. A DVPO would have had particular merit in this circumstance as they can be pursued without the victim's active support. They can provide a breathing space for the victim and the opportunity for agencies to work directly with her. It is uncertain whether the conditions were met for such an order as there had been twenty-seven months with no reports being made to the police and no documented injury. This meant that it was unlikely that there would have been sufficient evidence of the threat of violence that is required (Section 24 (1-2) of the Crime and Security Act 2010).[10] However, the IMR author recognised that it would have been good practice to have noted the rationale for not applying for one. West Midlands Police have been more pro-active around DVPOs in recent times and a new dedicated lead for civil orders is being introduced in the forthcoming restructure.

133. In this incident in October 2016, the initial attending police officer was concerned about Rita's vulnerability and the perpetrator's history of violence and assessed Rita as high risk although Rita was not calm enough to go through the DASH formally.

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[10]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575363/DVPO_guidance_FINAL_3.pdf

134. Rita was visited that afternoon by the Domestic Abuse Investigation Team and she presented in a much calmer and lucid manner and denied that abuse had taken place. This, together with the perpetrator's denial and what was seen as an absence of evidence, discouraged officers from taking the matter further. However, as the initial attending officer graded the incident as high, it should have been reviewed by the Safeguarding Sergeant. In the absence of a DASH having been completed, the sergeant would have been expected to use their professional judgement based on all the historic information available to the police to complete a risk assessment. If they had kept the report as high, then the case would have been heard at MARAC.

135. The absence of a DASH appeared to have contributed to this deviation from procedure. Completion of the DASH was not mandatory for West Midlands Police at the time and it was open to the professional judgement of the officer concerned whether one was needed. Officers reported that they only completed DASH in exceptional circumstances where the circumstances were familial rather than intimate-partner domestic abuse. This policy has since changed and DASH is now mandatory for all incidents in line with national guidance and is subject to systematic audit within the force. In order to support the mandatory practice, all response officers in West Midlands Police are able to undertake DASH when they attend an incident on an electronic hand-held device enabling easier completion and swifter referral to Safeguarding Teams where required.

136. Given the significant changes that West Midlands Police have made to their professional practice since their involvement with Rita and the perpetrator, the Force has not made new recommendations for itself. The shortcomings relating to non-use of DASH, lack of consideration of DVPO and protracted nature of referring to support agencies have featured in previous domestic homicide reviews and have been, or are in the process of being, addressed. However, most agencies involved in this review have made significant changes to their practice in response to domestic abuse in the intervening period and it will be incumbent upon each of them to be able to demonstrate that those changes have had the required effect. This issue will be taken up in the recommendations for this review.

## 5.2 Birmingham and Solihull Mental Health Trust

137. The Mental Health Trust had little contact with Rita in her own right. She was referred twice over a period of sixteen years, each time for low mood and she declined further assessment or intervention on each occasion. The initial referral in 2000 noted that the dominance of her son contributed to her low mood. However, she did not attend the appointments that were made with her and the information in this assessment would not have been able to be transmitted into or cross referenced with her son's future electronic records when his contact began with the Trust some fourteen years later.

138. Rita was referred again in November 2016 by her GP following the incident where her son was reported to have bent her fingers back and taken money from her account. The GP had requested an assessment under the Mental Capacity Act, as requested by the social worker, although it is not clear why the GP did not undertake this assessment. The mental

health triage nurse phoned Rita who downplayed the incident, minimised the abuse and declined further intervention. The nurse closed the case and notified the referring GP.

139. The Mental Health Trust have identified that it would have been good practice to alert the GP to any outstanding risks associated with closing the case. Likewise, good practice would have encouraged them to liaise with the social worker who had generated the referral for a Mental Capacity Act assessment. This would have given the mental health nurse the opportunity to hear directly from the referrer about the concerns leading to the referral. Whilst it would not have been possible to impose an assessment under the Mental Capacity Act in these circumstances, this liaison could have provided a chance to consider the circumstances more broadly and generate a multi-agency practitioner meeting if safeguarding concerns maintained.

140. The Single Point of Access does not consider that they have the capacity to undertake multi-agency liaison in all cases due to the volume of demand for their services. However, in this case they accept that, as the social worker had made the initial request, greater liaison was needed between partner agencies in sharing information relating to domestic violence and abuse.

141. All other contact between the Mental Health Trust and Rita was in the context of her son's care. The Trust assessed the perpetrator's condition as one of alcohol dependency and withdrawal with chronic hallucinations but not a mental disorder. At points of crisis and informal admission to hospital, he was discharged to Home Treatment services with whom he did not engage. The team were under the impression that he was actively avoiding contact with them.

142. The perpetrator made a number of disclosures to mental health practitioners about his potential to harm others. Between April and June 2014, the perpetrator disclosed hearing voices telling him to kill his mother as well as "two-way" domestic abuse with a partner and arguments. Practitioners were also aware of the perpetrator having been arrested with four kitchen knives in his possession as well as assaulting his mother by pushing her out of the window. There is no indication that practitioners attempted to gather information about the well-being of either person nor explore more details about the arguments and nature of the domestic abuse disclosed. They did not appear to have tested the validity of apparent paranoia; routinely enquire about others at home or challenge him about abusive behaviour. In this way there was no recognition of domestic abuse or their responsibilities to those that may be at risk.

143. At the same time, the perpetrator revealed during a Mental State Examination that he thought neighbours and somebody, who is thought to be his ex-partner, were accusing him of abusing children and his mother, and that neighbours could hear him through walls. These thoughts were attributed to alcoholic hallucinosis and paranoia, but the Mental Health Trust could find no evidence to demonstrate that risk to his mother, or indeed the children of his ex-partner, had been considered. Likewise, the perpetrator had described how he had "scared the crap" out of his mother when he had attempted to hang himself, but the Trust could find no evidence of ward staff seeking consent to offer his mother

support given that the incident must have been very disturbing for her to witness. When the Home Treatment Team briefly spoke with her two weeks later, she did not disclose any concerns. However, it is not clear whether this brief discussion focussed on her son's recovery, whether she was seen on her own or whether attempts were made at this time to offer her support over witnessing her son's suicide attempt.

144. No risk assessment could be found when he was discharged from hospital in 2014 or from Home Treatment, nor consultation with Rita about how she felt about him returning home on each occasion. Once discharged, the Home Treatment Team visited the perpetrator at home several times but missed the opportunity to talk with Rita on her own and allow her the opportunity to talk about her concerns and gain feedback from her as a carer.

145. The Mental HealthTrust identified that they had failed to record the name of the partner that the perpetrator had referred to as involving "two-way" domestic abuse. They recognised that they had lacked professional curiosity regarding the whereabouts of the children that he thought others were alleging that he had abused, albeit within the context of what practitioners had considered to be alcohol induced hallucinations of a conspiracy against him.

146. When the perpetrator was discharged home from hospital or home treatment services, there was no evidence that previous history of risk and harm to his mother was taken into account despite there being a risk indicator on their case records regarding him having knives and having assaulted his mother.

147. At the time of their involvement, the Mental Health Trust had no stand-alone domestic abuse policy or procedures. Since then, the Trust has recognised that there was insufficient understanding of how to recognise and respond to domestic abuse within their organisation and having introduced a specific domestic abuse policy in 2017, implemented an internal domestic abuse strategy (January 2017 – January 2020) which has included the roll-out of domestic abuse training.

148. The Trust has recognised that practitioners need to be particularly aware of the increased risk posed to family members where domestic abuse, substance misuse and mental health are seen together particularly when discharge planning. They have outlined how practitioners need to be aware of safeguarding risks when a service user is granted leave from hospital under Section 17 of the Mental Health Act[11] and that safeguarding should be considered in all discharge planning and transfer of care. They have recognised that special consideration needs to be given to who takes responsibility for leading on safeguarding matters in joint working environments, such as Psychiatric Liaison Service and acute hospitals, and how this is documented within multiple sets of care records. These requirements have recently been specified in the amended Trust Safeguarding Adults Policy ratified by the Trust Clinical Governance Committee on 02.10.18.

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[11] "Section 17" leave is the power of a patient's responsible clinician to grant detained patients leave from hospital. A detained patient is only allowed to leave hospital with this leave in place

149. Beyond these points, Birmingham and Solihull Mental Health Trust have recognised that their overall response lacked both professional curiosity and an “abuse informed” approach. Information about domestic abuse was recorded in 2014 and should have prompted consideration and a response. Moreover, there appeared to have been a lack of awareness that domestic violence and abuse can occur in any relationship including a familial relationship of mother and son.

150. In 2015, the Mental Health Trust introduced the role of Named Nurse for Domestic Abuse who sits within the Safeguarding Team and whose role includes promoting awareness through training and providing advice to clinicians. Since this role was introduced and mandatory training on domestic abuse provided to managerial and supervisory staff, the Trust has, for example, increased its referrals into Multi-Agency Risk Assessment Conferences (MARAC) and made significant advances in its approach to domestic abuse.

151. With few exceptions, the shortcomings that have been raised in this review regarding the mental health response have also been raised in other domestic homicide reviews that the Trust has been involved in across the Birmingham and Solihull area. These reviews have covered mostly the same period and largely come to similar conclusions:

- **Risk to Others:** that practitioners should evidence their consideration of the increased risk posed to family members where domestic abuse, substance misuse and mental health are seen together particularly when discharge planning.
  - All teams to implement a “think family” approach to delivering services to their service users.
  - All records will clearly demonstrate that all service users have been assessed and interventions planned within the family context they are in, or will be in, when discharged.
  - Children who will be in the service user’s life will have their names and dates of birth recorded, partnership working will be evident and appropriate information sharing undertaken.
  - When assessing service users who disclose information which might put family members or carers at risk of harm, staff should demonstrate how such risks are considered and mitigated.

- **Responsibilities to Carers:**

  - The Trust’s Care Coordinators must ensure, as part of their organisation of care, that all carers are advised of their right to a carer’s assessment. The offer must be clearly documented. If the offer is not accepted, the reasons should also be clearly documented, and a date set to revisit this with the carer.
  - The Trust should review its supporting information for carers to ensure that their entitlement to a carer’s assessment is explicit

- **Leave Arrangements.** Staff should be aware of safeguarding risks when a service user is granted section 17 leave from hospital and safeguarding should be considered in all discharge planning and transfer of care.

152. In order to promote improvements at an operational level, the Trust has made a recommendation for itself to write, promote and implement a Domestic Abuse Good Practice Guide for staff embodying the practical learning from domestic homicide reviews featured above. This will specifically reference guidance on coercive control and mental capacity; cross-generational abuse; multi-agency working; assessing and managing risk where previous history of abuse and talking with potential victims on their own.

153. In its action plan, the Trust has also recognised the need to give specific assurance of improvements made in identifying risks that service users pose to family members where domestic abuse, substance misuse and mental health are seen together, especially when discharge planning.

154. The Mental Health Trust will then need to provide a global assurance to the Community Safety Partnership that the introduction of the domestic abuse policy, strategy, named nurse, training programme and the recommendations above can demonstrate an improved approach to identifying and responding to domestic abuse in the lives of its service users and their families.

## 5.3 Birmingham City Council Adult Social Care

155. Adult Social Care became directly involved with the perpetrator in April 2014 after he had attempted to hang himself. An Approved Mental Health Practitioner (AMHP) undertook an assessment under the Mental Health Act in June 2014 when the perpetrator agreed to an informal admission to hospital. A bed was identified, and he was admitted to psychiatric care one week later.

