Plymouth Community Safety Partnership

Victim A

Year of Death 2017

Author: Paul Northcott

Date the review report was completed: 5th February 2019

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Preface

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

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

I would like to thank the panel and those that provided chronologies and Individual Management Reviews for their time and cooperation.

1.0 Introduction

1.1 This is the report of a Domestic Homicide Review (DHR) undertaken by Plymouth Community Safety Partnership (Safer Plymouth) and examines agency responses and support given to Adult A, prior to her death.

1.2 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed as a result of domestic abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.3 This report will consider the contact and involvement that agencies had with Adult A between the dates of 1st January 2005 and 23rd October 2017. The reason for choosing these dates is that they provide a comprehensive overview of the deterioration of Adult B's mental and physical state and his risk of violence. By doing this the content of the report covers the relationship that Adult B had with his wife, Adult D and their children. Whilst the panel were conscious that they didn't want to lose the emphasis on Adult A's life the detail provided in Adult B's background provides a unique insight as to his state of mind prior to the death of his mother.

1.4 Many of the lessons learnt and the subsequent recommendations also relate to the period that agencies interacted with Adult B, Adult D and their children. These were included as one of the purposes of the DHR is to improve interagency working and to protect potential victims and their families in the future.

1.5 By taking a holistic approach the review has sought to identify appropriate solutions to make the future safer. This report also summarises the circumstances that led to the review being undertaken in this case.

1.6 Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias, and any other bias toward any one agency or individual involved. Those leading the review have sought the views of family members and friends and have made every attempt to manage the process with compassion and sensitivity.

2.0 Summary

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

2.2 On a Sunday in October 2017 Adult A went to see her son at his home address. She had intended to visit Adult C after she had seen her son.

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

2.4 Adult A's family raised concerns that her death was not from natural causes, and that they believed that Adult B was responsible. Police conducted further enquiries and a forensic post mortem was conducted. As a result of this examination the pathologist concluded that there was no obvious medical reason that would account for Adult A's collapse. The provisional cause of death was listed as;

- Hypoxic ischemic brain injury.
- Out of hospital cardiac arrest.
- Compression of the neck.

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

2.6 Following the Police investigation Adult B was charged with the murder of his mother and he was remanded into custody. Whilst on remand in prison Adult B took his own life.

3.0 Timescales

3.1 Plymouth Community Safety Partnership (Safer Plymouth) commissioned this Domestic Homicide Review on the 3rd January 2018. The review adhered to the processes detailed in the Home Office Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016).

3.2 The decision to commission a review was taken by the Chair of Safer Plymouth and this was made within one month of the homicide of Adult A coming to their attention. The Home Office was informed of this decision on the 11th January 2018.

3.3 This review commenced on 11th January 2018. The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within six months of the decision made to proceed with the

review. For this reason an initial timetable was drawn up to ensure that agencies complied with this request;

05.01.18 Letter to all agencies informing them of DHR.
05.01.18 Letter sent to agencies to secure records.
09.03.18 IMR Authors to return report with chronology.
20.04.18 DHR Panel to meet to quality assure version 1 reports, IMR writers to be invited to meeting. Overview author and panel to ask questions and if necessary task Independent Management Review (IMR) writers to research additional information and make appropriate revisions to reports.
04.05.18 Final IMR reports to be submitted to panel (these reports must have been signed off by senior officer within relevant agencies).
11.05.18 All reports (including integrated chronology) to be submitted to independent author to compile overview report
15.06.18 Overview author to send draft Overview report to Panel
29.06.18 Panel to meet with independent author to discuss content of overview report
20.07.18 Independent author to make final changes to overview report and formally submit to Home Office. Panel to draw up an action plan to implement recommendations and monitor progress accordingly.

3.4 The Independent chair was appointed on 11th January 2018 and the first panel meeting was held on the 9th February 2018. During this meeting, the draft terms of reference were discussed.

3.5 The family of Adult A were contacted and invited to actively contribute to the review.

3.6 The Chair met with the family on five occasions. Contact outside of these occasions was maintained at their request through email.

3.7 Whilst the panel met on four occasions contact was made with panel members on a regular basis to clarify issues and matters of accuracy about their agencies involvement with the family.

3.8 The review concluded on 31st January 2019. The delay in reporting within the six month period specified in the national guidance occurred due to capacity issues within children's social services and primary care (GP) in the completion of their IMR's and reports. Safer Plymouth was kept updated regarding the progress of the review throughout the process.

3.9 The family were provided with a copy of the draft report on the 25th January 2019 to enable them to contribute further to its contents.

4.0 Confidentiality

4.1 The findings of this review are confidential. The Information obtained as part of the review process has only been made available to participating professionals, and their line managers. The family of Adult A were provided with a copy of the report prior to submission to the Home Office and were also advised about confidentiality.

4.2 Before the report is published Safer Plymouth will circulate the final version to all members of the review panel, the Chief Executives of their agencies, and the family members. Safer Plymouth will ensure that family members are involved in agreeing the publication date of the report.

4.3 The content of the overview report has been anonymised to protect the identity of the victim, perpetrator, relevant family members and all others involved in this review. The pseudonym/s were discussed with and agreed with the family. The pseudonyms are as follows;

Family composition and pseudonyms used.

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

5.0 Methodology

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

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

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

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

The purpose of the review was therefore set to;

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

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

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

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

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

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

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

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

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

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

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

individuals concerned.

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

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

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

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

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

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

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

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

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

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

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

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

14. Consideration of any equality and diversity issues that appear pertinent to Adult A, the perpetrator or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race,

religion and belief, sex and sexual orientation.

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

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

5.4 The methods for conducting DHR's are prescribed by the Home Office guidelines[1].

5.5 Following the decision to undertake the DHR Safer Plymouth arranged for all relevant agencies to check their records about any interaction that they had with Adult A and Adult B and their family.

5.6 Where it was established that there had been contact the Partnership ensured that all agencies promptly secured all relevant documents and those who could make an appropriate contribution were invited to become panel members. Agencies that were deemed to have relevant contact were then asked to provide an IMR, and a chronology detailing the specific nature of that contact.

5.7 The aim of the IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could or should be made to agency policies and practice. Where changes were required then each IMR also identified how those changes would be implemented.

5.8 Each agency's IMR covered details of their interaction with Adult A and Adult B (including his immediate family), and whether they had followed internal procedures. Where appropriate the report writers made recommendations relevant to their own agencies. Participating agencies were advised to ensure that actions were taken to address lessons learnt as early as possible. As part of this process IMR authors, where appropriate, interviewed the relevant staff from their agencies.

5.9 The findings from the IMR reports were endorsed and quality assured by senior officers within the respective organisations who commissioned the report and who are responsible for ensuring that the recommendations within the IMR's are acted upon.

5.10 On request from the Independent Chair some authors provided additional information to clarify issues raised individually and collectively within the IMR's. Contact was made direct with those agencies outside of the formal panel meetings. This additional information included recent DHR's and Safer Plymouth's 'Best Practice Guidance'[2].

5.11 In addition to the IMR's the Independent Chair received copies of certain statements made to the Police in order to ensure that the review report was comprehensive and balanced.

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[1] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Home Office: Dec 2016

[2] Safer Plymouth (2016/17) Best Practice Guidance on Identifying and Responding to Domestic Abuse and Honour Based Violence'.

5.12 Health services involved as part of the IMR process reviewed their own agency's records in relation to the contact that they had with Adult B. This research was undertaken in the public interest as it was felt that the information contained within them could provide invaluable information with regards to whether there was significant history or whether there were issues with regard to agency communication and information sharing.

5.13 The Independent Chair also met Adult A's family and spoke to her best friend. Additional meetings were also held with Adult D and Adult B's pastor. Telephone interviews were conducted with two of Adult B's friends. Two additional members of Adult B's family members were contacted but they choose not to take part in the review.

5.14 The following agencies supplied IMR's;

- Devon and Cornwall Police.
- Plymouth Access to Housing (PATH).
- Livewell Southwest.
- NHSE.
- Plymouth City Council – Community Connections.
- Children and Young Persons and Families Service (CYPS).
- Education.
- University Hospitals Plymouth NHS Trust.

Due to capacity issues the GP practices involved with Adult A and Adult B were unable to complete IMR's. This was raised with NHSE and in order to ascertain the required information specific questions were sent to the relevant GP's and a written summary was returned. NHSE did provide an independent GP to review the prescription regime in relation to Adult B.

5.15 Expert advice in relation to domestic abuse was provided by the Plymouth Domestic Abuse Service (PDAS) representative on the panel. The PDAS representative is a qualified IDVA (Independent Domestic Abuse Adviser) and has seven years' experience within the organisation as a service manager. She was able to provide considerable experience, challenge and expertise to inform those sat on the panel.

6.0 Involvement of family, friends, neighbours and the wider community

6.1 Family members of Adult A and Adult B were invited to contribute to the review and were each sent or given a leaflet prepared by the Home Office about the DHR process. The family were also provided with the Advocacy After Fatal Domestic Abuse Leaflet and signposted to support services. Initial contact was made through a letter, and where appropriate contact was also made via the police. Three family members chose to take up this invitation and were spoken too by the Chair and the Community Connections Technical Lead. The initial meeting with the family took place on Friday 16th February 2018.

6.2 During the review the Chair and the Community Connections Technical Lead maintained an on-going dialogue with the family. Frequency and methods of contact were agreed at the initial meeting. Adult A's immediate family were invited to meet the Panel but declined to do so. The family did however want a full understanding of the events that led up to the death of Adult A and felt strongly that all of the detail should be fully recorded in this report.

6.3 In view of the fact that neither Adults A or Adult B were in full time work during the time covered by the terms of reference no work colleagues were seen as part of this review.

6.4 The terms of reference were shared with those members of family who were seen by the chair of the DHR to assist with the scope of the review. All of those family members were encouraged to review the terms of reference and make changes. No additional changes were made.

6.5 The perpetrator's step mother (and through her it had been hoped to establish contact with Adult B's natural father) was contacted, initially by telephone and then via email, by the Independent Chair and ask to take part in the review. They decided not to take any further part in the review.

6.6 Contact was also made by the Independent Chair with a close friend of Adult A and two friends of Adult B all of whom were able to provide invaluable information for use by the panel.

6.7 The pastor of the church that Adult B attended, together with his wife, were also spoken to as part of the review process.