156. In respect of Rita, they were alerted on three occasions to safeguarding concerns arising from the domestic violence that Rita was experiencing from her son: the first in June 2014, followed by further alerts in November 2016 and March 2017.

157. On each occasion, social workers carried out a duty visit soon after each alert to ensure Rita's safety and wellbeing, although on the last visit they were only able to speak with her through the window as she would not, or could not, let the social workers inside. Each time that a social worker spoke with Rita, she declined any social work involvement and instead 'played down' their concerns. For example, when social workers disclosed to her what the police had reported, she challenged them saying that it was not her son's fault, that she usually got on well with him and that there was nothing to be concerned about. Likewise, when discussing the bank's accusations that her son had stolen money from her, she said that he had not been stealing and that the bank had been wrong to assume that he had.

158. The social worker spoke with the perpetrator about the allegations and he responded by claiming that his mother's behaviour was as a result of her deteriorating mental health and that he was not financially abusing her. The service was aware of his abuse of drugs and alcohol and their previous mental health intervention. Closer working with the GP and

mental health services could have helped identify and manage the heightened nature of risk as well as contextualise his responses.

159. On each occasion social workers decided that Rita did not present as having care and support needs and noted that she had refused all offers of support, including refusing a referral to Women's Aid approximately four months before she was killed.

160. The service acknowledged that there were missed opportunities to take action to protect Rita, particularly in their first contact with her in June 2014 when she had expressed a wish for her son not to be returned back to her address. On this occasion, she also requested assistance in helping her son to get the help that he needed. The service recognised that this had not been followed up sufficiently as there were no actions taken to establish whether the perpetrator had received a Mental Health Act assessment whilst in police custody. They consider that the case was closed without adequate checks to manage the risks and offer the perpetrator relevant support.

161. The service recognised that each time they responded, they recognised there were very serious safeguarding concerns: they responded immediately; visited Rita to discuss the allegations made; recorded the risk and the impact that this was having on Rita and were aware of her clearly stated wishes. However, no practitioner had seen a way of addressing the risk since the perceived options would have acted against her wishes and she appeared to have the mental capacity to make the choices she was indicating.

162. Whilst alert to the physical and financial abuse which was being investigated by the police, potential signs and patterns of coercive control were not identified and so the physical and financial abuse framed the social work response.

163. On reflection, social work staff agreed that there has been insufficient exploration around the power and control that the perpetrator exerted over his mother. There had also been a lack of understanding about whether Rita was under undue influence when rationalising and minimising her son's abusive behaviour. Indeed, each member of staff interviewed had been worried for Rita's safety and welfare and saw that the history of violence from her son and her repeated withdrawal of her statements to the police indicated that she was at risk of harm. However, as she was seen to have mental capacity to make decisions for herself and made the decision not to have further safeguarding assistance, her case was closed each time.

164. In order to understand why decisions were made in this way, the IMR author has suggested that there were conflicting principles and agendas which needed to be considered when assessing risk in this situation. Given that it was determined that Rita had mental capacity to make her own decisions, practitioners needed to question whether Rita was making an unwise choice to remain in an abusive relationship because sustaining a relationship with her son was more important than her safety or whether there was evidence of coercion?

165. Adult social care consider that they should have recognised that Rita was likely to have experienced coercion and control from her son and considered how this may have undermined or compromised her ability to make decisions. Having done so, this would have opened up the possibility of legal remedies and a more informed risk assessment with the potential to refer to the Multi-Agency Risk Assessment Conference (MARAC) if the risk had reached that high threshold.

166. Neither was there evidence of professional curiosity about family circumstances and history. A holistic look at the family may have given some insight into family dynamics and inter-relationships as well as the significance of the traumatic family history.

167. Having recognised that staff were not sufficiently equipped or supported to respond to domestic and coercive control, the service are already taking action to improve their response. They are rolling out safeguarding training around domestic abuse and coercive control to all social work teams and including the interface between domestic abuse and adult safeguarding. In this way, staff can apply their knowledge of domestic abuse to the principles and judgements including within adult safeguarding such as empowerment, agency, mental capacity and the impact of coercion and control.

168. In order to embed this training, Adult Social Care have developed operational guidance around domestic abuse, coercive control and adults with care and support needs. This document includes outline guidance and operational information to staff on how and when to work with MARAC to safeguard adults with care and support needs experiencing domestic abuse.

169. It is clear that Adult Social Care are focussing heavily in the support to social workers at the front-line with a view to improved practice responses to the interface between domestic abuse and adult safeguarding. However, they have made specific recommendations to address their individual learning from these circumstances:

- Social Workers needed greater insight into coercive control and how it operates in cases of domestic abuse.
- Social workers needed greater insight into the need to consider more than one model of viewing citizen's decision making in cases of domestic abuse, so that in addition to considering the principles of the Mental Capacity Act and Making Safeguarding Personal, the possibility of the exertion of undue influence is also a consideration.
- Social Workers needed greater insight into the need to consider multi agency decision making in complex cases of high risk.
- Social workers needed greater insight into the function of DASH and MARAC and knowledge of when and how to follow this route.
- Social Workers needed greater insight into considering a Think Family approach in domestic abuse cases where both victim and perpetrator have care and support needs.
- The Adult Social Care Contact Point needed to ensure staff considered past case history before making case decisions in relation to adult safeguarding cases.

170. The means of addressing these recommendations feature in their action plan.

## 5.4 The General Practice

171. Rita received treatment for several health conditions including diabetes and depression during the period examined in this review. The care from GPs and nurses was, in general, provided through regular and frequent home visits as Rita had difficulty walking due to having had two toes removed through diabetes. The General Practice was aware of her caring responsibilities for her son and how she had significant difficulties coping at times. They were also aware of the incidents of domestic abuse reported to the police which Rita often minimised or denied after the event.

172. Rita sometimes challenged her diabetes diagnosis and stopped taking her medication. She also had periods of not eating which, alongside not taking her medication, could leave her disorientated. In 2016, the perpetrator advised the GP that his mother was suffering from memory loss and confusion and that she had hallucinations.

173. The GP undertook a six-item cognitive impairment test which gave no evidence of memory loss but made a referral to the specialist clinic, to which she declined. She declined all health referrals that the GP made and frequently cancelled appointments with the practice itself. Although there may have been a clinical explanation for Rita's periodic confusion and memory loss, there does not appear to have been consideration given to her son's motivations for sharing his concerns, despite there being earlier records of known abuse and despite the cognitive test not demonstrating impairment.

174. Although the incident in 2014 was misleadingly recorded as an assault rather than domestic abuse, there was little evidence of practitioners considering Rita's documented history when attending her. Only one GP considered, in 2014, that the reason she may have been cancelling appointments could have been her son's presence in the home saying, "I could imagine he could overhear and get paranoid which is why she is trying to avoid [us]". Although she was offered a surgery visit as a remedy at this time, neither this documented record nor incidents of domestic abuse were followed up thereafter. Indeed, there were several occasions when Rita did not answer the door or was said, by the perpetrator, not to be at home when practitioners undertook pre-arranged visits. It was generally considered plausible that she was out at the time despite her needing home visits as she had difficulty walking.

175. The General Practice was aware on two occasions that Rita did not want her son to come back home and missed opportunities to speak with her on her own about her concerns. They also misled her on one occasion by reassuring her that he was unlikely to be discharged when in fact he was discharged within the week. There was no evidence that his return to her home was considered potentially coercive or that Rita was minimising her experiences and retracting her allegations within the context of domestic abuse. On the contrary, one GP went so far as to say tell the social worker that she had not been assaulted and had a good relationship with her son. This appeared to be a reflection of the practice only looking at individual incidents and taking what Rita said at face value without reference to her prior experiences.

176. The practitioners involved have received training on domestic abuse. However, the Practice had no specific policy or procedure on domestic abuse to guide their decision making and there was no point at which practitioners considered that discussion with their Practice Safeguarding Lead, or during their regular Practice Meeting, was required in this case. As a result, the Clinical Commissioning Group have recommended that this General Practice adopts Identification and Referral to Improve Safety (IRIS) which is an evidence-based programme of specialist domestic abuse training, support and referral pathway. In doing so, it would improve practitioner's ability to: identify domestic abuse and coercive control; understand the dynamics of domestic abuse relationships, including familial relationships; encourage accurate recording, encourage direct questioning and have a direct referral mechanism to the specialist domestic abuse service in place. The CCG had also recommended that the Practice adopted a domestic abuse policy and procedure which has been actioned and completed.

## 5.5 Staffordshire and West Midlands Community Rehabilitation Company

177. In July 2014, probation services became involved with the perpetrator after he had been convicted of the assault on his mother where he pushed her out of the ground floor window. Staffordshire and West Midlands Probation Trust, then one organisation but which went onto divide into the National Probation Service and a Community Rehabilitation Company, undertook a pre-sentence report and recommended to the courts that he receive a two-year supervised community order and a mental health assessment. The Court decided to sentence without a full Mental Health Act assessment being undertaken.

178. The pre-sentence report author had correctly identified the perpetrator's offence as domestic violence related and completed a Spousal Assault Risk Assessment identifying a medium level of risk to his mother, in connection with the perpetrator living with Rita, drinking and worsening mental ill-health. Whilst the pre-sentence report was considered by the IMR author to be of an acceptable quality, there were some aspects which were unclear such as the perpetrator's intentions of residence upon his release. It was also the case that no domestic abuse or mental health 'alert' risk flags were added to the case management system which may have helped the case manager to identify concerns more readily, thereafter.

179. Indeed, after sentencing, the allocated case manager did not appear to have a clear understanding of the risk that the perpetrator posed. The perpetrator consistently failed to attend his probation appointments, often phoning with excuses. The case manager's priority became to secure his attendance at appointments and speak with him about his behaviour in person. In an effort to see him, the case manager often re-arranged appointments to the day that they were speaking on the phone.

180. As a result of his failure to attend appointments the perpetrator was breached twice during a three-month period. There was an opportunity to breach him slightly earlier when Rita contacted the service concerned for his whereabouts. However, the case

manager was trying to give the perpetrator an opportunity to attend and failing to do so, requested a 'fast-track' breach warrant which was executed swiftly.

181. The IMR author considered that there were clear opportunities for the case manager to take a more inquisitive and investigative risk-based approach to the telephone conversations that were held with the perpetrator when he was providing his excuses for non-attendance. These conversations could have provided opportunities to explore information that was already known to the case manager from the perpetrator's files concerning his relationship with his mother, his alcohol use and mental health. There was also the opportunity to consider financial abuse, given that the pre-sentence report had recognised that the perpetrator was dependent upon his mother financially and not claiming welfare benefits in his own right. Latterly these telephone conversations provided an opportunity to consider the impact of being curfewed and tagged to his mother's home where the index offence of assaulting his mother, had occurred. Moreover, at no point did the case manager consider the need to undertake a home visit in this case.

182. As the service's focus was on the perpetrator's attendance and enforcement activities to deal with his non-attendance, the case manager did not request information from the police about any domestic abuse call-outs. The case manager did not contact the psychiatric hospital or consider safeguarding adult concerns in respect of Rita. Neither did the case manager contact the electronic monitoring service once the perpetrator had been made subject to curfew. Each of these would have been expected practice and would have demonstrated robust partnership information sharing for the purpose of risk management.

183. Staffordshire and West Midlands Community Rehabilitation Company (SWM CRC) commented upon how they prepared the court for making decisions regarding the sentencing of the perpetrator. The initial pre-sentence report resulted in a corresponding suspended community sentence. However, the court did not require a mental health assessment to be undertaken as recommended. The panel heard that it was not unusual for recommendations for a Mental Health Assessment not to be taken up by the court, particularly as this would delay sentencing.

184. Whilst it is not within the scope of a domestic homicide review to comment on court decisions, it is within our scope to consider whether reports for court are of a sufficient standard and whether improvements could be made. Having assessed the risks, the initial pre-sentence report specifically stated that a curfew would be inappropriate. Subsequent breach applications made no recommendations for a curfew and yet the court sentenced the perpetrator to a curfew to the home of the victim of the index offence. Although these were ultimately matters for the court, the IMR author considered that there may have been a need for greater clarity in the recommendations contained within the second breach application. The quality of breach applications was addressed as a matter with the individual officer rather than leading to a wider recommendation.

185. At the time of SWM CRC involvement in this case, Community Rehabilitation Companies were at the start of a transition from public to private ownership and were still governed

by Probation Trust national policies and practices. Since this time, SWM CRC have gone through a significant period of change including the development of its own policies, procedures and practice guides. In particular, the service has developed a 'Risk of Harm Guide' incorporating required practice in responding to domestic abuse and adult safeguarding. The service has also established a performance management framework which informs the levels and nature of management oversight of practitioners and cases. Whilst policies and procedures have not been dissimilar to those inherited from the Probation Trust, the practice guide and performance management of cases and people have strengthened the service's response to domestic abuse and adult safeguarding. However, in response to this case, the service has made specific recommendations for itself concerning:

- Improving risk management responses to domestic abuse through flagging cases; gathering and exchange of risk information with police, health, electronic monitoring and relevant agencies; embedding the practice guide in local teams
- Reviewing individual and team adult safeguarding practices
- Ensuring that all community cases are enforced in a timely way and explicitly reflect the nature of the abuse and risk posed by the offender in recommendations for court

186. As with other agencies who have made significant changes to their service's approach to domestic abuse in the intervening period, the Community Rehabilitation Company will need to provide assurance to the Community Safety Partnership that these changes have been made and that they have had the required effect.

**5.6 University Hospitals Birmingham NHS Foundation Trust**

187. Rita attended the Emergency Department of Good Hope Hospital having told paramedics that her son had pushed her out of the window. As well as contacting the police, Hospital staff rightly raised an adult safeguarding alert with the local authority.

188. The perpetrator was admitted twice to the Hospital with psychosis and auditory hallucinations. He was known to suffer from depression and had disclosed his use of cannabis and being an alcoholic. On both occasions, he left the ward before assessments had been undertaken and the Hospital ensured that internal and police emergency responses enabled the perpetrator to be returned to the ward unharmed each time.

189. Although, positive action was taken on each occasion when the perpetrator absconded, the Hospital Trust reflected that in 2014, nursing and medical staff would have needed to be familiar with the operation of a wide range of separate policies and procedures concerning missing patients, self-harm, clinical holding and restraint and observation of patients at risk. These have since been drawn together into an Enhanced Observation Care Bundle providing an easier reference to the patient's current and previous patterns of behaviour, alongside practical guidance and de-escalation techniques for those at risk of

absconding. Had this system been in operation at the time of the perpetrator's admission, the assessment may have been more robust in continuously identifying patterns of behaviour that indicated that he was at risk of absconding and enabled de-escalation techniques to be identified earlier.

### 5.7 Lloyds Banking Group plc

190. Rita visited the local branch of her Halifax bank, which is part of the Lloyds Banking Group, a number of times to discuss her son's access to her account and to disclose domestic abuse. Banking staff initially blocked her son's online access to her account and escalated their concerns to the bank manager when Rita wanted to reinstate her online account access. At this point, she was adamant that she was not being coerced by her son to do so. Aware that the police were involved, the bank did not take further action but encouraged her to contact the police should further concerns arise.

191. Lloyds Banking Group advised that had the same scenario happened more recently, then bank staff would have invoked the Banking Protocol and contacted the Police directly. Since this time, frontline staff have received training on applying the Banking Protocol, which includes coercive control and financial abuse, along with customer vulnerability training. The Banking Protocol was developed and implemented through a partnership between the police, trading standards and the finance industry. The scheme enables banks to report any suspected fraud incidents and customers acting under duress, with affected branches being made a priority and receiving an immediate police response. Since the implementation of the Banking Protocol, the Banking Group has been able to demonstrate its successful application to support vulnerable customers.

192. Moreover, Lloyds Banking Group have signed up to delivering the UK Finance Financial Abuse Code of Practice and are raising awareness to customers through the publication of an Industrywide Consumer Guide. The Banking Group has been working with several charities including Surviving Economic Abuse, SafeLives, Women's Aid and Refuge to further enhance the training and support offered.

193. Whilst appreciating these developments, the review panel suggested that as well as notifying the police, the Banking Group should consider reporting their concerns about adult abuse to the relevant local authority in such cases and that this additional step needs to be written into their procedures.

## 6. THEMATIC ANALYSIS. LEARNING & RECOMMENDATIONS

194. There is no doubt that agencies were faced with an array of complex dynamics between mother and son and the circumstances that they encountered were by no means clear or constant. They encountered periods when Rita wanted to support and care for her son and appeared to have a strong relationship with him. At other time she could not cope with him and there was clear evidence of domestic abuse. Many manifestations of abuse

were either minimised or had other plausible explanations. In this section, we will consider the overarching themes arising within the review and whether every aspect of the criminal and civil law was utilised to protect Rita.

## 6.1 Indicators of domestic abuse, coercive control or neglect

195. A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Section 7, Statutory Guidance). In addition to examples of physical abuse, there were other indicators of abuse, not all of which can be evidenced even with the benefit of hindsight. However, the review has found little indication that domestic abuse was considered when these potential indicators of abuse beyond the physical were known.

### 6.1.1 Physical Abuse and Neglect

196. Agencies identified several incidents of physical domestic abuse, particularly those which brought police attention. However, despite often having access to the home, practitioners did not always identify wider possible indicators of abuse. From as early as 2014, it was known by all key agencies responsible for safeguarding adults, that she had been pushed out of the window by her son. Thereafter, enquiries should have been made of any issues, no matter how plausible the explanation given of how they happened. For example: in January 2015 the practice nurse noticed that she had experienced sudden weight loss; in June she was unsteady on her feet after reportedly having had a fall.

**Learning Point:**
Domestic abuse is rarely an isolated incident and generally, those incidents which come to agencies attention are usually accompanied by ongoing abuse. Therefore, past known incidents of domestic abuse need to frame future assessments and all incidents should be looked at holistically to give a clearer overview of abuse and risk.

### 6.1.2 "Gaslighting" and Disguising Abuse

197. The perpetrator told the GP, the police and the social worker that his mother was losing her memory and was getting confused. From the GP Practice perspective, there had been a number of factors which would support that view. She had periods of not taking her diabetic medication and not eating. She frequently cancelled or missed appointments and was not at home for pre-planned home visits. On at least one occasion, she warned the GP that she might forget her appointment. In response, the GP undertook cognitive tests and found her cognitive functioning to be normal.

198. Whilst there were other explanations available, there appeared to be no consideration given to the possibility that the perpetrator was manipulating both his mother and practitioners in order to avoid being held accountable for his abuse. Gaslighting is a term used to describe how a person is manipulated into questioning their own memory, perception or sanity and may have applied to Rita's experience. This type of coercive control can be very psychologically damaging and disorientating for victims, who,

witnessing disbelief and apparent collusion between their abuser and the medical practitioner, may well feel helpless and lose confidence in themselves and the services that they need (Davendralingam, 2018).

199. In early analysis of domestic homicide reviews in the West Midlands, it was observed that health professionals were entirely reliant on information given by perpetrators when assessing both their needs and any risk they might pose to others (Neville & Sanders-McDonagh, 2014). This strengthens the need for professionals to seek evidence to test the plausibility of perpetrator's accounts of their own and their victim's behaviour and make safe enquiries with the victim.

**Learning Point:**
In order to conceal their abusive behaviour, perpetrators of domestic abuse will often manipulate victims and professionals by questioning their victim's perceptions and mental health. Practitioners need to be curious and consider the possibility that they are being manipulated in this way.

### 6.1.3 Minimisation

200. It is very common for domestic abuse victims to minimise their experiences and withdraw allegations after emergency services have dealt with their immediate crisis. Having called the police, Rita consistently minimised her experiences and mostly interpreted her son's behaviour as being caused by his mental ill-health. This was particularly evidenced when her son told her that he was trying to protect her from his threatening hallucinations by throwing her out of the window.

201. There were occasions when Rita admitted that she felt safer with the perpetrator being held in custody or in hospital but that she would let him come back home. Not unexpectedly, she appeared to have complex and sometimes contradictory feelings about her son.

202. There is no doubt that supporting victims of abuse who do not identify their experiences as abusive, as many do not, is difficult for agencies with limited time to build the trusting relationship that is needed to identify and address the abuse (Knight et al., 2016). Victims may fear what may happen once domestic abuse has been reported. These barriers would appear to be particularly hard to overcome for older mothers with abusive grown-up children for whom they may feel guilt or responsibility. They may particularly feel that they have no choice but to take their grown-up child back home if they have nowhere else to go.

**Learning Point:**

Practitioners need to try to understand the range of complex reasons that will cause victims to minimise their accounts of the abuse that they experience and recognise the particular barriers that older parents and carers will often face.

### 6.1.4 Controlling and withholding medical services

203. Women experiencing domestic abuse will often face barriers to accessing the services they need and, in some cases, they will be prevented from attending appointments by their abuser (Beaulaurier, 2007). We have seen that Rita often cancelled or missed pre-planned appointments. When practitioners called at the house, the perpetrator said that his mother was out on a number of occasions, despite her poor mobility. With one exception, the difficulties that agencies had in engaging with Rita for her basic healthcare do not appear to have been questioned in the light of known domestic abuse. Indeed, the issue of inconsistent or reluctant contact with healthcare providers is a known indicator of neglect (West Midlands Adult Safeguarding, 2016).[12] Only one GP recognised that it was possible that Rita was cancelling appointments because of her son's paranoia, but this appeared to be seen in the context of his mental health rather than the risk that he may have posed to his mother.

204. Despite Rita having some impaired mobility, her need for home visits was not well documented in GP records. It is not impossible that the perpetrator did not want his mother to be seen by GPs or nurses anywhere but the home where she could be observed and prevented from speaking openly, had she wanted to. Whilst the extent of the perpetrator's manipulation is not known in this case, it remains important for practitioners to be recognising that some behaviours can be indicators of abuse or neglect.

205. On another occasion, Rita asked the GP to prescribe smaller amounts so that there were not left-over medicines in the home. This suggested that either she was getting confused or that the perpetrator was stealing her medication. There was no indication that the context for this request was explored by the GP although it was possible that Rita was trying to manage her own safety in this way.

**Learning Point:**
Practitioners need to be curious when individuals repeatedly miss or cancel appointments and consider the possibility that they are being abused or neglected.

### 6.1.5 Economic abuse

[12] https://www.ssaspb.org.uk/Guidance/Adults-Safeguarding-Multi-agency-policy-procedures-for-the-protection-of-adults-with-Care-Support-needs-in-the-West-Midlands.pdf

206. The perpetrator economically abused his mother by not claiming welfare benefits himself and relying upon her income. There are also strong indicators that he stole from her and mis-used her bank account to support his excessive alcohol use and his gaming lifestyle.