6.8 On the 25th January 2019 the family were given a draft copy of the review report. The family were left in private to review the report and given sufficient time (five days) to read it before a further meeting was held with them to discuss the content.

7.0 Contributors to the Review

7.1 The contributors to the DHR were;

- Devon and Cornwall Police – IMR.
- PATH – IMR.
- Livewell Southwest - IMR.
- Children Young People and Family Services - IMR.
- National Health Service England (NHSE) – IMR.
- Plymouth City Council – Community Connections - IMR.
- Education – IMR.
- University Hospitals Plymouth NHS Trust - IMR.
- PDAS- IMR.
- Adult B's GP- Letter of response.
- Family members - Information.

- Adult B's Pastor- Information.
- Friends of Adult A and Adult B.

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

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

8.0 The Review Panel Members

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

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

8.2 The Community Connections Technical Lead for Safer Plymouth was given delegated authority to make decisions on behalf of Plymouth City Council and provided the Chair of the Safer Plymouth Board with regular updates setting out progress of the review against the timescale that was set for it.

8.3 Responsibilities directly relating to the commissioning body, namely any changes to the terms of reference and the agreement and implementation of an action plan to take forward the recommendations in this report, are the collective responsibility of Safer Plymouth.

9.0 Author of the Overview Report

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

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

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

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

10.0 Parallel Reviews

10.1 At inquest HM Coroner recorded that Adult A had been "unlawfully killed" by Adult B.

10.2 Livewell Southwest completed a Serious Incident Requiring Investigation review in relation to that organisations contact with Adult B and his family and this was considered as part of the DHR process.

11.0 Equality and Diversity

11.1 The review adheres to the Equality Act 2010 and all nine protected characteristics[3] were considered by the panel as part of the terms of reference and throughout the review process.

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

[3] Age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation.

11.3 Adult A had two children and Adult B had five children. Two of these children were from a previous relationship and three from his relationship with Adult D. Adult A was fully committed to her family and this meant that she felt a duty to protect her son and try and address his welfare needs no matter what impact it was having on her own life.

11.4 Adult B was violent towards Adult A on the day of her death. The panel did however acknowledge that as a female Adult A and Adult D were statistically at a significantly higher risk of experiencing domestic abuse and specifically domestic homicide. Evidence[4] has shown that domestic abuse is a gendered crime and whilst females can be perpetrators of domestic abuse they are in the minority. Statistically, women are more likely to be victims of domestic abuse. In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years experienced domestic abuse in the last year, of which 1.6 million were women and 786,000 were men (Office for National Statistics, 20179:2).

11.5 Adult B's mental health was declining and this fact was known widely to his family and friends and the panel therefore considered questions of vulnerability in this context. Adult B was receiving personal independence payments (PIP).

11.6 Adult B would not have been considered vulnerable according to organisational criteria based on national guidelines[5].

11.7 Adult B was known to hold strong religious beliefs and was a member of the Anglican Church. The combination of his religious beliefs and the deterioration in his mental health impacted on his decision making and behaviour. His physical health conditions may have also increased perceptions of his vulnerability to those that came into contact with him and obscured the risk factors that he posed. This will be explored further in section 16.0.

11.8 Adult D is from the Philippines and from the account provided by her it was apparent that her strong cultural and religious beliefs were factors that prevented her from leaving Adult B once his behaviour, and their relationship, had started to deteriorate. There has been nothing identified to suggest that she or her family were prevented from accessing services due to language or cultural differences.

11.9 Where this family had contact with services, their background and personal needs were recognised and recorded in records by professionals. There has been nothing found during this review that would indicate that they felt that they were treated with discrimination, although they were concerned about the levels of service provision available to treat and support those with mental health issues.

[4] Musimbe-Rix, S (2020)

[5] The Care Act 2014. Definition of vulnerable adult - Vulnerable adult is someone who 'No Secrets' says 'is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him- or herself, and or unable to protect him- or herself against significant harm or exploitation'

12.0 Dissemination

12.1 Following approval from by the Home Office the final report will be disseminated to the following organisations;

- Family members
- Safer Plymouth
- PATH
- Livewell Southwest
- Devon and Cornwall Police
- Children Young People and Families Services
- Plymouth Domestic Abuse Services
- University Hospitals Plymouth NHS Trust
- NHSE
- Education
- Plymouth City Council (PCC) Early years

12.2 In accordance with Home Office guidance all agencies and the family of Adult A and Adult B are aware that the final overview report will be published. IMR reports will not be made publicly available. Although key issues have been shared with specific organisations the overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.3 The family of Adult A will be provided with the final version of the overview report prior to publication.

13.0 Background Information (The Facts)

13.1 Adult A lived on her own. She lived in a two bedroomed semi-detached house on a housing estate in Plymouth and had been resident at the house for a number of years.

13.2 At the time of the incident Adult B lived alone in a flat in a multi occupancy dwelling. He had been at the flat for only a few weeks. One Sunday afternoon in October 2017 Adult A went to Adult B's home address. This visit was planned as Adult A would regularly visit her son and take him food and ensure that his welfare needs were being met.

13.3 Later that same day Adult B rang the emergency services stating that his mother had collapsed and that he had commenced CPR.

13.4 Adult B later described (to Adult C's husband) how Adult A had sat on his bed and that she had stated that she was not feeling well. He stated that she then fell onto the floor and then onto her back. Adult B stated that her dentures slipped and were causing her breathing difficulties. He had then tried to commence CPR. During the 999 call Adult B had stated that his mother 'was sat on the bed, turned blue and fell off on to the floor'. CPR instructions were given to the Adult B over the phone by the call taker prior to the ambulance crew attending. The crew stated that 'poor CPR' had been delivered by the son.

13.5 Adult C had made arrangements for her husband to collect Adult A from Adult B's home address on that same Sunday. That afternoon Adult C's husband tried to ring Adult A on her mobile telephone but there was no reply. Shortly after this Adult C's husband received a phone call from Adult B stating that Adult A had fallen onto the floor and was not breathing. Adult C and her husband travelled to the address and on arriving an ambulance was in attendance and treating her mother.

13.6 Adult A was subsequently taken to hospital and despite the treatment that she received she later died from the injuries that she had sustained.

13.7 Following the incident, the family discussed concerns about the circumstances in which Adult A had died and the injuries that she had sustained to her face and neck. As a result of these conversations the family later informed the Police that they had concerns that Adult B was not telling the truth.

13.8 A forensic post mortem showed that Adult A had died from unnatural causes and Adult B was arrested on suspicion of murder.

13.9 Adult B was later charged with the murder of Adult A. Adult B appeared before Plymouth Magistrates Court where he was remanded in custody and transferred to a prison.

13.10 Whilst on remand Adult B took his own life.

14.0 Chronology

14.1 The detailed chronology below has been included for the benefit of Adult A's family who had raised a number of relevant questions which they wanted answering. The family also wanted to have a full insight in relation to the history leading up to Adult A's death as they felt that they were largely unsighted about the detail. A summary of the relevant events can be found at paragraph 15.0

14.2 The chronology includes details of incidents that have been recorded by agencies involving Adult B and Adult D. Whilst the terms of reference and IMR's covered the period between 1st January 2005 and 23rd October 2017 this

chronology starts in 2006 as this was when relevant agency contact occurred from. The reason for including this history is that it documents agency interaction with Adult B, and clearly evidences his declining mental health and his propensity to commit abuse.

22.02.2006 Adult B and Adult D had a verbal argument and this had escalated and the Police were called.
The initial risk assessment by the attending officer was graded as 'standard' but then raised by the domestic violence (DV) risk assessor to high. This was the first risk assessment which was graded as high and this was due to the fact that this was the second recorded incident in 12 months. There had been two previous non-crime domestic incidents recorded by the Police where Adult B and Adult D had been involved in verbal arguments. The first recorded argument occurred in 2005. All appropriate referrals were made. The incident was not referred to a Multi-Agency Risk Assessment Conference (MARAC) as this was not established within the Force area until February 2007.
June 2008 Following a request from Adult D a designated safeguarding lead (DSL) from Education attended the home address of the family. During the visit Adult D stated that she was struggling to cope with the children as Adult B was suffering from depression. Adult D informed the DSL that Adult B's GP was aware and that he had an appointment with Harbour[6]. Adult B was hoping to attend Broadreach[7] to help him with his addiction to prescription tablets.
26· 08.2010 Adult B was seen by a consultant psychiatrist and was diagnosed with chronic fatigue syndrome, generalised anxiety disorder and benzodiazepine dependence.
13.09.2011 Adult B was diagnosed with benzodiazepine dependence.
It was recorded that Adult B had Cognitive Behaviour Therapy in the past which is used for the treatment of anxiety, depression and psychosis.
16.09.2015 Adult B pushed Child B2 out of stationary car causing an injury to their head.
This is the first report to an agency that violence was being used by Adult B. When a joint visit was conducted Child B2 stated that Adult B had previously hit him with a toilet plunger. Child B2 stated that he had been hit on many occasions, although when asked to clarify this he could not be specific. On this occasion Adult D stated that she was able to protect Child B2. When Child B2 was asked whether they would be scared about going home they stated, 'don't know a bit'. There is also an indication that the family had stated that they were struggling to cope. A strategy discussion and a visit took place. The voice of child was recorded. This was the first recorded incident where it was disclosed that Adult B had leukaemia. This condition had been diagnosed in 2001 and was being successfully treated.
16.09.2015 Adult D and Child B2 attended a meeting at the child's school concerning

[6] Harbour – Drug and Alcohol Treatment Service.
[7] Broadreach is a registered charity, offering treatment and support services for men and women whose lives have been adversely affected by addiction.