207. Unbeknown to agencies at the time, neighbours were aware of twice daily deliveries of alcohol. After her death, his bedroom was found to contain expensive, high-specification technology and gaming equipment. It transpired that Rita had received an inheritance from her father in the region of twenty thousand pounds and it was suggested by a family member that this may have supplemented Rita's pension to pay for the perpetrator's lifestyle.

208. Although adult safeguarding alerts were raised by the police after the alleged theft from the bank account was realised, there was no indication that the broader nature of economic abuse was investigated. When social workers asked the perpetrator about the misuse of his mother's bank account, he convinced them that she was confused. There was no record of the police investigation probing the potential theft. Police, probation and mental health services knew that the perpetrator was not claiming welfare benefits and was financially dependent upon his mother but did not probe further.

209. Financial abuse is noted in the Care and Support Statutory Guidance in relation to adults with care and support needs (Department of Health and Social Care, 2018, para 14.24). It is also cited within the Statutory Guidance that accompanies the law on coercive and controlling behaviour in section 76 of Serious Crime Act 2015. The Statutory Guidance recognises the need for, "[a]n assessment of the power dynamics in a relationship should consider the control and access to finances as this can be a feature of controlling or coercive behaviour". (Home Office, 2015, p.7). In order to seek a prosecution for controlling or coercive behaviour, it would have to be shown that the behaviour was repeated or continuous in nature and only behaviour that occurred after the introduction of the legislation in December 2015 could contribute to that assessment. Although the reported incident in October 2016 did not in itself demonstrate the repeated or continuous nature of the abuse, further enquiries may have been able to demonstrate that it had been ongoing and there was no indication that the police had considered this particular episode in this way.

210. We have seen that the Halifax Bank considers that, more recently, it would have responded more robustly to Rita's disclosures around domestic and financial abuse. In that year, the Citizens Advice Bureau and the British Banking Association launched a report, *Addressing Financial Abuse*[13], advising banks how to understand and support victims of financial abuse. Since this time, UK Finance[14] have issued *Financial Abuse Codes of Conduct.* The Lloyds Banking Group, incorporating the Halifax Bank, have adopted these codes and has been pro-active in training and supporting its staff to respond to domestic

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https://www.citizensadvice.org.uk/Global/CitizensAdvice/Debt%20and%20Money%20Publications/Addressing%20Financial%20Abuse%20-%20AFD%20report.pdf

[14] The British Banking Association is now known as UK Finance

abuse since. Whilst these new Codes of Conduct encourage banks to contact the police, the Review Panel also considered that there should be a greater connectivity to adult safeguarding processes in the local area and a recommendation is being made to UK Finance in this regard

**Learning Point:**
Practitioners need to be curious and open to the possibility of economic abuse. In this case agencies were aware that the perpetrator was not claiming benefits, abused alcohol and withdrew money from his mother's bank account but did not appear to identify this as economic abuse or contribute to understanding of coercive control.
If we miss economic abuse, we may potentially be missing the opportunity to uncover other possible forms of abuse.

### 6.1.6 Mental illness as a symptom of domestic abuse

211. Rita had been treated for depression periodically since experiencing harrowing domestic abuse from her former husband in the 1980s. Practitioners should be aware that domestic abuse causes a severe loss of self-esteem, anxiety, depression and disorientation (Rose et al, 2011; Department of Health, 2017). It is also important to recognise that, whilst there is still little research in this area, there are indications that older women experiencing abuse may also experience higher rates of mental ill-health (Knight et al., 2016). There was no indication that Rita was asked about her experiences of current or historic abuse and how they may be affecting her depression.

**Learning Point:**
The causal relationship between experiencing domestic abuse and experiencing mental ill-health is well-evidenced and practitioners need to be routinely asking questions about individual's experiences of violence and abuse.

### 6.1.7 Imprisonment and isolation

212. In a rare set of disclosures in October 2016, Rita told the police and neighbours that her son was abusing her physically, financially and making her stay in her bedroom. Whilst the physical and financial abuse appears to have been explored and communicated between agencies, there was no further mention in agency responses of the perpetrator's possible restraint of his mother.

213. Had agencies been made aware of this allegation, it may have helped contextualise their future contact. For example, after a further incident had been reported in March 2017, the police domestic abuse officer tried to contact Rita for three weeks, only to be allowed to speak with her through her window. Likewise, a social worker following up this report could also only speak with Rita through an upstairs window.

214. Rita's weight loss was identified by the GP as early as 2015 and her decreasing weight, with clothes becoming too big for her, was recorded in the practice nurse's notes in mid

2016. Had the GP practice known about her allegations of being falsely imprisoned, they could have reassessed the possible causes of her weight loss.

215. A few months before her death, the neighbours noticed Rita in her bedroom window noticeably having lost more weight. Despite gesturing to her and asking her if she was alright, Rita did not open the window but merely gestured back to say that she was.

### 6.1.8 Changes that could indicate neglect

216. Unexpected weight loss may be an overt indicator of neglect but there were other changes in Rita's life that could be also be indicators such as a deterioration in her home. In 2014, the Police identified that Rita's home was clean and tidy and that Rita took care of her home. Neighbours commented upon how Rita had always been house-proud, but in her final year, there were indicators of a deterioration in both her home and garden and the gardener and window-cleaner were left unpaid. After the death, a member of Rita's family was shocked to see the poor state of her home.

217. It is not known how much deterioration had occurred since agencies last attended the home and could have observed this for themselves. The GP practice had not been in the house for eleven months prior to the death being discovered. The police were the last to visit the house five months before the death was discovered but that was in response to Rita's complaint that the perpetrator was drunk and knocking over furniture.

**Learning Point:**
Practitioners need to be aware of, and take seriously, all of the indicators of abuse and neglect including those generated by the isolation of the victim and unexpected changes in their day to day lives.

### 6.1.9 Experiencing domestic abuse as an older mother from an adult son

218. A recent study Benbow et al. (2018) examined domestic homicides of older people, predominantly women, and identified four key themes across these reviews: alcohol and drug misuse, mental health, financial abuse and a history of domestic abuse. Each of these issues has been found to be relevant in this case.

219. Rita's experience of domestic abuse will have been compounded because she was an older mother. Whilst most victims face barriers to understanding their experiences as domestic abuse as well as barriers to finding out what options are available to them, older women face particular barriers. For older women experiencing domestic abuse, research has found that they are: more likely to experience abuse from a family member; less likely to leave their abuser and their domestic abuse is more likely to be invisible to services (Safe Lives, 2016). Older women are more likely to experience poor health, poor mobility and have dependency upon an abuser through their own care needs. Moreover, generationally held attitudes may make it even harder for older women to understand their experiences as abuse (Safe Lives, 2016)

220. However, these barriers will often be exacerbated when they are also the mother of the abuser. It is common for most victims of domestic abuse to experience conflicting emotions. For example, victims will often feel a combination of shame, guilt, care, responsibility, loyalty and fear (Stark, 2007). These conflicting emotions are themselves often borne of emotional and psychological abuse. However, they will leave a victim particularly vulnerable to abuse if they are the parent of an abuser who has multiple needs himself, where feelings of responsibility will understandably run deeply. Rita may also have felt the need to defend herself as a mother, and her son as an abuser, from the judgement of others. These feelings do not take place in a social vacuum but reflect a society which continues to have significant expectations of the mothering role and expected behaviours. It is reasonable to anticipate that for older women, these societal expectations may be even more entrenched, hence the intersection of both gender and age is important to understand (Roberto et al, 2013).

221. Rita's own feelings towards her son cannot be known. At times, practitioners observed a strong bond and both victim and perpetrator verbalised their care for each other on many occasions. Nonetheless, there were other occasions when she expressed concerns which evidently conflicted such as when she specifically asked for help because of the abuse that she was experiencing. She had also said that she could not cope and that she was 'frightened to death of him'. Her capacity to make decisions and turn down offers of help will be considered later.

**Learning Point:**
Older mothers will face significant barriers to disclosure and help-seeking about domestic abuse that they experience from their grown-up children and these barriers will be compounded by the barriers that practitioners have in identifying domestic abuse for this group of women.
Older woman's ability to seek support from different sources may also be limited by health or mobility issues.

222. For Rita, each opportunity that was missed to effectively engage with her, or to take action against the perpetrator, will have meant that she will have lost trust and confidence in agencies to be able to protect her, making future engagement even harder. All agencies were able to demonstrate that they had, or were in the process of improving, their practice in response to domestic abuse and coercive control. An example of the need to understand safe practice has been in regard to creating a safe environment for making enquiries with the victim. There were several times when Rita was asked about her safety, but it was not clear whether she was asked whilst on her own and out of earshot of the perpetrator. The National Institute for Health and Social Care Excellence (NICE) make this clear within the first of their Quality Standards on domestic abuse [QS116] (NICE, 2016).

**Recommendation 1: Driving Consistency in Practice Response to Domestic Abuse**
Birmingham Community Safety Partnership should seek assurance that local agencies are capable of identifying the breadth and range of domestic abuse; of using the tools and pathways to respond; have sufficient supervision and escalation procedures to be able to respond effectively to domestic abuse.

**Recommendation 2: Domestic Abuse and Older Women**
Birmingham Community Safety Partnership should work with specialist domestic abuse services to develop the evidence base and share best practice in working with older women who may be subject to domestic abuse.

**Recommendation 3: Economic Abuse**

Birmingham City Council promotes the adoption of the Financial Abuse Codes of Conduct through its business districts, through the West Midlands Combined Authority and through the Greater Birmingham and Solihull Local Economic Partnership and promotes opportunities for multi-agency training on domestic abuse and coercive control amongst financial institutions in the city.

**Recommendation 4: Economic Abuse**
Birmingham City Council to share this report with UK Finance with a view to them considering adding to the Financial Abuse Codes of Conduct that any safeguarding concerns are reported to the local authority where an individual with care and support needs may be subject to abuse or neglect. This report to be shared with Surviving Economic Abuse, WAFE, Safe Lives and UK Finance who have been working with UK Finance in the development of Codes of Conduct.

## 6.2 Alcohol, Drugs and Mental Health

223. The perpetrator's first known assault of his mother in 2014 was put down to an episode of psychosis when he was hearing voices telling him to kill her. However, thereafter, his condition was diagnosed to be alcohol and cannabis induced. That is not to say that he did not experience auditory hallucinations and paranoia after this date but, because they had been caused by substance misuse, his condition was untreatable unless he engaged with substance misuse treatment. Indeed, his auditory hallucinations did get better for a while when he undertook a brief period of detox.

224. The review established that the perpetrator had experienced substance misuse from an early age and that his consumption of alcohol during the period under review was at times very high. Because the perpetrator was not registered with a GP, opportunities for screening his alcohol use rarely presented themselves and it did not appear that he was tested for alcohol whist in custody.

225. In March 2017, the perpetrator disclosed in custody that he had consumed 20 pints before his frightened mother called the police. At one time, he was found to have a line of credit at the local shop and was receiving two deliveries of alcohol per day. An estimation of his intake suggested that he may have been consuming over 100 units per day during this period and that he was also taking cannabis which would have interacted further with the alcohol. By comparison, the current government guidelines recommend no more than 14 units of alcohol per week on a regular basis (Department of Health, 2016).

226. The perpetrator was never actively engaged in treatment and so the impact of his substance misuse on his behaviour was not assessed from this perspective. Neither was it

known whether his substance misuse was a form of self-medication. Substance mis-use teams made attempts to engage the perpetrator on three separate occasions, to no avail, and he declined alcohol rehabilitation. After he had breached his supervision, probation services recommended a requirement to address alcohol misuse, but this was not taken up by the court. It appeared ironic that the perpetrator's persistence in avoiding engagement with his court-mandated supervision requirement led to him not being required to comply with supervision at all. In this way, the perpetrator could well have thought of himself above the law. He was repeatedly allowed to go back and continue to drink and abuse without any consequences for his behaviour.

227. There also appeared insufficient curiosity into why Rita asked the GP to prescribe medication over shorter periods so that she would have less spare medicine in the home. It was possible that this was motivated by her son's taking her medication for his own use or to sell.

228. Rita appeared to understand her son's behaviour to be caused by his mental illness and alcohol abuse. Indeed, there appears no doubt that the perpetrator was affected by mental and behavioural disorders. Moreover, the degree of his alcohol abuse alone could also have caused some cognitive impairment. The degree to which these contributed to his abuse of his mother is not known.

229. Nonetheless it is now apparent that Rita was subjected to a deliberate, repeated pattern of abuse and the factors of alcohol and substance misuse cannot therefore be seen as causal to that abuse. It is possible, however, that the perpetrator was motivated to control and abuse his mother, at least in part, to ensure unfettered access to her money in order to maintain his high alcohol intake.

230. Guidance produced by Alcohol Concern and the AVA Project (2016) concerning change-resistant drinkers recognised that problematic alcohol use and poor engagement with alcohol treatment featured regularly in domestic homicide reviews. The guidance went on to encourage interventions that assertively engage drinkers involved in domestic abuse.

231. Most significantly, the impact upon Rita of her son's alcohol misuse and the heightened risk that she may have faced because of it did not appear to have been a taken sufficiently seriously by several agencies.

**Learning Point:**
Practitioners need to 'Think Family' and understand the impact of mental health and substance misuse upon others that they live with. They also need to be professionally curious and consider how someone's substance misuse is being funded.

Wherever possible, Alcohol Treatment Orders need to be considered where a perpetrator of domestic abuse is convicted of an offence.

**Recommendation 5: Think Family in the context of substance misuse and mental health**
Agencies should provide assurance to the Community Safety Partnership about how their services have improved in addressing the risks to family members living with or caring for those with problematic mental or behavioural disorders and substance misuse.

**Recommendation 6: Assertive Engagement with Alcohol Treatment**
Birmingham City Council should consider whether there is sufficient capacity within commissioned services to assertively engage with change resistant drinkers where there are serious risks or vulnerabilities involved.

### 6.3 Safeguarding Adults, Mental Capacity and Coercive Control

232. Despite having been known as a strong, independent and feisty woman, Rita was in poor health, with reduced mobility and had become physically frail. Nonetheless, she did not consistently have care and support needs in the sense of day to day care. It was predominantly the abuse from her son that brought her into consideration as a 'vulnerable adult' within the terms of the Care Act 2014.

233. We have seen that older people often face additional barriers in identifying their experiences as abusive and that these barriers are often compounded when the abuse comes from their children. At the same time, practitioners will also have less experience describing abuse as domestic abuse rather than elder abuse. This is more than a matter of semantics as the policy, practice and pathways of domestic abuse and safeguarding adults have emerged discreetly. As a result, there is a risk that older women experiencing domestic abuse could fall through a gap between professional disciplines (LGA,2014; Bow, 2018).

234. In this case, there were missed opportunities to identify the patterns of coercive control which form a greater part of the language of domestic abuse. For example, it was known that Rita had been assaulted by her son. However, the assault, her weight loss and allegations of confusion were not considered by the GP Practice in the context of domestic abuse. One GP identified the possibility that Rita was being prevented from attending appointments, but these concerns were not followed up. Neither was it sufficiently considered that the coercive control she was experiencing may have distorted her thinking and affected her capacity to make decisions freely.

235. From both a domestic abuse and an adult safeguarding perspective, a tension exists between empowering an individual through enabling their self-determination and protecting them from harm. As well as understanding domestic abuse and coercive control, practitioners need to balance key practice considerations, including:

- the principles of person-centred and outcome-focused practice of *Making Safeguarding Personal*

- the six statutory *Key Principles of Safeguarding Adults*
- consideration of capacity to make decisions and the application of the Mental Capacity Act
- the principles of risk assessment and risk enablement

236. In this case, agencies could be seen as balancing the considerations by

- Responding to the stated wishes of Rita that the social worker and police should take no further action
- Following the principles of "Making Safeguarding Personal" outlined in the Statutory Guidance of the 2014 Care Act (Department of Health, 2018) in respecting her apparent choice to remain in a relationship with her son even if it was abusive.
- Presuming Rita's mental capacity to make these decisions freely
- Adhering to the principles of the Mental Capacity Act, including the point that respecting that the making of an unwise choice is not evidence that an adult lacks mental capacity.

237. At critical junctures, Rita was therefore deemed to have capacity to make decisions about her life, no matter how unsafe or how unwise professionals considered those decisions to be. She was seen to be unfettered in her decision to have her son return home after he had assaulted her or when he experienced threatening hallucinations which put her at risk. However, practitioners needed to have considered that Rita's refusal of support might have revealed evidence of coercion and the exertion of undue influence by her son and that coercive control may have distorted her views about her relationship with her son.

238. Rita appeared to experience a range of conflicting emotions towards her son but at times, there are strong indicators that the level of fear and coercion within the relationship impeded her decision-making capacity. Indeed, services knew at different times that Rita was frightened, economically abused, psychologically manipulated, deprived of her basic needs, imprisoned in her room, her perspective distorted by saying that she was confused, forgetful and suffering dementia. Having hurt her already, the threat of physical harm remained, whether said explicitly or not. It is possible, but not known, that he may have been restricting access to medical services. The perpetrator was therefore controlling aspects of her everyday life and limiting Rita's "space for action" (Sharp-Jeffs, Kelly and Klein, 2017). Had the full extent of agencies' knowledge been triangulated and considered in the context of coercive control, it would be reasonable to assume that Rita's decision-making capacity, at least at times, was compromised and so open up other avenues of potential intervention.

**Learning Point:**

Practitioners need to consider how coercive control may be impacting upon a person's ability to make decisions and judgements freely, unfettered by fear, coercion, manipulation and undue influence. A judgement that a victim is free to make 'unwise decisions'[15] cannot be made until coercive control has been considered.

## 6.4 Multi-Agency Management of Threat and Risk

239. A thematic analysis of domestic homicide reviews undertaken by Standing Together Against Domestic Violence, identified key indicators of risk associated with familial domestic homicide including an abuser having: suicidal thoughts; a sense of entitlement, including to financial resources; a history of violence against women; addiction issues and where the abuse is of a victim who is already socially isolated (Sharp-Jeffs and Kelly, 2016). Moreover, we have seen that the position of an older mother with some degree of a caring role for an adult son with multiple needs carries additional risks of domestic homicide for the mother (Bows, 2018). However, agencies faced challenges to effectively assessing the risk that she faced. In the main, the perpetrator did not engage with any services and appeared to be avoiding contact with them. Nonetheless, the perpetrator had a known history of alcohol and cannabis induced hallucinations and psychosis. He had a conviction for assault, a documented history of knives and one conviction for possession of a bladed weapon in a public place. For some services working with him, there was an apparent lack of consideration about the threat that he posed to his mother. For example, probation services acknowledged that they had been focussed upon his being compliant with his supervision requirements after the conviction for a domestic abuse related offence, rather than being risk focussed.

240. Rita was seen to resist help from her neighbours and professionals and was perceived to be feisty and independent. The disclosures she made had been incremental. However, by October 2016, she had revealed that she was experiencing financial abuse and daily physical violence from her son whom she was "frightened to death of". She went on to withdraw allegations and minimise her experiences each time, making it difficult for agencies to appreciate and manage the risks that she faced.

241. Whether through MARAC or other informal mechanisms, there were missed opportunities for a practitioner's meeting to be called enabling a more holistic and multi-agency approach to addressing risks and needs.

242. The first significant missed opportunity came in June 2014, where the perpetrator's mental health was found, by mental health services and the local authority, to not warrant detention under the Mental Health Act and he was also discharged from mental health Home Treatment services on the grounds that his mental and behavioural disorder was caused by his substance misuse. However, we have seen that his case was closed without an adequate multi-agency risk plan. As there had already been some dispute of his diagnosis within the police custody suite, it would have been best practice to call a

[15] According to the principles of the Mental Capacity Act 2005

professionals meeting to consider how the perpetrator's risk could be addressed thereafter.

243. The episode in October 2016 provided a further missed opportunity for multi-agency consideration of the threat that the perpetrator posed. By this time, agencies had each received a catalogue of allegations including financial and physical abuse and were aware of Rita's own fear and minimisation of the abuse. The absence of a DASH being completed failed to cement the attending police officer's understanding of high risk and generate a referral to a Multi-Agency Risk Assessment Conference (MARAC) despite strong indicators such as: her age and frailty; the scale of her disclosures; the history of previous incidents and her saying how afraid she was of her son.

244. In the main, agencies were approaching risk episodically rather than collating the sum total of information that was already held at their disposal. Even if Rita had not, on further consideration, met the threshold for MARAC, had a practitioner's meeting been convened in October 2016 or March 2017, in respect of her safeguarding, there could have been a collective consideration of the risks that she faced and reflection on methods of engaging with her to develop the trusting relationship. It would also have enabled broader consideration of the powers available to agencies to take action against the perpetrator.

245. Birmingham's Domestic Abuse Prevention Strategy 2018-2023 has identified the need for the development of a 'domestic abuser management framework' to ensure that agencies, individually and collectively, consider the range of tools and powers available to protect domestic abuse victims and hold perpetrators to account. A framework for the management, disruption, diversion and control of domestic abuse perpetrators may be familiar to police offender managers managing high risk abusers but needs to be known and considered by all practitioners working to safeguard victims whether the persons are known to MARAC or not.[16]

246. In this case, we have seen that the police may have considered applying for a Domestic Violence Protection Order, although it was far from certain that one would have been granted. However, the statutory guidance framework on coercive and controlling behaviour guides police to ask questions about 'rules, decision making, norms and fear in the relationship, rather than just what happened' (Home Office, 2015, s2.27) when looking into identifying the offence. Had any agency built that trusting relationship they would have had a better understanding of the coercion and risks that she faced and enabled a fuller exploration of the options that she had to be safe whilst maintaining some relationship with her son, if that was what she wanted.

247. There was no indication that other options had been considered such as the possibility that her son could be re-housed and therefore not disadvantaged by actions to keep her

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[16] For example, Safe Lives provide a list of actions that can be taken against abusers at MARAC. Available at http://www.safelives.org.uk/sites/default/files/resources/Perpetrator%20guidance%20for%20MARACs_0.pdf

safe. Of course, there is no indication that he would have taken up the offer, but this decision alone may have helped Rita understand more about their relationship.

248. As a local authority landlord, pursuing an application for an Anti-Social Behaviour Injunction against the perpetrator could have been considered. This could have had the effect of excluding her son from the property as well as make positive requirements, such as requiring him to attend alcohol treatment, although it is not known if the conditions for such a requirement had been met (Home Office, 2017). It should be noted that enforcement on these types of injunction usually relies upon a victim telling agencies that the injunction had been breached, reinforcing the need for victim engagement and consent.