non-attendance. During this meeting Child B2 stated that he was afraid of Adult B because he was 'hitting him hard' on a frequent basis. He stated that he was 'scared of him'. Adult D left the meeting so that Child B2 could talk freely. Child B2 then stated that Adult B hit him with a plunger and a belt and that it happened at least once a week. Child B2 stated that Adult B had caused injuries which had prevented him from attending college.
DSL made a report to children's social care. A single assessment[8] was completed and Child B2 stated that they felt happy and safe at home.
06.11.2015 DSL contacted Children's Social Services as they were concerned that Child B2 had not been contacted about the incident that occurred on the 16.09.2015. Social Care confirmed that they had visited the home address the previous week and their assessment concluded 'that there were no safeguarding concerns'. The DSL asked the social worker whether they had spoken to Child B2's General Practitioner (GP) due to the allegations made regarding physical assault. The social worker advised that they hadn't done this but reassured the DSL that the case would not be closed until this had been completed.
01.01.2016 Report to Police by Adult D stating that following an argument over one of their children having access to a mobile phone Adult B had taken hold of Adult D's upper arms and kicked her bottom.
Adult B was interviewed and cautioned (in accordance with Adult D's wishes) after he admitted the offence of common assault. This was the first reported incident of violence involving Adult D. Adult B had no previous recorded convictions. During his detention Adult B was subjected to a risk assessment when he was processed in the custody centre. He disclosed that he had leukaemia and a mental health problem which included panic attacks (a side effect of his Myalgic Encephalomyelitis (ME)). He saw a health care professional and was also subjected to a pre-release risk plan which identified no issues. The schools' were informed of this incident through the dissemination of a Child at Risk Alert (CARA).
10.05.2016 Adult B contacted his GP regarding his anxiety state. The notes state that Adult B felt that he was 'sinking into depression'. Agreement was reached for him to start venlafaxine.
13.05.2016 Adult D called Adult B's GP to report that he had 'massively increased consumption of diazepam', and that he was not rationing it and was showing 'all the signs of dependency'. His GP suggested that he would contact the Harbour Centre and that future script requests shouldn't come from Adult B. The notes state that Adult D would supervise him**.**
26.08.2016 Adult B was seen by his GP due to ongoing dizziness after he had stopped his diazepam. He was awaiting a scan and records state that there was 'no alcohol' (suggesting that he was not drinking alcohol at that time).
September 2016 Adult B stopped going to church.
16.09.2016 Adult B contacted his GP surgery as he was tired and couldn't sleep. Amitriptyline was prescribed.
03.10.2016 Adult B attended his GP's surgery with chronic fatigue syndrome. He was described as having some anxiety, under financial stress and aching all over. Adult B's

[8] The Single Assessment is a detailed assessment to determine whether the child is 'in need', requires a protection plan or requires immediate protection and the nature of any services required.

Gabapentin dosage increased. A 'not fit for work note' was issued.
08.11.2016 Adult B spoke to his GP and stated that his Chronic Fatigue syndrome (CFS) was getting worse and that there was marked fatigue. He stated that he was sleeping poorly. He further stated that he was anxious and low as Adult D was leaving him. Gabapentin was prescribed. Referred for ME[9] support group (*which he never attended*).
15.11.2016 Adult B contacted his GP stating that he had ongoing aching, fatigue, restless sleep and low mood. The notes record that the stress of Adult D leaving has 'clearly exasperated the situation'.
17.11.2016 Adult D attended a police station to report abuse which she had been suffering over the past sixteen years. During the completion of the Domestic Abuse, Stalking and Harassment and Honour Based Violence risk assessment (DASH) Adult D stated that approximately ten years ago Adult B held a knife to her face, dragged her by the hair across the floor and punched her in the face causing injury.
Adult D stated that she had concerns about Adult B's mental state and his paranoia. She stated that she was not scared of Adult B and that she knew what a 'healthy' home environment was. She stated that she had voiced her concerns about his mental health to his GP although the review has been unable to confirm this specific report. Safeguarding advice was provided.
18.11.2016 Adult D attended the police station to report ongoing domestic abuse issues that she had been experiencing over the past sixteen years. She stated that Adult B's behaviour was getting worse and that he was controlling and paranoid. Adult D believed that he had undiagnosed mental health problems and stated that he drank to excess and over medicated on diazepam. Adult D stated that Adult B believed that she was seeing another person and that he was constantly wanting to know where she was and who she was with.
This incident was graded as 'standard' and VIST's were completed for the children. The report states that Adult D wanted additional assistance from other agencies as she didn't know what to do as his behaviour was getting worse. The report also states that Adult D was at the end of her tether. Safeguarding advice was provided, and a referral made to PDAS. The report states that she was going to speak to Adult B's GP. Adult B's GP, whilst not being able to provide specifics, stated that he did speak to Adult D on numerous occasions about Adult B.
18.11.2016 Adult B spoke to his GP. His GP described how he sounded like his normal self and was 'definitely not delusional or mentally certifiable'. Adult B was worried that Adult D was 'flying off the handle'. The GP suggested Relate[10] to help with their relationship problems. Adult B admitted to drinking two glasses of port a day.
21.11.2016 Adult D spoke to Adult B's GP in a distressed and agitated state to report that Adult B continued to drink, and that he felt deluded as 'evidenced by his desire to question and repeat his scans. The GP recorded that he felt that this behaviour was more a sign of Adult B's 'hope for a definitive different diagnosis and possible cure as he can see what his ME is doing to his relationship and his life in general'. The GP offered support and suggested counselling which he states did not go down well.
22.11.2016 Children's Social Services received a referral from the Police in relation to the reports by Adult D regarding domestic abuse.

[9] Myalgic Encephalomyelitis
[10] Relate- Marriage and relationship guidance and counselling services.

A single assessment was completed with the outcome of a children in need plan[11] to prevent the children witnessing further domestic abuse. The plan stated that Adult D was going to seek support from PDAS and Adult B was going to see his GP about his mental health and substance/alcohol misuse issues.
28.11.2016 Adult B was spoken to by his GP. The notes state that he had chronic fatigue syndrome with exhaustion and lack of sleep. Adult B was also experiencing panic attacks. His Gabapentin was reduced and pregabalin and alzain prescribed. A not fit for work note was issued.
07.12.2016 Adult B called his GP surgery with anxiety. He stated that his wife was leaving him and that he was not sleeping. Adult B requested diazepam which was refused due to him previously being addicted to it. The GP recorded that it was 'urgent to contact options for counselling'.
Adult B's GP has stated that all appropriate referrals were made. There has been nothing found in records that would contradict this.
12.12.2016 Strategy Meeting held. Adult B advised to move out of his home address pending assessment.
Children's Social Care have stated that their staff cannot direct an adult to leave a property and can only ask parents to make the right decisions for their children. On the 08/12/16, when a social worker requested that he left the property friends of the family were present and they agreed to remain with Adult D. Adult D had, according to records, stated that she was happy with this arrangement.
14.12.2016 Non-crime domestic incident reported by Adult D to the Police. The report stated that she had sought legal advice and would remove the children if there were further incidents. The report stated that on 02/12/2016 Adult D had received a text from Adult B stating that he would throw a brick in her face.
The report details that there were concerns about Adult D not supporting Police and it was noted that she had previously failed to engage with PDAS. Adult B had moved temporarily out of the home address to live at his mother's address, but he had broken an informal agreement and had returned.
22.12.2016 Adult B contacted his GP surgery stating that he had ongoing problems relating to child protection. Adult B requested more diazepam. A long discussion took place regarding the GP's reluctance to prescribe more due to Adult B's previous addiction. The notes state that that there were clear instructions to prescribe no more tablets from Adult B's own GP.
Despite there being clear instructions, the GP prescribed seven tablets of 5mg diazepam. This will be discussed in the analysis section of this report.
04.01.2017 Adult B rang his GP stating that there was a hearing that was due to take place regarding his custody battle, that he was suffering from financial stress and that the impending divorce was exasperating his stress. After discussion the GP agreed to a short term prescription of zopiclone but no more diazepam.
06.01.2017 Strategy meeting held. Representatives of all three of the children's schools attended. The decision was that the case did not reach threshold for child protection. Working agreement put into place for Adult B to engage with a CYPS support worker to work on anger management and to recognise the impact of his behaviour on his

[11] Child in need plan (CIN) - A CIN Plan is drawn up following a Single Assessment which identifies the child as having complex needs and where a coordinated response is needed in order that the child's needs can be met.

children. A DSL stated that they did not agree that the case did not meet threshold and asked for her objections to be minuted. The DSL felt that Adult D and all of the children were vulnerable. A social worker advised that Adult B would not be allowed to see his children until he had a mental health assessment.
The strategy notes were checked by Children's Services and they recorded that the decision was that the basic needs of the children were being met and parents were engaging with a working agreement. On review the threshold was deemed to be appropriate. A CiN[12] plan was required to provide support to family. This was completed. Records state that social worker would speak to GP to request information with regards Adult B's medication and whether there was a need for a mental health assessment. The working agreement was to stipulate that Adult B should engage with a family support worker on anger management.
13.02.2017 Adult B rang his GP stating that he was not sleeping and had ongoing anxiety.
14.02.2017 Adult B contacted his GP stating that he was under huge stress due to Adult D returning to her home country with their children. He stated that he was devastated and denied drinking alcohol.
23.02.2017 Adult B's GP was contacted by social services who informed him that Adult B was allegedly buying diazepam online. The social worker informed the GP that Adult B was being abusive to Adult D. The GP stated that this did surprise him due to him being physically weak and 'by temperament too non-aggressive to make this credible'. The GP recalled that Adult D was strong and the adult figure in the relationship and stated that he could not envisage Adult B abusing her. The notes record that Adult D used to control Adult B's alcohol and medication by confiscating them and the GP concluded that 'I wonder how much this is a statement made with the custody battle in mind'.
The Review has established that the GP had received relevant safeguarding training and they were fully aware of how manipulative Adult B could be. They were also aware of Adult B's dependency of drugs and the lengths that he would go to in order to get them. The GP described how Adult B was a man who was committed to his faith and his family and that they had based their observations on how Adult B had presented to them and their knowledge of the family. In relation to the statement that they made they stated that; ' I am also well aware from years of experience as a Doctor that allegations of abuse or violence are often made in an attempt to sway the decision about any custody battle and therefore these reports always need to be corroborated by first-hand information. I am very reluctant to take at face value any allegations of abuse under these circumstances and never found any corroborative evidence to support this.' All professionals should have been open minded in their approach to safeguarding and should be able to recognise that domestic abuse can be perpetrated by anyone at any time in a relationship. The statement made by the GP appears to demonstrate a lack of understanding in relation to domestic abuse and demonstrates a poor knowledge or expected recording practices.
24.02.2017 Adult B contacted his GP to state that he had ongoing stress and was not sleeping. He stated that Adult D was going back to her home country. Repeat medication was prescribed (Atarax and Hydroxyzine).
27.02.2017 Adult B contacted his GP and stated that he had ongoing stress but that social workers have accepted that he is not violent or a risk to his children. He also