249. All other avenues exhausted and had the local authority considered that there was a serious risk to life, it could have taken further action. Where an absence of capacity is temporary and due to the undue influence of an abuser, the local authority could have made an application to the High Court, as long as the intervention was seen to be both necessary and proportionate. The Court has powers to approve interim injunctions which could restrain the perpetrator from behaviour such as assaults, threats, taking her money (as in [2011] EWHC 1022 (Fam))[17].

250. Whether or not the conditions were met for specific orders or action, professionals needed to consider whether Rita was subject to coercive control in the decisions that she was making when she turned professionals away and consider what actions that they could take to protect her rather than merely stepping away. Moreover, the need for collective multi-agency decision making is clear. Practitioners already had the power and means to call a multi-agency practitioner's meeting but either it was not considered, or practitioners lacked the confidence to draw agencies together in this way. It is therefore welcomed that Birmingham Safeguarding Adult Board has recently launched multi-agency *Risk Enablement Guidance* to address situations whereby agreement about managing complex risk is not possible or refused. Through this locally developed guidance, multi-agency staff are empowered to take a collective view with relevant partners to gain a full picture and plan any strategy to address it.

251. Moreover, Birmingham Safeguarding Adult Board are delivering learning events across the safeguarding workforce focussing on learning from serious incidents involving domestic abuse, coercive control, the application of the Mental Capacity Act and applying professional curiosity within this Risk Enablement approach.

252. More than anything else, there is a need to build a trusting relationship with the victim. Although the police response officer had built a rapport with her, it does not appear that any service had built or sustained sufficient trust with Rita to know whether she was fearful of the possible negative impact that outside intervention may have on her or her relationship with her son.

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[17] http://www.bailii.org/ew/cases/EWHC/Fam/2011/1022.html

**Learning Point:**
Domestic abuse is rarely a one-off incident and needs to be considered as a pattern of repeated and escalating abuse and coercive control. Agencies need to consider the known history of violence and abuse to assess threat and risk from domestic abuse effectively

BSAB Risk Enablement Guidance empowers practitioners to effectively and collectively assess and balance the safety and wellbeing of vulnerable adults experiencing domestic abuse but needs to be understood in the context of coercive control

Risk management requires practitioners to understand the resources and powers available to partner agencies and how these could be used to reduce the threat and risk from domestic abuse perpetrators.

**Recommendation 7: Managing Perpetrators of Domestic Abuse**
Birmingham Community Safety Partnership should further develop its 'Domestic Abuser Management Framework' and evidence how practitioners across agencies are familiar with the range of multi-agency powers to divert, manage, disrupt or prosecute domestic abuse perpetrators in MARAC and non-MARAC settings.

**Recommendation 8: Holding Perpetrators to Account**
In light of concerns regarding previous sentencing of the perpetrator, this report should be sent to the West Midlands Criminal Justice Board for their consideration.

**Recommendation 9: Risk Enablement and Coercive Control**
Birmingham's adult social work and commissioned domestic abuse agencies should provide assurance to Birmingham Community Safety Partnership of how Risk Enablement is being applied to effectively address the needs of adults experiencing domestic abuse.

## 7. CONCLUSION

253. This combined domestic homicide and safeguarding adult review has revealed that Rita was subject to a deliberate and repeated pattern of abuse from her son over the three years before her death at the age of 81. She incrementally revealed that she had been subjected to daily physical assaults and that she was "frightened to death" of her son who had experienced hallucinations and paranoia from his severe substance misuse.

254. Whilst responding to reports of physical assault, by and large, agencies did not appear to consider other indicators of potential domestic abuse and neglect such as: restricting Rita access to medical appointments; Rita's sudden weight loss; imprisonment in her room and economic abuse that she was experiencing. Neither did practitioners appear to consider that the perpetrator may have been manipulating his mother and themselves around the issue of her memory and apparent confusion.

255. Whilst it was evident that agencies failed to identify the indicators of ongoing domestic abuse, the circumstances were not easy for agencies to deal with thereafter. Rita commonly withdrew her allegations and rationalised her son's behaviour making it difficult to assess the risks that she faced. Likewise, the perpetrator largely avoided contact with agencies, did not engage with treatment for substance misuse and repeatedly breached his supervision requirements with probation. In the absence of him being registered with a GP, he was often invisible to services in between the reports of his assaults on his mother.

256. Nonetheless, there were missed opportunities to question the possibility of coercive control when physical violence brought mother and son into contact with agencies. At these times, greater professional curiosity could have explored whether Rita was acting of her own volition when minimising her experiences of abuse, withdrawing allegations and resisting support and whether she had capacity to make free and unfettered decisions.

257. There were a number of times during these five years when it would have been advisable to refer Rita to MARAC or convene a practitioner's meeting to consider, from a multi-agency perspective, how the threat and risk could be managed. For example, there appears to have been missed opportunities to offer the perpetrator alternative accommodation or, if un-cooperative, take civil action against him and exclude him from Rita's home. The police could have considered a Domestic Violence Protection Notice or, as this was unlikely to be gained, they could have given greater consideration to building a case around coercive control. Ultimately, all other routes exhausted, the local authority could have considered assessing the undue influence, that her coercive and controlling son appeared to be exerting over Rita's decision making, as an issue of mental capacity.

258. Overall, practitioners needed to apply a greater understanding of domestic abuse and coercive control to the circumstances that they were faced with and thereafter employ professional curiosity, pro-active engagement with Rita and multi-agency risk management to safeguard Rita effectively.

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## 9. OVERVIEW ACTION PLANS

Overview Report Recommendations – Driving Consistency in Practice Response to Domestic Abuse

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **1.** | Birmingham Community Safety Partnership should seek assurance that local agencies are capable of identifying the breadth and range of domestic abuse; of using the tools and pathways to respond; have sufficient supervision and escalation procedures to be able to respond effectively to domestic abuse. | Local | 1.1 VAWCSG undertakes audit of compliance with West Midlands Domestic Violence and Abuse Standards | Violence Against Women and Children Steering Group supported by BCC Comm-issioning Centre for Excellence[18] | Self-assessment framework provided to agencies.<br><br>Returned by agencies.<br><br>Analysed and presented to Violence Against Women and Children Steering Group and shared with BSAB. | On-going | Increased identification of individuals experiencing domestic abuse.<br><br>Increased referrals to specialist domestic abuse services.<br><br>Increased referrals to MARAC.<br><br>Increased identification of individuals experiencing domestic abuse. | DA project Ongoing. |

[18] Birmingham City Council Commissioning Centre for Excellence provides the secretariat for Birmingham Violence Against Women and Children Steering Group

|  | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
|  |  | Local | 1.2 Annual Adult Safeguarding Assurance Statement provided by agencies for 2019 significantly questions agencies' response to domestic abuse. | BCSP | Annual assurance framework provided to agencies.<br><br>Returned by agencies.<br><br>Analysed and presented to BSAB Scrutiny.<br><br>Shared with Violence Against Women and Children Steering Group. |  | Earlier intervention resulting in reduced domestic abuse related serious harm.<br><br>Increased multi-agency strategy meetings.<br><br>Increased calls by professionals to Birmingham Domestic Abuse Helpline for help and advice. | Completed |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | Local | 1.3 Review the outcomes of commissioned multi-agency training. | BCSP | Analysed and presented to Violence Against Women and Children Steering Group and BSAB. | | | Completed |
| | | Local | 1.4 See also recommendation 7 below. | | | | | |

**Overview Report Recommendations – Domestic Abuse and Older Women**

| | Recommendation | Scope | Action to take | **Lead** | **Key milestones achieved in enacting recommendation** | **Target Date** | **Impact Monitoring** | **Completion/ RAG/ Outcome** |
|---|---|---|---|---|---|---|---|---|
| **2.** | Birmingham Community Safety Partnership should work with specialist domestic abuse services to develop the evidence base and share best practice in working with older women who may be subject to domestic abuse. | Local | 2.1 BCSP supports Birmingham and Solihull Women's Aid in the evaluation of their Older Women's Domestic Abuse Service. | BCSP | Evaluation commissioned and undertaken.<br><br>Evidence-based best practice in working with older women affected by domestic abuse established. | Ongoing | BSWA services showing increase in engagement with older women. Good practice established and training provided internally and for partner agencies. | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | Local | 2.2 Best practice guidance developed. | Violence Against Women and Children Steering Group supported by BCC Comm-issioning Centre for Excellence | Local guidance developed drawing from both evidence base and research base. Guidance promoted through local networks, training and supervision. | Ongoing | Evidence and research based best practice guidance drives improved responses to older women affected by domestic abuse.<br><br>Indicators for older women:<br>Increased number victims identified<br>Short-term: Increased number referred to MARAC<br>Medium-long term: reduced serious harm | Completed as per 2.1 with Multi- agency Present-ations held at the DA Shadow Board on a monthly basis. |

**Overview Report Recommendations – Economic Abuse**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **3.** | Birmingham City Council promotes the adoption of the Financial Abuse Codes of Conduct through its business districts, through the West Midlands Combined Authority and through the Greater Birmingham and Solihull Local Economic Partnership and promotes opportunities for multi-agency training on domestic abuse and coercive control amongst financial institutions in the city. | Local | 3.1 Promotes the adoption of the Financial Abuse codes of Conduct through its business districts, through the West Midlands combined Authority and through the Greater Birmingham and Solihull Local Economic Partnership. | B'ham City Council | Promotion<br><br>Adoption | Ongoing | Increased number of financial institutions making referrals to domestic abuse services and referrals to adult safeguarding and the police regarding domestic abuse. | Ongoing |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | Local | 3.2 Include local financial institutions in opportunities for multi-agency training on domestic abuse and coercive control. | BCSP and BSAB | Multi-agency training advertised with local financial institutions and financial forums.<br><br>Take-up of places on multi-agency domestic abuse training. | | | Learning event to be carried out on publication of report. |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | National | 3.3 Birmingham City Council liaises with Surviving Economic Abuse, WAFE and Safelives concerning their work with UK Finance and consider including within their Financial Abuse Codes of Conduct, guidance on making referrals to adult safeguarding where they have concerns that an individual with care and support needs is subject to abuse or neglect. | BCC Comm-issioning Centre for Excellence | Liaison<br><br>Adoption | | Financial Abuse Codes of Conduct expressly include guidance on when and how referrals should be made to adult safeguarding as well as the police when concerns for a victim's safety and well-being are concerned. | Ongoing |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **4.** | Birmingham City Council to share this report with UK Finance with a view to them considering adding to the Financial Abuse Codes of Conduct that any safeguarding concerns are reported to the local authority where an individual with care and support needs may be subject to abuse or neglect. This report to be shared with Surviving Economic Abuse, WAFE, Safe Lives and UK Finance who have been working with UK Finance in the development of the Codes of Conduct. | | | | | | | To be completed after publication. |