[12] Child in Need Plan

stated that he was living in the family home again. The report states that he had come into the practice with his mother and that he was becoming increasingly reclusive.
03.03.2017 Adult B called his doctor and stated that he was 'emotionally in pieces' as Adult D intended to take his children to her home country. He was described as agitated and paralysed with emotion. On this occasion he was begging with the doctor for a few diazepam tablets to help him through the situation. His GP discussed his extreme reluctance to give him the tablets and then prescribed him ten tablets on the understanding that they were his 'crisis supply' and would not be repeated.
The prescribing of drugs to Adult B has been reviewed by an independent and suitably qualified Health professional who concluded that it met the standards expected and was in line with National guidance.
08/03/2017 Children's Social Services received a referral from a paediatrician after Child B2 admitted that they were not eating and they presented as being withdrawn and that there were continued reports of domestic abuse occurring in the household. Section 47[13] enquiries initiated. Adult B agreed that he would move out of the family home and stated that he would stay with his mother.
13.03.2017 Adult B moved in with Adult A.
14.03.2017 Adult B spoke to a GP on the telephone. The entry states that there were mental health concerns. Adult B had described his situation and the fact that his family could not cope with his mental health. He stated that he had locked himself in his bedroom for five days and could not stop shaking. He stated that he didn't have his medication as he was asked to move out of the family home. His GP discussed their reluctance to prescribe medications which he had previously seemed dependent upon. Notes state that GP wasn't able to have a sensible conversation with Adult B as the conversation seemed to revolve around an overarching demand for anxiolytics. GP notes state that he was being supported by Adult A and that Adult B had been to the Community Mental Health Team. Adult B was requesting zopiclone and lorazepam which he had in 2008. He was offered a review appointment on 15.03.2017. Adult B was described as being in a 'unilateral drug seeking state'.
The GP considered the risks and signposted Adult B to additional support. He prescribed Lorazepam and zopiclone (There are reflections in the notes made by the GP that this course of action seemed reasonable if he [Adult B] genuinely didn't have any drugs with him due to his sudden departure from the family home).
15.03.2017 Adult B seen by a GP. At that time, he was accompanied by Adult A. The entry states that he had no suicidal thoughts and that he had been to the CMHT. He was described as shaking. He was given advice and referred to mental health.
17.03.2017 Adult B attended Emergency Department (ED) with Adult A following the advice given by his GP. The notes stated that his GP had tried to manage him through primary care but that he had become increasingly preoccupied with benzodiazepine and hypnogogic medication and that he had been misusing them. The entry provides the detail regarding his breakup and the fact that his family could not cope with his mental state. Adult B described how he found it difficult to sleep and this was confirmed by Adult A. Adult B described that when he woke up he felt 'full of anxiety, fear and torment'. When asleep he stated that he had nightmares that he would die. Adult B stated that he

[13] A Section 47 enquiry means that Children's Social Care must carry out an investigation when they have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'

was starting to have thoughts that he would rather die and that he could not continue to live like that. Records state that there was however 'no planning, or intent, when having suicidal thoughts'. Adult A was described as being tearful and unable to cope with his behaviours at home and that she was struggling to know how to help him. She also reported that she was unable to sleep adequately and that she was physically and mentally exhausted. The report details that there was no violence or aggression and that there were no safeguarding issues. The record of assessment concludes; • That Adult B has no plan or intent to act on any suicidal thoughts and he has not done anything to harm himself before. • That there is no evidence of harm to others… Current home environment is safe but is breaking down….. Adult B requested to go to the Glenborne[14] Unit so that 'people could see how much he is suffering over several days'.
Adult B was not deemed to require treatment and declared medically fit for discharge. He was referred to psychiatric liaison for an assessment prior to discharge. Adult B was referred for an urgent outpatient appointment with the Community Mental Health Trust (CMHT) but there was an acceptance that this could take six to eight weeks. The fact that Adult A was being supported by the CMHT was felt to be an appropriate level of support. Adult A was offered advice and signposted to her GP. A referral to the Home Treatment Team (HTT) was considered but it was felt that Adult B was 'not in immediate risk of harm to himself or others'.
17.3.2017 Referral received by Livewell Southwest from Adult B's GP. The GP stated "I would appreciate if you could kindly review this 53-year-old gentleman with chronic anxiety disorder and benzodiazepines dependence, who presented with recent worsening following eviction from his family home by his wife as she could not cope with his mental health problems. [Adult B] currently lives with his 75-year-old mother and feels that his body is locked within himself, cannot stop shaking and has ill-sustained suicidal thoughts, though there is no active plan at the moment. He denies any overdosing or suicidal attempts in the past."
20.03.2017 Adult B called his GP surgery asking for more Zopiclone. He stated that he had left his medication at his estranged wife's house. He was advised to get the medication back.
20.03.2017 Adult B called his GP surgery and spoke to another doctor. He stated that he was living at his mother's house and was not able to get Zopiclone. The GP had been told the same story previously (17.03.2017) and refused to issue another prescription.
22.03.2017 Call received by Police from Adult B raising concerns about Adult A. He reported that she had been feeling low since the death of her husband three years ago. Adult A then mentioned that fact that following the failure of his marriage he had moved in with her and whilst this was meant to be a short-term arrangement this had lapsed into nine days. He stated that this had become too much for Adult A and that afternoon she felt like taking a lot of tablets and killing herself. The matter was resolved as Adult A

[14] Mental Health Unit in Plymouth.

stated that she no longer felt suicidal.
This matter was referred to Adult A's GP.
22.03.2017 Adult B contacted his GP surgery by phone. He stated that he was feeling stressed due to his separation from his wife and family. He stated that he wanted to continue with his Zopiclone. The GP strongly warned him of the dangers of addiction. Adult B accepted this but asked for a repeat prescription due to his current circumstances. The GP agreed to a one-off script. The GP surgery reviewed Adult B's scripts. They were concerned regarding the amount of Zopiclone that had been taken by him in March. This matter was referred to his own GP for review on his return from leave. There was a strong recommendation that there was a graded reduction programme.
24.03.2017 Adult A attended her GP surgery following the referral by the Police Central Safeguarding Team. It was recorded that she was in a low mood and not sleeping. She stated that Adult B had been living with her and that she found this a 'bit upsetting'.
27.03.2017 Adult B called his GP and stated that he was still stressed and not sleeping. He stated that social services were involved with his family. It was recorded that he had clearly become addicted to zopiclone and the GP records that no further scripts should be given. It is also recorded that he has follow up appointments with psychiatrists. Adult B was given the details of the Harbour Centre for support. A temporary prescription was given until he had a psychiatric review. Adult B explained that he was currently living with his mum and that she would 'kick him out' if he didn't sleep. The doctor didn't accept this and offered to talk to her.
28.03.2017 Adult B sent a text to his pastor stating' I am at my mums, she is full of demons, swearing, calling me a loser, please pray'.
29.03.2017 Adult B contacted his GP via the telephone stating that he was 'in torment', was agitated, not sleeping, weak and stressed.
30.03.2017 Adult B contacted his GP by telephone stating that he was feeling 'wobbly' and 'tingly in the head'. He stated that he had difficulty walking and maintaining his weight. He was given advice regarding his script.
31.03.2017 Adult B contacted his GP via the telephone. He stated that he was very stressed and low as Adult A was fed up with him and 'wanted to kick him out of the house'. He felt light headed and dizzy and he was not eating or drinking. He was also struggling to concentrate.
04.04.2017 Adult B attended his GP Surgery stating that he was stressed and could not sleep due to a social services meeting which was being held the following day. Hydroxyzine was suggested.
05.04.2017 Initial child protection conference. Child B2/B3 made subject of a social services child protection plan with a category of emotional abuse.
Records state that Adult D was working with PDAS and seeking a restraining order.
07-10.04.2017 *Several t*elephone calls made by a social worker to Adult B who stated that he wasn't well enough to meet and that he would advise them about his address when a future meeting was arranged.
17.04.2017 Adult B had been offered an outpatient clinical assessment appointment but he did not attend. A letter was sent to him offering him another date (22.06.2017).
21.04.2017 Core meeting[15] was held. Concerns were raised about Adult B's mental health. Adult B did not attend.

[15] A Core Group is the group of family members and professionals who meet regularly if a Child Protection Conference makes a child the subject of a Child Protection Plan.

25.04.2017 Adult B sent a text to his pastor stating, 'also have leukaemia and not taken daily tablets for 6 weeks due to not being able to eat, very ill, please pray'.
27.04.2017 Adult B sent a text to his pastor stating 'you thought that it was a mental problem with me when it was not, my body is shutting down and close to death because of brain damage that has been the problem since the start. Mercy will you pray'.
01.05.2017 Adult B sent a text to his pastor stating' been given 2 days to live'.
02.05.2017 Non-crime domestic reported by Adult D to the police concerning a report of harassment. Adult D stated that she didn't want further contact with Adult B due to him suffering from 'some sort of mental breakdown'. Both Adult D and Adult B given advice.
05.05.2017 Adult B attended his GP surgery together with Adult A and his stepmother. At that time, he presented with anxiety and stated that his stress was increasing. He was also suffering from an irritable bladder. Adult A stated that she was not happy to continue to accommodate him. Adult B was referred for CBT[16]. He had already been referred to the CMHT.
This was the last face to face consultation that Adult B had with his GP.
07.05.2017 Adult B sent a text from his mother's phone to his pastor stating '[Adult B] is near death please pray'.
14.05.2017 Non-crime domestic reported by Adult D to the Police. Adult D stated that Adult B was exposing his children to psychological abuse as he was trying to maintain contact with them by stating that he was dying. This was despite a voluntary arrangement put into place to prevent Adult B from contacting his children. Adult D came home to find Adult B in their house. Adult B left once asked to do so.
Social Services advised Adult B not to have contact with his children. No formal plan had been put into place.
19.05.2017 Core Group meeting held. Adult B did not attend. It was noted at the meeting that Adult B was not engaging with the plan or support services.
08.06.2017 Adult B was seen by a consultant neuropsychologist. He stated that he believed that Adult B's problems were 'predominantly psychiatric' and that he seemed 'mentally unwell'. Adult B had stated that he believed that he was possessed by the devil. There was no indication of suicidal tendencies or ideation. The neuropsychologist acknowledged that there appears to be a lot of strain on Adult B's mother and in his opinion there was a risk to her in terms of coping with him. The neuropsychologist also stated that he thought that Adult B would benefit from a psychiatric assessment.
The term 'risk' was questioned by the panel and it was ascertained that this related to her mental and physical health due to the pressure of having Adult B living with her.
22.06.2017 Adult B was offered an urgent appointment for the 27.06.2017.
27.6.2017 Adult A was seen in out-patients clinic. He was accompanied by Adult A and his step mother. The doctor examining him concluded that **'**this 53 years old man has diagnoses of generalised anxiety disorder, chronic fatigue syndrome and benzodiazepine dependence in the past'. He went on to state that Adult B had stopped all of his medication three months previously and his mental health had deteriorated. The records state that he had been referred by his GP for assessment regarding his generalised anxiety disorder and weakness. They also stated that he had become over-religious and believed that he was possessed by evil spirits which made him sick and weak. The records also state that he claimed to have experienced God and the Holy

[16] Cognitive Behavioural Therapy.