**Overview Report Recommendations – Think Family in the context of substance misuse and mental health**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **5.** | Agencies should provide assurance to the Community Safety Partnership about how their services have improved in addressing the risks to family members living with or caring for those with problematic mental or behavioural disorders and substance misuse. | Local | 5.1 Agencies negotiate with VAWCSG about how assurance can be provided. | Violence Against Women and Children Steering Group supported by BCC Comm-issioning Centre of Excellence | Indicators agreed.<br><br>Indicators monitored.<br><br>Indicators analysed and presented to Violence Against Women and Children Steering Group. | | Indicators about how Think Family improvements can be measured to be agreed but must include older women and caring responsibilities. | Completed |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | Local | 5.2 BSAB monitor how the 'Three Conversations Model' is being applied to social care approaches to working with older mothers experiencing domestic abuse. | BCSP | Indicators developed to include informed and effective assessment of risk; management of risk.<br><br>Methodology for assessing outcomes in respect of domestic abuse agreed. | | Indicators regarding improved engagement with older women experiencing domestic abuse leading to more informed assessment and management of risk and empowerment of individual at risk. | Ongoing |

**Overview Report Recommendations – Assertive Engagement with Alcohol Treatment**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **6.** | Birmingham City Council should consider whether there is sufficient capacity within commissioned services to assertively engage with change resistant drinkers where there are serious risks or vulnerabilities involved. | Local | 6.1 Review of levels if engagement of individuals with multiple needs. | BCC Comm-issioning Centre for Excellence | Review<br>Analysis | | | |
| | | Local | 6.2 Consideration of priorities and capacity to commission or extend contracts to enable assertive outreach. | BCC Comm-issioning Centre for Excellence | Prioritisation and budget decisions. | | | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion / RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | Local | 6.3 Promotion of ability of front-line workers to make professional referrals to CGL. | BCSP/CGL | Promotion activity undertaken | | Increased number of professional referrals to CGL.<br><br>Increased engagement with change resistant drinkers. | Ongoing |

**Overview Report Recommendations – Managing Perpetrators of Domestic Abuse**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **7.** | Birmingham Community Safety Partnership should further develop its 'Domestic Abuser Management Framework' and evidence how practitioners across agencies are familiar with the range of multi-agency powers to divert, manage, disrupt or prosecute domestic abuse perpetrators in MARAC and non-MARAC settings. | Local | 7.1 Develop 'Domestic Abuser Management Framework'. | Violence Against Women and Children Steering Group supported by BCC Comm-issioning Centre of Excellence | Liaison amongst agencies.<br><br>Pathways agreed.<br><br>Framework established and promoted.<br><br>Monitored by VAWCSG. | | Indicators to include: number of domestic abusers arrested, charged and sentenced for domestic abuse related crimes; number of Anti-Social Behaviour Injunctions taken; number of breaches of civil orders acted upon; number of evictions from social tenancies for domestic abuse perpetrators; multi-agency referrals to MARAC; reduction in serious harm. | Completed |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | Local | 7.2 Promote front-line service's awareness of the range of multi-agency powers to divert, manage, disrupt or prosecute domestic abuse perpetrators in MARAC and non-MARAC settings. | Violence Against Women and Children Steering Group supported by BCC Comm-issioning Centre of Excellence | Multi-Agency Training Information provided. Guidance provided. | | | Ongoing |

**Overview Report Recommendations – Holding Perpetrators to Account**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **8.** | In light of concerns regarding previous sentencing of the perpetrator, this report should be sent to the West Midlands Criminal Justice Board for their consideration. | Local | Share report with West Midlands Criminal Justice Board. | BCSP | Report shared. | | Informing future sentencing plans where domestic abuse is a feature. | To be Completed after publication. |

**Overview Report Recommendations – Risk Enablement and Coercive Control**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **9.** | Birmingham's adult social work and commissioned domestic abuse agencies should provide assurance to Birmingham Community Safety Partnership of how Risk Enablement is being applied to effectively address the needs of adults experiencing domestic abuse | Local | 9.1 Undertake annual adult safeguarding self-assessment on impact of Risk Enablement Guidance where domestic abuse and coercive control involved. | BCSP | Annual self-assessment. | | Indicators to include (proxy) indicators for DVA victim safety outcomes. | Ongoing |

## 10. INDIVIDUAL ACTION PLANS

**Individual Agency Recommendations – BIRMINGHAM CITY COUNCIL – SOCIAL CARE AND HEALTH**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **1.** | Social Workers needed greater insight into coercive control and how it operates in cases of domestic abuse. | Local | 1.1 Delivered learning package to all adult social work teams. | Social Care and Health | Social Workers will have insight into coercive control and how it operates in cases of domestic abuse.<br><br>Case file audit of adult safeguarding cases.<br><br>Case file audits will demonstrate appropriate actions taken; future Serious Incident reports will not feature a lack of consideration of past history. | October 2018 | i) The training was delivered to all adult social work teams by 10/2018.<br>ii) Random case file auditing of safeguarding cases took place each quarter until June 2018 and will recommence from 2$^{nd}$ quarter of 2019. | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | iii) Up until this point no audits had identified lack of appropriate actions relating to this learning point and no similar serious incidents had been identified by any other means of reporting. | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | 1.2 Adult Social Workers attend Adult Safeguarding Board sponsored events aimed at multi-agency partners – "Learning from domestic homicide reviews". | Social Care and Health | Social Workers will have insight into coercive control and how it operates in cases of domestic abuse.<br><br>Case file audit of adult safeguarding cases.<br><br>Case file audits will demonstrate appropriate actions taken; future Serious Incident reports will not feature a lack of consideration of past history. | April 2018 | i) Adults social workers are encouraged to attend these events as places become available, however the sessions are very popular and this has limited attendance<br>ii) Comment as at 1.ii and iii<br>iii) Comment as at 1.ii and iii. | |

**Individual Agency Recommendations – BIRMINGHAM CITY COUNCIL – SOCIAL CARE AND HEALTH**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **2.** | Social workers need greater insight into the need to consider more than one model of viewing citizen's decision-making in cases of domestic abuse, so that in addition to considering the principles of the Mental Capacity Act and Making Safeguarding Personal, the possibility of the exertion of undue influence is also a consideration. | Local | 1.1 Disseminated learning outcomes/lessons learned to adult social workers from this and other IMRs and serious incidents involving complex cases, to raise awareness and understanding of how domestic abuse/coercive control and the need for these to be considered alongside of the Mental Capacity Act when evaluating an adult's ability to make decisions. | Social Care and Health | Social workers have greater insight into the need to consider more than one model of viewing citizen's decision- making in cases of domestic abuse, so that in addition to considering the principles of the Mental Capacity Act and Making Safeguarding Personal, the possibility of the exertion of undue influence is also a consideration. | October 2018 | Learning was disseminated by October 2018. | |

**Individual Agency Recommendations – BIRMINGHAM CITY COUNCIL – SOCIAL CARE AND HEALTH**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | | | Case file audit of adult safeguarding cases.<br><br>Case file audits will demonstrate appropriate actions taken; future Serious Incident reports will not feature a lack of consideration of the possibility of the exertion of undue influence is also a consideration. | | Comments as at 1.ii) and iii).<br><br>Comments as at 1.ii) and iii). | |

**Individual Agency Recommendations – BIRMINGHAM CITY COUNCIL – SOCIAL CARE AND HEALTH**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **3.** | Social Workers need greater insight into the need to consider multi-agency decision-making in complex cases of high risk. | Local | 1.1 Adopted Birmingham Safeguarding Board's Multi-agency Risk Enablement Guidance. | Social Care and Health | Social Workers have access to practice guidance on supporting citizens manage risk in their lives.<br><br>Case file audit of adult safeguarding cases.<br><br>Case file audits will demonstrate appropriate actions taken; future Serious Incident reports will not feature a lack of consideration of the principles of the guidance, especially with regard to involving multi-agency partners in complex case decisions. | July 2018 | Guidance published and launched in July 2018.<br><br>Comments as at 1.ii) and iii).<br><br>Comments as at 1.ii) and iii). | |

**Individual Agency Recommendations – BIRMINGHAM CITY COUNCIL – SOCIAL CARE AND HEALTH**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | 1.2 Briefed all social work teams on the Birmingham Safeguarding Board's Multi-agency *Risk enablement guidance* and stress its emphasis to address situations whereby agreement about managing complex risk is not possible or is refused. | Social Care and Health | Social Workers have insight into the need to consider multi-agency decision making in complex cases of high risk.<br><br>Case file audit of adult safeguarding cases.<br>Case file audits will demonstrate appropriate actions taken; future Serious Incident reports will not feature a lack of consideration of the principles of the guidance, especially with regard to involving multi-agency partners in complex case decisions. | July 2018 | Completed<br><br>Comments as at 1.ii) and iii). | |

**Individual Agency Recommendations – BIRMINGHAM CITY COUNCIL – SOCIAL CARE AND HEALTH**

| | **Recommendation** | **Scope** | **Action to take** | **Lead** | **Key milestones achieved in enacting recommendation** | **Target Date** | **Impact Monitoring** | **Completion/ RAG/ Outcome** |
|---|---|---|---|---|---|---|---|---|
| **4.** | Social workers need greater insight into the function of DASH and MARAC and knowledge of when and how to follow this route. | Local | 1.1 Drafted and launched operational guidance: *Domestic Abuse, Coercive Control and Adults with Care and Support Needs Brief Operational Guidance, including working with MARAC.* | Social Care and Health | Social workers to have insight into the function of DASH and MARAC and knowledge of when and how to follow this route.<br><br>Case file audit of adult safeguarding cases.<br><br>Case file audits will demonstrate appropriate actions taken; future Serious Incident reports will not feature a lack of consideration of DASH and MARAC. | November 2017 | Completed<br><br>Comments as at 1.ii) and iii).<br><br>Comments as at 1.ii) and iii). | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | 1.2 Briefed all social work teams. | Social Care and Health | Social workers to have insight into the function of DASH and MARAC and knowledge of when and how to follow this route.<br><br>Case file audit of adult safeguarding cases.<br><br>Case file audits will demonstrate appropriate actions taken; future Serious Incident reports will not feature a lack of consideration DASH and MARAC. | October 2018 | Completed<br><br>Comments as at 1.ii) and iii).<br><br>Comments as at 1.ii) and iii). | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **5.** | Social Workers need greater insight into considering a Think Family approach in domestic abuse cases where both victim and perpetrator have care and support needs. | Local | 1.1 See action 1.1 for Rec. 1 above (issue addressed in same material). | Social Care and Health | Social Workers have insight into considering a Think Family approach in domestic abuse cases where both victim and perpetrator have care and support needs.<br><br>Case file audit of adult safeguarding cases. | October 2018 | Completed<br><br>Comments as at 1.ii). | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | | | Case file audit of adult safeguarding cases. Case file audits will demonstrate appropriate actions taken; future Serious Incident reports will not feature a lack of consideration of a Think Family approach in domestic abuse cases where both victim and perpetrator have care and support needs. | | Comments as at 1.ii). | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | 1.2 To specifically target AHMP practitioners to ensure the risk of focusing too narrowly on the statutory Mental Health Act assessment in their role is understood. | Social Care and Health | Social Workers have insight into considering a Think Family approach in domestic abuse cases where both victim and perpetrator have care and support needs.<br><br>Case file audit of adult safeguarding cases. | May 2019 | Date planned for October 2019. | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | | | Case file audits will demonstrate appropriate actions taken; future Serious Incident reports will not feature a lack of consideration of a Think Family approach in domestic abuse cases where both victim and perpetrator have care and support needs. | | Comments as at 1.ii) and iii). | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **6.** | ACAP (the Adult Social Care contact point) needed to ensure staff considered past case history before making case decisions in relation to adult safeguarding cases. | | 1.1 IMR Author to explain review findings to ACAP Manager; Manager to ensure practice point explained to staff. | Social Care and Health | Prior to deciding to take no action in adult safeguarding cases, ACAP staff will check past records for safeguarding history so that this informs decision process.<br><br>Case file audit of cases closed in ACAP. | October 2018 | Completed | |