Spirit entering his body. They stated that he felt very anxious, had panic attacks and that he remained largely housebound. The records further state that he appeared to have 'psychotic symptoms in addition to generalised anxiety disorder.'
A care plan was put into place for Adult B. Adult B agreed to take medication as prescribed. A request was made to South CMHT for assessment regarding allocation of a Community Social Worker (CSW) to support Adult B for exposure to work and to monitor his progress in the community. This person could also help him to attend psychological therapy. Adult B was also referred to a team psychologist. He was assessed as having no risk of taking their own life or self-harm behaviour.
03.07.2017 Adult B was discussed at a CMHT meeting and agreement was reached that he should be allocated a support worker.
06.07.2017 Report by Adult D to Police that Adult B had turned up at the family's home address unannounced and had attempted to gain access**.**
Police had considered harassment legislation but due to the contact that Adult D had initiated with Adult B a Police Information Notice (PIN)[17] could not be issued.
10.07.2017 Adult B's GP surgery declined to prescribe zopiclone due to concerns of addiction. Alternative medication was prescribed**.**
15.07.2017 Adult B sent a text to his pastor stating that his [wife] 'and the boys needs your help urgent as they are in a desperate place, I have acute leukaemia'.
18.07.2017 Adult B attended hospital feeling unwell and complaining of shortness of breath. He showed signs of dehydration.
27.07.2017 Adult B contacted social services requesting that a meeting which was due to be held on 27.07.2018 should be cancelled and that the social worker should contact his family to state that they had cancelled the meeting. Adult B advised that he needed to be truthful with his family.
27.07.2017 Adult B attended a meeting with children's social services together with Adult A. He stated that he had a hospital appointment regarding his mental health but that he wasn't attending appointments at Harbour and that he was drinking alcohol. Adult B stated that he was dying of leukaemia and could not see his children. He did not want to discuss the notes of the CP meeting or plans for the children. Adult B spoke to the social worker in private and stated that his family wanted to ruin Adult D, they hated her and that he did not want his family involved. Adult B was given advice regarding contact.
09.08.2017 Adult B cancelled his appointment with a psychiatrist as he stated he needed a home visit. He stated that he was not confident about leaving the home environment.
15.8.2017: A home visit was conducted by a senior mental health practitioner - Adult A and Adult B's step mother remained with them for the duration of the appointment.
During this visit advice and support was discussed with Adult B and he was signposted to services including CBT which would support Adult B in linking his thoughts, interpretations and perceptions with his behaviours to try to break some of the patterns of thinking and behaviour. Adult B also expressed interest in attending some groups in order to meet other people. The mental health worker agreed to discuss his case with the multi-disciplinary team meeting (MDT) to think about how South CMHT might support him, and then write to him to inform him of the outcome of their discussion.
15.08.2017 Adult B contacted social care and stated that he was receiving unwanted

[17] *Police information Notice – This was a notice served on offenders who were allegedly committing harassment offences. This notice warns the offender of the consequences of breaching certain conditions. The notice is no longer in use by Devon and Cornwall Police.*

calls from his father and stepmother. He stated that he had blocked the calls but that he was still receiving messages from other private numbers.
17.08.2017 MDT meeting held. Agreement was reached that Adult B required community support worker input.
Records state that Adult A had described her son as 'if he had gone back to being a little boy'.
20.08.2017 Report by Adult A that her son had poisoned her fish using bleach.
Police had attended the address to issue a PIN to Adult B in relation to his wife when this incident was disclosed by Adult A. Adult A stated that this was out of character. A DASH risk assessment was completed and graded as standard.
20.08.2017 Records show that Adult B had left Adult A's address and was sofa surfing with a friend where he stayed for one night.
21.08.2017 Adult D reported to police that Adult B had been contacting her via the telephone and visiting the marital home. Adult D made it clear that she did not want any further contact from Adult B. On the day of the report Adult B had climbed into the back garden of the home address via a neighbour's property. Adult B had left prior to police arrival.
The report states that Adult B's mental health was deteriorating and that he was suffering from anxiety and depression. Police attended Adult A's home address to speak to Adult B. Adult A spoke to the officers about her concerns about his mental health and the fact that they were struggling to get support due to the time that it took to get referrals and the fact that he would not engage. Despite no consent being given details were shared by the police with Adult B's GP which should be seen as good practice. DASH completed.
21.08.2017 Adult B reported as a high risk missing person. Adult A had received a text message from Adult B stating, 'I'm going to end my life as I have nothing to live for'. Adult A stated that her son had been taken to hospital by ambulance that morning for anxiety. Adult B was alleged to have pretended to drink bleach. Adult B had discharged himself from the hospital. Adult B later sent another text stating 'I know you won't care if I take my own life'. Adult A stated that he hadn't been out of the house in a year.
Officers searched Adult B's bedroom and stated that it was obvious that he wasn't taking his medication. Adult B slept at a friend's house. Housing records state that Adult B had fallen out with Adult A (it would appear this related to the incident involving her fish) and that she had stated that she no longer felt safe with him in her house.
21.08.2017 Adult B presented at hospital feeling unwell with mental illness. He was described as being a moderate risk of self-harm. He was diagnosed with suspected anxiety and referred to outpatient and a conversation took place with the duty psychiatric nurse. Records showed that he was open to community mental health services who would follow his case up. He was discharged.
Adult B was advised that he could contact his CMHT for support if he required it. No further input was deemed necessary from psychiatry liaison at the hospital at that time as Adult B was not presenting with a psychiatric emergency.
21.08.2017 Adult A called the duty CHMT. She stated that she had some concerns about Adult B's behaviour, and that last week he had killed her fish by putting bleach in the tank and that he had put it into his mouth. She explained that he had gone to the emergency department (ED) that morning but they had discharged him. The call taker explained that due to confidentiality, they were unable to share the outcome of previous

assessments. The call taker tried to call Adult B to get his permission but there was no answer. The call taker advised Adult A that if she had concerns that she should take Adult B back to ED.
On the records regarding the incident there was a note from the psychiatric liaison nurses' assessment that he wasn't telling them the same story as Adult A, hence the discharge.
22.08.2017 Adult A and Adult B's step mother attend a police station and spoke to a police enquiry officer about their concerns, Adult B's behaviour, and his use of medication. Assistance was given in relation to Adult B's accommodation.
The station enquiry officer gave suitable advice and provided assistance with finding accommodation. This should be seen as good practice.
22.08.2017 Adult B was contacted by a psychiatrist to follow up the call received from Adult A on the 21.08.2017.
During this call Adult B reported that following the visit to him last week, his mental health had deteriorated. He stated that he was unaware that his mother had called the CMHT and he denied the incident with the fish or that he had drunk bleach. He informed the psychiatrist that he felt that he needed to go to a psychiatric hospital and that he needed support to find somewhere to live. Adult B was signposted to a housing provider. The psychiatrist informed Adult B that they would seek further advice from South CMHT. A call and a referral were made to the insight team[18] that day.
22.08.2017 Adult D was sat in her dining room when she saw Adult B stood in the garden looking into the window.
Adult B was arrested interviewed and stated that he had leukaemia and that this was the reason that he wasn't allowed to see his children. The Crown Prosecution Service agreed to charge him with harassment and Adult B was released from police custody with specific bail conditions. A police officer spoke with social services stating that the children were victims of severe emotional abuse and that Adult B uses his illness as an excuse for his behaviour.
22.08.2017 PIN Notice issued to Adult B.
23.8.2017 Telephone call received by the duty CMHT from Adult B's step-mother. She wanted to discuss her concerns regarding his behaviour. She explained Adult A was distraught because Adult B had told her that he had poured bleach into the fish tank and killed all of the fish. Adult B's step-mother said Adult B had been texting his mother constantly pleading to be able to return to the house and also to suggest he would take his own life. The report stated that he mainly sends text messages in the evening. Adult B's step mother spoke of Adult A's worries and concerns and how frightened she was of "Adult B's behaviour" because the "fish tank incident is out of character". His step mother said that Adult A and Adult C had met with Adult B briefly as he continued to refuse to tell them where he was staying and he was asking for money. Adult B's step-mother informed the team that Adult A and Adult C were shocked by his current appearance (he was dishevelled and unkempt). Adult B and his sister had not seen each other for over 12 years. Adult A had spoken of her concerns about Adult B's appearance and wellbeing as well as being concerned over him having little money and no housing. Adult B's step-mother was very clear that Adult A did not wish for Adult B to return to living with her as she was frightened by his behaviour, so much so that she had family staying with her in case he came to the property. The police had also advised that Adult A was not left

[18] Insight team specialise in treatment of first episode psychosis.

alone.
Adult B's step-mother was given the details for Plymouth Access to Housing (PATH) as she was looking to find out where she could get advice and help in terms of housing. The review has been unable to ascertain who was staying at Adult A's house.
23.08.2017 Adult B was arrested interviewed and admitted the offence of harassment. He stated that he had leukaemia and that this was the reason that he could not see his children. He was charged and released with conditions not to contact Adult D or be within the vicinity of the home address.
Police spoke to social services and informed them that the children had been subjected to severe emotional abuse by their father and that they had stated that they were frequently scared of him. They also stated that they did not wish to see him.
***2*3.08.2017** Adult B was taken to the Salvation Army regrading temporary accommodation.
24.08.2017 CMHT informed of Adult B's arrest.
24.08.2017 Adult B signposted by the Salvation Army to Community Connections as they felt that they could not accommodate him due to him being vulnerable*.*
24.08.2017 Adult B spoke to his GP in relation to his chronic fatigue syndrome and ongoing exhaustion. Notes stated that he was gradually coming off his diazepam. Notes also state that he 'needs meds. 3 issued'.
It was not clear what medication was prescribed to Adult B on this occasion.
29.8.2017 Telephone call by CHMT to Adult B. No reply.
CHMT spoke to Adult A and Adult B's step mother. They updated CHMT about recent events.
25.08.2017 – 07.09.2017 Adult B housed in temporary accommodation as he was classified as homeless.
29.08.2017 Attempts made to contact Adult B by the CMHT. There was no reply. Adult A and Adult B's step mother were contacted and spoken too.
04.09.2017 Adult A, Adult B and his step mother attended a police station and spoke to a station enquiry officer. Advice was given regarding his impending court case.
18.09.2017 Adult B attended hospital. Adult B stated that two weeks previously he had consumed bleach and that he had seen his doctor as he was feeling unwell. He stated that he was diagnosed with suspected depression. Contact was made with a psychiatric nurse. Notes indicate that there was no physical evidence of harm from drinking the bleach. Notes state that there was an appointment with the Community Mental Health Team the following day. The doctor stated that they were happy that Adult B had mental capacity and as he had an appointment with an Insight Team the following day he did not require Psychiatric Liaison.
19.09.2017 Adult B attended court and was convicted of harassment. He received a conditional discharge for twelve months, fined and issued with a restraining order not to contact Adult D.
19.9.2017 The Insight team had a telephone call from Adult B. He said that he was feeling physically unwell which he attributed to his ongoing leukaemia treatment. He requested that the appointment was cancelled and rescheduled.
19.9.2017 Telephone call received by the Insight team from Adult A saying that she had ongoing concerns for Adult B's mental health. She also stated that she was aware that he had cancelled his appointment that day. Adult A felt that he could have attended that day and she believed that he was avoiding getting help.

26.9.2017 Adult B attended an assessment with the Insight team. At that time he was accompanied by his step mother. Adult B had tried to cancel previous appointments with the Insight Team citing poor physical health. The report update states; He appeared casually dressed and reasonably kempt. He suggested that he did not have any significant mental health concerns although he acknowledged that his mood was low and that he had been under a considerable amount of stress. Throughout the interview Adult B remained even in his tone, with reasonable eye contact and provided a confident and plausible account to recent and past events. Adult B outlined his personal history and described, what seemed to be a happy long-term relationship with his wife. Adult B acknowledged there had been some challenging times, such as when he was diagnosed with leukaemia. He described how his construction business had become very stressful to manage and that in 2011 he had been diagnosed with generalised anxiety and chronic fatigue syndrome. He stated that the relationship with his wife deteriorated significantly in the previous year resulting with him having to leave the marital home and limited contact with his children. Following this he attempted to live with his mum (Adult A) but this arrangement did not work out, culminating in Adult B seeking help from the city council. Adult B was now staying in temporary accommodation. Notes state that he was finding this period of his life very challenging and that he was seemingly unable to make plans for the future or tackle everyday tasks. The notes further state that Adult A and Adult B's step mum were concerned by some recent odd behaviour (which seemed linked to his brittle relationship with mum) and his inability to address pressing financial and domestic issues. His domestic arrangements/plans remained somewhat opaque and it was unclear whether Adult B harboured thoughts of re-establishing contact with his wife. When he left the marital home he had few possessions and was under the belief it was a temporary measure. It was clear at that time that Adult B was still finding it difficult to process this episode of his life. Adult B denied the existence of any psychotic symptoms. The assessment stated that there was no evidence of an emerging psychosis. It was clear that Adult B had faced some serious challenges in his life and is struggling to come to terms with the recent separation from his wife and denied access to his children. Undoubtedly these events have added to his overall anxiety and sense of hopelessness. Adult B was still trying to make sense of recent events and summon the motivation to address day to day tasks. The notes state that Adult B did show reasonable insight into his behaviour and that there was a sense of wellbeing which was indicated by his desire to continue to receive support from the CMHT. Adult B was receiving support from BCHA[19] staff. It was acknowledged that Adult A and Adult B's step mother were supportive and that there appeared to be regular communication between all three parties. Adult B was discussed by the MDT and they concluded that his case was not appropriate for the Insight Team. There was a recommendation for continued support through the CMHT.
The fact that Adult B was not referred to the insight team for additional support was reviewed within the Livewell Southwest IMR and this decision was felt to be proportionate and in line with Adult B's presentation. There is no information available that suggested that this decision as outside of policy or that there were deficiencies in practice.
02.10.2017 Adult D reported to police that Adult B had breached his restraining order by

[19] A charity that helps people take control of their lives.

calling her on her mobile. Adult D stated that she was anxious and that her husband was unstable. An appointment was made to see Adult D on the 5th October 2017.
Adult B's court appearance and the issue of the restraining order appear to have had no deterrent effect on Adult B or his behaviour.
08.09.2017 – 16.10.2017 Adult B placed into supported temporary accommodation.
16.10.2017 Adult D reported to police that Adult B had breached his restraining order. Adult B had followed his son after he had left school and he had later called his wife to ask why his son had run away from him.
The ViST states that Child B3 was extremely frightened by Adult B and that he appears unstable at present. A DASH was completed and graded as High Risk.
17.10.2017 Adult B was offered alternative temporary accommodation through PATH.
19.10.2017 Adult B arrested for breaching his restraining order and following interview he was released under further investigation.
Adult B made no comment in interview. The children were not covered in the wording of the restraining order and a decision was made that further evidence was required to prove the phone contact on the 2nd October 2017. Adult B was released under further investigation. A referral was made to MARAC.
October 2017 *Adult A pronounced dead*.
25.10.2017 Call received by PATH from a resident living at the same address as Adult B stating that Adult B was acting strangely, trying to enter other flats and that he had thrown bleach in another resident's food on the preceding Monday.
26.10.2017 PATH offer of temporary accommodation to Adult B withdrawn due to his behaviour.
27.10.2017 Adult B was subject of a Mental Health Assessment (MHA) at a Plymouth Police station: Adult B had been arrested for breach of court harassment order. At the time of arrest, he had been expressing "odd beliefs and ideas". In interview, Adult B reported that he was under stress following the breakdown of his marriage. He stated that he had difficulty in sleeping and switching off his mind. Adult B stated that he felt agitated and frustrated and that his mother passed away and that he had tried to resuscitate her. The professional attending stated that there was 'no evidence of clinical depression or elation' and that Adult B was not responding to external stimuli and there was no evidence of psychosis. At that time Adult B appeared to have good insight and full capacity. It was felt/recorded that Adult B posed no immediate risk to himself or others but "Risks are likely to increase in response to external stressors"
28.10.2017 Adult B breached his restraining order once more.
October 2017 Adult B arrested for the death of his mother.
October 2017 Adult B took his own life in his cell in Prison.

15.0 Overview

15.1 This overview will summarise what information was known to the agencies and professionals involved about the victim, the perpetrator and their family. It will also include any other relevant facts or information about the victim and perpetrator.

15.2 Adult A was a small framed petite lady who was fiercely independent and had lived at her home address for twenty-seven years. Adult A had lived alone following the death of her third husband which had occurred some five years prior to the incident. Adult A had two children during her first marriage, Adult B and Adult C.

15.3 Adult A was clearly dedicated to her family and they had become her priority, particularly after the death of her husband, whom she missed greatly. On a daily basis Adult A would contact her family either in person or on the telephone, and she was prepared to travel on public transport to see them. Her friends stated that she loved her family unconditionally and she was described by Adult C as 'a giver, not a taker'. People were constantly amazed at the amount of energy that Adult A had, and she was a person who was always on the go and helping other people. Adult A was described by those that knew her as fit, active and healthy (apart from a thyroid condition which she was taking medication for).

15.4 Adult A would often go out shopping and liked to garden. Since the death of her husband she didn't like to spend much time in her house, but she would always return home to look after her parrot. This parrot had been given to Adult A by her late husband so that it would keep her company.

15.5 Adult B was almost the opposite to his mother and over the years he found it difficult to cope with life. He has been described as a quiet unassuming character. Growing up Adult B was described as being 'bright' and competitive. He enjoyed football and fishing which were interests which he continued to follow in later life. Adult B had attended mainstream school and enjoyed his studies. Adult B later went to college to study as a quantity surveyor and received a higher national certificate on the completion of his course. He then went to work full time for a construction company. During his adult life he had worked for numerous construction companies.

15.6 Adult B had been a partner in a business with his natural father. This working relationship with his father reportedly broke down due to a number of issues including Adult B's mental health and resulted in him walking away from the business. Those that knew him described how he had become very bitter about this and how this had compounded his mental health problems. Adult B later became a partner in a decorating business, but again found it difficult to cope with the stress of work and had a second nervous breakdown in 2003/2004. Following this Adult B had become unemployed once more.

15.7 Adult B met his first wife at the age of twenty-five and had two boys from the relationship. Adult B and his wife split up after five years of marriage.

15.8 From an early age Adult B would constantly seek attention (particularly from his natural father) and when he didn't get it friends and family members described how he would become 'down' in his mood. Friends felt that this ideation for his father, and the fact that Adult B felt that his feelings were not reciprocated, was a significant trigger which impacted on his mental health. Adult B's GP has stated that from the interaction that he had with him it was apparent that Adult B wanted;

'*to emulate his father who was successful….and he wished always for his father's approval which was never forthcoming. He therefore felt that he was a chronic failure by virtue of his inability to support his family or to emulate his father's wishes for his life. I [the GP] believe this led to a chronic low self-esteem and a*

passive dependent negative personality, which was constantly looking for excuses to justify his failure in his father's eyes'.

15.9 A friend stated that they felt that Adult B's relationship with his natural parents was complicated in many respects and that on occasions Adult B would be caught between the two of them.

15.10 Adult C has described how she had a difficult relationship with her brother, and whilst she attempted to maintain contact with him this became increasingly difficult due to a disagreement between the two. Adult C stated that she felt that Adult B's mental health had started to deteriorate since 2007 onwards, and she felt that his religious beliefs had an adverse effect on him. As a result Adult B and his sister had become estranged.

15.11 As part of the review process the panel considered whether Adult B was exposed to domestic abuse during his childhood. There is nothing recorded in agency records or information gained from friends and relatives that would suggest that he was exposed to violence or abuse.