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | | | Case file audits will demonstrate appropriate actions taken; future Serious Incident reports will not feature a lack of consideration of past history. | | Comments as at 1.ii) and iii). | |

**Individual Agency Recommendations – BIRMINGHAM & SOLIHULL CCG**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **1.** | Primary Care Medical Service to become an IRIS Practice. | Local | Primary Care Medical Service to become an IRIS Practice. | Practice Safe-guarding Lead | Iris is embedded and referrals are made to the Advocate Educator.<br><br>Dates are arranged for the IRIS training sessions.<br><br>Training is completed.<br><br>Monitoring of referrals made to Advocate Educator. | December 2018 | GP Practice has completed the IRIS Training in early May 2019 and have already submitted 8 referrals to the IRIS Team. This short-term referral rate to IRIS is positive in practitioner recognition and response to DV. There will be continued monitoring of sustained progress via the IRIS monitoring. | Completed August 2019 |

**Individual Agency Recommendations – BIRMINGHAM & SOLIHULL CCG**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **2.** | Primary Care Medical Service to revise their domestic abuse policy, to include direct questioning. | Local | Primary Care Medical Service to revise their domestic abuse policy, to include direct questioning. | Practice Safe-guarding Lead | Practitioners have a consistent approach to inform their practice in addressing domestic abuse.<br><br>Primary Care Medical Service inform BSol CCG of the progress of this policy.<br><br>Domestic Abuse Policy is in place at the Primary Care Medical Service. | January 2019 | There is a consistent approach to responding to domestic abuse within the Primary Care Medical Service. A Domestic Abuse policy is in place to adhere to. | Completed August 2019 |

**Individual Agency Recommendations – BIRMINGHAM & SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **1.** | To write, promote and implement a Domestic Abuse Good Practice Guide for staff embodying practical learning from DHRs generally and in relation to this DHR that it will provide guidance on coercive control and mental capacity; cross-generational abuse; multi-agency working; assessing and managing risk where previous history of abuse and in context of discharge planning; talking with potential victims on their own. | Local | 1.1 To implement a Domestic Abuse Good Practice Guide. | Named Nurse for Domestic Abuse with Clinical Service Managers from local areas | That all clinical staff have a practice resource available to support their clinical practice, namely a Domestic Violence and Abuse Safeguarding Good Practice Guide. This guide will contain information taken from previous DHR recommendations, from safeguarding training and Trust Safeguarding Policies – Domestic Abuse and Adults Safeguarding.<br><br>Domestic Abuse Audit. | January 2019 | This guide has been written and launched.<br><br>During routine advice calls staff are asked if they have used the practice guide and are signposted to it on the trust's webs page.<br><br>Safeguarding Facilitators are promoting and checking on use in local teams as a routine aspect of their contact with services.<br><br>Our annual audit is currently underway.<br><br>Updated – **31 July 2019.** | |

**Individual Agency Recommendations – BIRMINGHAM & SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | | | Strategic Safeguarding Committee.<br><br>Annual audit programme – Domestic Abuse Audit. | | | |

**Individual Agency Recommendations – BIRMINGHAM & SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **2.** | Staff should evidence their consideration of the increased risk posed to family members where domestic abuse, substance misuse and mental health are seen together particularly when discharge planning. | Local | 2.1 Staff's consideration of Think Family Risk Assessment should clearly be documented in the appropriate section of electronic records when risks related to dual diagnosis and domestic abuse are evident. | Clinical Managers and CPA Lead | All staff can evidence thorough risk assessment of both service users and their family members and carers with regard to the risks associated with dual diagnosis and domestic abuse. This assessment will inform ongoing decision-making – such as discharge planning.<br><br>Care Programme Approach Record Quality Audits. | This is an expected standard operating procedure. | This is an ongoing standard – so effectively may never be marked as "complete".<br><br>However, there is an audit being conducted currently and CPA audit is standard operating procedure.<br><br>The organisation's dual diagnosis policy is out for consultation following a review.<br><br>Update – **31 July 2019.** | |

**Individual Agency Recommendations – BIRMINGHAM & SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | This would include a formulation of single agency and/or multi-agency decision-making rationale and contingency planning. | | Bespoke Safeguarding Audits.<br><br>Annual audit of CPA.<br><br>Assurance audits relating to safeguarding standards. | | | |

**Individual Agency Recommendations – SWM CRC**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **1.** | To strengthen Case Managers' practice in responding to domestic abuse. | | 1.1 Targeted local team activity to seek assurance and/or improvement of Local CRC risk management response for the following: | Local Senior Manager for CRC | That practitioner responses to domestic abuse are strengthened through effective recording, information sharing and assessment.<br><br>That these concerns become part of future monitoring arrangements. | 31/12/19 | Improved focus on risk management responses ensuring that:<br>1. All relevant DA and CP risk cases are discussed in supervision. This is now happening routinely and all practitioners in Birmingham have pre-arranged supervision as a minimum six weekly. | |

**Individual Agency Recommendations – SWM CRC**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | 2. All risk flags are being routinely reviewed by practitioners. Current 64% completed of our 27274 active risk registers, up from 20%, with a trajectory to achieve minimum of 90% by year end. | |

**Individual Agency Recommendations – SWM CRC**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | 1. To ensure that all cases have correct alert flags (e.g. domestic abuse and safeguarding adults) applied to aid identification.<br><br>2. Exchange of risk information with other agencies (in this case, Police and Electronic Monitoring Services is evidenced). | | 1. Use of Management information (MI) data to show number of "alert" flags reviewed in the period and number of recorded Police domestic abuse checks. | | Data shows no outstanding alerts, these are now reviewed every day as part of the performance management framework and overseen by managers. | |

**Individual Agency Recommendations – SWM CRC**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | 3. Exchange of risk information with other agencies (in this case, Police and Electronic Monitoring Services) is evidenced.<br><br>4. Assessments are completed in all cases, where information is available and respond explicitly to domestic abuse where known. | | Success measures will form part of the CRC's Quality Management Framework. | | Set up improved risk information sharing processes in relation to police Domestic Abuse concerns and EMS. Training for all practitioners has reiterated what is required. Also, monitoring of the quality of practice through monthly audits of cases for all practitioners is now embedded in Birmingham, with feedback through supervision and Performance Improvement Plans put in place where required. | |

**Individual Agency Recommendations – SWM CRC**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | | | These issues are measured by MI (e.g. Case Management Dashboard and Quality Audits) and by quality measures with individual performance framework (PMF).<br><br>An assurance statement from local team manager against actions. | | Our Board level scorecard report also now demonstrates risk register completion rates, and this is showing a month on month improved trajectory for 2019.<br><br>All managers held to account every month for delivering their teams' quality audits. These are demonstrating overall improvements but some way to go to consistently achieve required quality of practice for every case. | |

**Individual Agency Recommendations – SWM CRC**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | 1.2 To re-issue the Risk of Harm Go to Guide. Local Team Manager to discuss expectations around domestic abuse routinely in supervision with Case Managers. | Local Team Manager | To ensure Case Managers' clarity and develop practices around domestic abuse and adult safeguarding.<br><br>Local manager to advise local Regional Manager that action has been completed.<br><br>Improved identification of domestic abuse and adult safeguarding risk factors in case management and improved response from risk management. | 20 August 2018 | Every Case Essentials and the Service User Journey have been produced to simplify and clarify expectations for all practitioners in relation to required practice around domestic abuse and safeguarding.<br><br>Every Practitioner in Birmingham has completed a training workshop for Domestic Abuse and Safeguarding during May, June and July 2019. | |

**Individual Agency Recommendations – SWM CRC**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | Monthly Case audit system now in place to identify and address deficits in practice and share good practice. | |

**Individual Agency Recommendations – SWM CRC**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| **2.** | Adult Safeguarding | | 2.1 To review individual and team adult safeguarding practices and referral thresholds. | Local Team Manager | That all team members have clarity on when an adult safeguarding referral is required and how to do it.<br><br>By Local Team Manager and auditing arrangements.<br><br>Improved understanding of adult safeguarding in domestic abuse settings particularly child on parent situations. | 31/12/19 | All team managers have delivered this to their teams, including confirmation of local procedures, thresholds and practice as per the BSAB website.<br><br>Monthly case audit system now in place to review and improve practice where required. | |

**Individual Agency Recommendations – SWM CRC**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Improved use of adult safeguarding referrals routes in domestic abuse cases including economic abuse. | | Two recent cases that have been escalated to the Regional Manager have demonstrated improved knowledge by practitioners of child on parent (in one case older relative) abuse and improved multi-agency working.<br><br>Acknowledge we can still do more, and a specific Adult Safeguarding training package is currently being finalised for delivery across RRP to all case managers. | | |

**Individual Agency Recommendations – SWM CRC**

| | Recommendation | Scope | Action to take | Lead | Key milestones achieved in enacting recommendation | Target Date | Impact Monitoring | Completion/ RAG/ Outcome |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | Improvements in the practice of the case manager responsible for this case is being overseen closely in line with the RRP policy. | |

| Individual Agency Recommendations – SWM CRC | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Recommendation** | **Scope** | **Action to take** | **Lead** | **Key milestones achieved in enacting recommendation** | **Target Date** | **Impact Monitoring** | **Completion/ RAG/ Outcome** |
| **3.** | Enforcement | | To ensure that all community cases are enforced in accordance with timescales and include:<br>• the timely completion of good quality breach reports that make recommendations that reflect accurately issues of domestic abuse and safeguarding | Local Team Manager | That the Case Manager can evidence effective enforcement activity according to timescales and quality breach reports in relation to domestic abuse and adult safeguarding cases. | 31/12/19 | We have improved our performance in Birmingham significantly and are now held to account by our HMPPS Contract Managers around a number of additional Enforcement measures. Specific improvements have resulted from a revised practice where every case that has two or more acceptable absences has to be discussed and a management oversight record placed on file. | |

| Individual Agency Recommendations – SWM CRC | | | | | | | | |
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| | **Recommendation** | **Scope** | **Action to take** | **Lead** | **Key milestones achieved in enacting recommendation** | **Target Date** | **Impact Monitoring** | **Completion/ RAG/ Outcome** |
| | | | • Include the nature of that threat and actions required through breach action to manage those risks | | Local manager to dip sample 10 of the Case Managers' cases relating to domestic abuse, where enforcement has been undertaken to:<br>• Review timeliness<br>• Review quality of breach reports<br>• Ensure clear recommendations have been made that support management of domestic abuse and safeguarding. | | Timely enforcement rates have also improved and are achieving the required targets, as measured through our contractual Service Level Agreements.<br><br>The manager is audit sampling cases and has so far completed 12. These are showing mixed levels of practice improvement and remedial actions have been required to bring to the required standard. | |

| Individual Agency Recommendations – SWM CRC | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Recommendation** | **Scope** | **Action to take** | **Lead** | **Key milestones achieved in enacting recommendation** | **Target Date** | **Impact Monitoring** | **Completion/ RAG/ Outcome** |
| | | | | | Feedback to regional manager that activity has been undertaken and outcomes including any further actions should they be required. | | Regional Manager and Team Manager discuss progress regularly as part of formal supervision process. | |