15.12 Adult B married his second wife in 1999 and even at that time Adult D described her husband as appearing depressed. She had initially put this down to the fact that he missed his children from his first marriage as they had moved away. It was at this time that he had been prescribed benzodiazepines to which he later became addicted. Adult B and Adult D had three children all of whom have been described as quiet, and unassuming. Those interviewed as part of the Education IMR described them as 'an ordinary family, quiet (but not unusually so) and polite'. There is evidence within the Education IMR that on occasions Adult B could come across as insincere when discussing his children and that he could be 'overly loving with [them] and [was often] plying them with gifts' (Adult D discussion with DSL 3 – Education IMR).

15.13 During the marriage between Adult B and Adult D they experienced a number of difficulties in the relationship which centered around Adult B's mental and physical health. Adult D was also a victim of domestic abuse. Adult D described how her marriage had quickly become loveless as a result of the behaviour of Adult B, and the fact that he had a number of extra marital affairs. Adult D further described how her husband was physically, emotionally and financially abusive and that she was trapped in the relationship due to her religious and cultural beliefs, and her sense of duty. Adult B had refused to divorce his wife. Throughout the difficult times in their relationship Adult D stated that she was constantly supported by Adult A.

15.14 In adulthood Adult B continually suffered from bouts of depression and was described by Adult D, family members, and friends as a very negative person.

15.15 In 2001 Adult B was diagnosed with leukemia which he said was a result of Adult D poisoning him. He was successfully treated for this condition but had also suffered from a nervous breakdown. During this time Adult B stayed in his house, bed ridden for about eighteen months. Although in remission he constantly

referred to his leukemia when he became low and on many occasions those that knew him described how he would use it as an excuse for his behaviour. In 2004 he was diagnosed with chronic fatigue syndrome and at that time it was also felt that he was suffering from 'significant chronic anxiety and depression[20]. At times Adult B also suffered from paranoia, and due to his declining mental and physical health he was unable to work, which in turn had led to his family falling into debt. In order to overcome this Adult B would take out large loans for his family to live on. Adult B was also known to be manipulative. He had made numerous threats to take his own life over the years, and these were generally made when he was unable to get his own way or the attention that he wanted.

15.16 During his periods of depression Adult B would rely heavily upon those around him, particularly Adult D and Adult A. He would become reclusive; fail to eat a healthy diet and he would not look after himself. Often he would fail to wash and those that knew him described how there would be a marked deterioration in his appearance. He would become obsessed about his physical and mental health and he would constantly call ambulances and visit his GP. On occasions he would make his family push him to appointments in a wheelchair as he was convinced that he was dying. Adult B would also insist on paying for scans at a private hospital in Plymouth as he wouldn't believe the diagnosis that was being given to him. He had also convinced himself that he had a brain tumor. Adult B often felt that others were ignoring his needs and was resentful of this. His friends and his family have described how Adult B constantly wanted others to do as he wished and was described as needing to be in control.

15.17 In order to treat the conditions that Adult B presented with he had been prescribed anti-depressants, valium and chemotherapy tablets. Adult B would often fail to take his medication and Adult A, Adult D and his pastor would often have to prompt him to do so. What is apparent is that Adult B had become addicted to diazepam and he would often try and obtain repeat prescriptions in order to feed his habit. This can be clearly seen in the chronology within the Health IMR and from information provided by his GP. Attempts were made as far back as 2006 to try and gradually wean him off of these prescribed drugs. There was also anecdotal evidence from Adult D and his friends to suggest that Adult B was buying diazepam over the internet.

15.18 As a result of Adult B's behaviour the family struggled financially, and this was confirmed by friends, family and was recorded in agency records (GP Notes dated 03.10.2016). Adult B was described by those that knew him as being very generous. These financial difficulties were compounded by the fact that Adult B found it impossible to work during the periods of his life when he suffered from anxiety, depression and CFS. His GP has recalled how, during these periods in his life, he would have to carry out home visits due to the symptoms that Adult B was suffering from. Adult D has described how she had to work in order to try and alleviate some of these difficulties and to support her husband.

[20] Account provided by Adult B's GP.

15.19 In 2005 and 2007 Adult B had further mental breakdowns and would isolate himself in his house. During that time Adult D described herself as 'more of a mother in the relationship than a wife'. During the times that he was housebound Adult A would constantly visit her son to attend to his needs and try to promote his recovery.

15.20 Adult B's health severely deteriorated in 2007. He refused to eat and drink and had started to become paranoid about his wife's movements. He would check her phone and demand to know where she had been. Adult B had also become increasingly insecure about his own well-being and would sleep with a rolling pin and medical book by the side of his bed.

15.21 During 2007 Adult B's level of violence also increased and Adult D has stated that on one occasion he had dragged her into their kitchen by her hair and put a butcher's knife to her throat threatening to kill her. Adult D stated that her husband would become physically abusive the more that he became depressed. Despite the close relationship that Adult D had with Adult A she never disclosed the level of abuse that she was suffering to her.

15.22 Adult D had reported that she had been the victim of abuse in the relationship with Adult B over a number of years. The first reported incident was in 1st January 2016. When speaking to a Domestic Abuse Officer (DAO) from the Police on the 17th November 2016 Adult D claimed that she had 'suffered emotional and physical abuse' for some ten years within the relationship.

15.23 Adult B and his wife regularly attended a church within the Plymouth area and both had strong religious beliefs. Family members described Adult B as being fanatical and that they believed that the church had a detrimental effect on him. Adult B first became involved in the church in 2008. His friends within the church, and his pastor, have described Adult B as an active member of the church and he would be a regular attendee at services and social activities. Adult B would also invite the congregation into his house for social and religious gatherings.

15.24 In 2009 Adult D reported to Child B2's school that she was struggling to cope with her children as her husband was having difficulty managing depression. Adult D stated that her husband would spend 'a lot of time doing nothing'. At that time Adult D told a DSL who was carrying out a home visit that her husband's GP was aware of his declining health and that Adult B was due to attend an appointment with Harbour. She also stated that Adult B was due to attend Broadreach to help him overcome his addiction to tablets.

15.25 Adult D has described how she had telephoned several agencies for help during the period of her husband's decline, including a local psychiatric unit and drugs and alcohol support services, (although the Review was unable to verify this). Adult D has also described how, in her opinion, the level of response from agencies was variable, although she could not give specific details.

15.26 Adult D has stated that she remained with Adult B due to her religious and cultural beliefs, and through a sense of duty. Adult D has also stated that she had never seen herself as a victim of abuse.

15.27 On a housing options casework form which Adult B had completed to determine his suitability for temporary accommodation he acknowledged that a member of the household had suffered 'domestic or other abuse, harassment or violence' stating that there had been 'lots of arguments in front of the children'. The document further records that the youngest child was 'poorly due to [the] situation'. There was no disclosure of violence at that time but the comment was never explored further (see paragraph 16.5.7).

15.28 In 2010 Adult D started to attend the church with her husband. The two of them also attended the social events arranged by the church. Both Adult B and Adult A were described by the pastor during that time as 'generous and hospitable'.

15.29 Adult B would like to talk about his Christian experiences and he would also like to discuss the power of demonic forces. Adult B often said that the spirit of hell and death was against him and his family. Adult B was described by those in the church as tending to concentrate on the negative side of life.

15.30 In 2014 Adult D approached the church for some marital guidance counselling as she had suspected Adult B was having affairs. As a result, both Adult B and Adult D would meet representatives from the church on a weekly basis in an attempt to overcome their difficulties. It was during these sessions that Adult D revealed that Adult B was controlling her financially. It was about that time that those in the church also saw a decline in Adult B's health. Adult B had stated to one of the members in the church that he had ME[21] and they had associated this with his deterioration in health.

15.31 Over time Adult B visited the church less frequently and although a group from the church would meet on a weekly basis at this home address he would not come downstairs to speak to them. On one occasion the pastor went to see him in his bedroom. Although Adult B stated that he was unwell the pastor stated that he looked healthy and he described him as being 'delusional' in thinking that he was ill.

15.32 In March 2016 his pastor described how Adult B deteriorated even further and that he was claiming that he felt worse than he had ever done before. Adult B stated he didn't want to leave the house and that he felt that he was going to die.

15.33 In October 2016 Adult B's pastor advised him that it may be better for him to find another church as he felt that any advice that he gave him only made him angry and resentful. His pastor also thought that Adult B was not as ill as he often claimed and that his problem was more mental than physical. The decision to ask Adult B to leave was not taken lightly and from the interview with the pastor it was

[21] Myalgic Encephalomyelitis

apparent that this weighed heavily on his conscience. Adult B had however become increasingly difficult to manage and the pastor felt threatened by his attitude and confrontational behaviour.

15.34 The last time that his pastor saw Adult B in person was in December 2016.

15.35 Adult B's behaviour had a huge effect on his children particularly Child B2 and Child B3 both of whom had prolonged periods of absence from school due to stomach complaints and the stress of the home environment. In 2017 Child B3 was hospitalised due to the stress of living at home with his father. Child B3 had refused to eat or drink and the paediatrician at that time refused to discharge him as long as his father remained at home. Adult B's children became the subject of a child protection plan.

15.36 Child B3 was assessed by a psychologist and they confirmed that their issues were psychological. In many ways their behaviour mirrored their fathers with a refusal to get out of bed, eat and a desire to withdraw themselves from the outside world. On the 4th April 2017 Adult D had stated to a Child B3's head of year that his hospitalisation was 'due to the trauma caused by [Adult B]. Child B3 had even considered taking their own life.

15.37 Despite all of the problems that Adult B suffered during this period in his life the love and devotion shown by Adult A was unwavering and unconditional. From the evidence provided by family and friends it is clear that Adult A would spend a lot of time visiting her son. Adult B was described as 'the apple of Adult A's eye'. Many thought that Adult A 'molly coddled' her son and both Adult D and Adult C have described how she would even personally groom him. Their relationship has been described as complex by another family member. Adult C described how their mother would shower attention upon him. Despite their relationship it was felt by one of Adult A's friends that Adult B did not completely confide in his mother and that there were certain aspects of his life that he deliberately kept from her.

15.38 Adult B's behaviour resulted in intervention by children's social services, in early 2017 and in March that same year and he was forced to leave the marital home. Family, friends and his GP felt that this event had a huge impact on Adult B. One friend recalled that it was about this time that Adult B would text him stating that he was dying and asking him to pray for him. On this occasion his friend felt that Adult B was trying to be manipulative and therefore he avoided contact with him.

15.39 Following the breakup of his marriage Adult B went to live with his mother in the March of 2017. This had a huge impact on Adult A, and according to family members affected her health and prevented her from doing the things that she loved. During that time his mother became increasingly concerned about his behaviour and his mental state. Adult A had tried to get help from services and was assisted in doing so by the step mother of Adult B. Adult A described to a friend how Adult B's behaviour had become increasingly erratic and how he would stare at her and that this unnerved her. She had also described how Adult B used to keep a knife under his pillow 'for the demon' and on occasions she would wake up and find him standing over her, staring at her (something that he had previously

done to his wife). Adult C described her mother as being frightened of Adult B. On one occasion Adult A had discovered that her fish had been poisoned by Adult B. Adult B had poured bleach into the fish tank and when confronted he stated that he had done as his mother had shouted at him. Adult A also suspected that he had also injured her parrot's wing.

15.40 After the incident with the fish a friend of Adult A's stated that she could not trust him anymore and that she was concerned about 'what he could do'.

15.41 Adult B would rely on his mother to meet his every need. Despite his dependence upon his mother Adult B would often treat her poorly and he could become verbally abusive.

15.42 In July 2017 Adult C's husband contacted Adult Social Care to try and get some additional care to support Adult A in looking after her son. He felt at that time that Adult B was suffering from mental health issues and that he was making it difficult for Adult A to live in her home. Adult C's husband stated that the advice that he was given at the time was to ask Adult B to leave the house and make himself homeless. Enquiries with adult social care have identified that this contact was not treated as a referral as Adult B did not meet the requirements of being a vulnerable adult.

15.43 Adult B had come to the attention of secondary mental health services in March 2017, following a referral by his GP for assessment of apparently worsening mood and 'exacerbation of his symptoms of anxiety'. This deterioration appeared to be as a result of social stressors; the break-up of his marriage, homelessness and financial difficulties.

15.44 Adult B was offered an outpatient appointment (OPA) at a Plymouth hospital in April 2017 but failed to attend. He was offered a further OPA in June 2017. Following his attendance at the OPA he was referred for further assessment in relation to community support and a psychology input. Following that assessment in July 2017, there were numerous contacts with Adult B and his family. There were further concerns expressed by them about his deteriorating mental health and the emergence of psychotic symptoms. Adult B was referred to the Insight team [22] for assessment around these psychotic symptoms. There was some difficulty with engagement, but he was finally assessed in September 2017. From the assessment there was no evidence of emerging psychosis.

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

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

15.46 In September 2017 a friend of Adult B received a phone call from him stating that he had been 'kicked out' of his mother's address and had nowhere to stay. Feeling sorry for Adult B his friend invited him to stay with him. When Adult B arrived at the address he was described as 'stinking' and he was very low in his mood.

15.47 In respect of housing, following him leaving Adult A's address, Adult B was referred to PATH and deemed a priority case following a homeless application to Community Connections. As a result of this application Adult B was housed within multi occupied accommodation in the Plymouth area. After Adult B had moved into temporary accommodation Adult A continued to provide him with all the care and support that he required. Adult A would visit him on a daily basis to take him food and clothing.

15.48 As Adult B's condition continued to deteriorate he was involved in numerous incidents of harassment involving his wife, and he also appeared to become more reliant upon the support from Adult A. Adult A had however become increasingly afraid of him and less tolerant. Adult A had subsequently turned to her first husband and his partner for support and advice. Adult B had become increasingly mistrusting of this relationship as the months progressed.

15.49 There was evidence of the growing tension between Adult A and Adult B in Health records. On the 26th September 2017 a mental health nurse had seen the two of them at an arranged appointment and recorded that Adult A would often be seen as critical of Adult B. This professional also recorded that Adult B had trouble accepting criticism.

15.50 Adult B had become increasingly paranoid. One family member recalled that once he had moved into temporary accommodation Adult B had become obsessed that Adult A had made him some sandwiches which tasted 'funny' and that he believed that his mother had put something in them to make him ill. Adult B would frequently mention this and that upset Adult A. Often the two of them would argue about this alleged incident.

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

15.52 Adult B's behaviour was also becoming more unpredictable in relation to those outside of the family setting. Throughout 2017 his pastor and friends had received text messages from Adult B of a religious nature which appeared to show a steady decline in Adult B's mental state.

15.53 Following investigations into the breaches of the injunction Adult B was arrested and processed by the police. Adult B had breached the injunction on three occasions and he was subsequently charged to appear before Plymouth

magistrate's court. Adult C's husband has recalled that Adult B was worried about his court case, believing that he was going to be sent to prison.

15.54 During this time family members had sought help from agencies and professionals including Adult B's GP and a neuropsychologist. Adult B was a regular user of health services and in particular his GP practice. He was seen by a number of GP's within the practice during the time period deemed relevant to this review. He also paid for numerous scans privately as he was convinced that he had a brain tumour.

15.55 Adult B was prescribed numerous drugs including diazepam to assist with the management of his medical conditions and his family have described how his dependency on this particular drug impacted upon his quality of life and meant that he struggled to cope with daily life.

15.56 Community health records document the concerns that professionals had in relation to Adult B's addiction to prescribed drugs. As a result of his addiction and his manipulative behaviour Adult B would attempt to circumvent the system and would constantly contact his GP surgery in order to obtain more drugs on prescription. The GP's in the practice were aware of this and his own GP stated that he was actively trying to manage the situation. GP's did however continue to prescribe certain drugs to alleviate the symptoms that he was presenting with which enabled him to deal with times when he was at crisis.

15.57 From the information available from friends, family and agencies it would appear that Adult B would drink alcohol but the frequency of this was difficult to determine. Records held by the GP stated that he would drink two glasses of port a day but information from Adult D would indicate that he was drinking to excess on occasions and this compounded his condition.

15.58 In October 2017 Adult A attended Adult B's home address as part of her regular routine of visiting him to check on his welfare. On that occasion she also took a new coat with her as she was concerned that Adult B wouldn't have one if he was sent to prison. At some stage during that same afternoon Adult A was assaulted and sustained injuries which proved to be fatal.

15.59 The details of what is known to have happened on that day are recorded in paragraph 13.

16.0 Analysis

16.1 This part of the overview will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It can consider whether different decisions or actions may have led to a different course of events. The analysis section seeks to address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice should be highlighted.

16.2 The analysis considers the previous sections within this report and the content of the IMR's, including the chronology of events. The information obtained from family and friends has also been pivotal in the analysis as they have been able to provide an invaluable insight into the life of both Adult A and Adult B, which was not captured in agency records.

16.3 The review panel analysed each agency's involvement and how individuals responded to Adult A and Adult B and addressed their specific needs. In this particular review it was felt that any analysis should also take due cognisance of the decline in Adult B's behaviour as exhibited in the domestic abuse that he inflicted upon his wife, his escalation in terms of risk, and any opportunities for agency intervention that could have prevented the tragic event from occurring. As a result of this analysis a number of issues will be raised in this section of the report which relate to how Adult D and her children were dealt with by agencies. The panel felt that the inclusion of these issues was extremely relevant if partnership working was to improve in the future, and also to address the terms of reference for the review.

16.4 Evidence of Domestic Abuse in Adult A and Adult B's relationship

16.4.1 In examining how and why the events in this particular case occurred, the first area for analysis is to determine whether Adult B was abusive, coercive or controlling towards Adult A or whether he had a history of such behaviour in any previous relationship. This was deemed to be important as panel members wanted to explore whether in the lead up to the tragic death of Adult A agencies had been aware of the risk that Adult B posed, in view of his past behaviour.

16.4.2 From the information available Adult B became violent following the breakdown of his first marriage and this has been reinforced by his first wife who, during the police investigation, described him as a 'gentle and kind man'. He was also described by his GP as having 'a passive and gentle disposition'.

16.4.3 Adult B was violent to Adult D during their relationship particularly in the early stages of their marriage. Adult D on reflection has stated that Adult B had become depressed following the breakup of his first marriage and the separation from his children. Adult B's depression, his decline in mental health, and his addiction to medication, which will all be explored later in this report, appear to have had an impact on his propensity to become violent and are recognised risk factors in domestic[23] and elder abuse[24],[25].

16.4.4 In terms of the level of violence in the relationship, Adult D reported a number of historic physical assaults to the police and had confided in her pastor that Adult B would beat her 'black and blue'. During one consultation Adult B was asked by his

[23] Zhang (2020)
[24] Elder abuse (also called "elder mistreatment", "senior abuse", "abuse in later life", "abuse of older adults", "abuse of older women", and "abuse of older men") is "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person."
[25] Santos, M (2020)

GP as to whether there was any abuse in the family and he stated he had been slapped on one occasion by Adult D but he denied ever harming or hurting his family.

16.4.5 Whilst there would not appear to have been any specific pattern to the frequency of Adult B's violent behaviour it has become apparent during this review that he did exhibit a consistent level of coercion and control in the relationship with his wife.

16.4.6 Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another. The Cross-Government definition of domestic abuse and abuse[26] outlines controlling or coercive behaviour as follows;

'*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'.*

16.4.7 The impact of coercive control on an individual's mental and social wellbeing is now considered to be so serious that it became an offence in law in December 2015, under the Serious Crime Act 2015.

16.4.8 The components of coercive control[27] are a number of behavioural traits and can include:

- Unpredictable mood swings.
- Excessive jealousy and possessiveness.
- Isolation-preventing partner from seeing family or friends.
- Control of the partner's money.
- Control over what the partner wears, who they see, where they go, what they think.

These components were all evident in the relationship that Adult B had with Adult D. Controlling behaviour such as that shown by Adult B is known to be a key marker for fatal domestic violence[28] which is why it is an integral part of the DASH risk assessment process. As in this case though, predicting such an escalation in behaviour is difficult for professionals to assess and the risks mitigated without all of the available information.

16.4.9 Adult D has stated that she was subjected to emotional abuse over a ten-year period (5th April 2017). On one occasion (18th November 2016 – Education IMR) Adult D stated to work colleagues that she was 'exhausted by the mental cruelty endured on a daily basis at home'.

[26] Domestic abuse; Home Office (2016)
[27] Controlling or Coercive Behaviour in Intimate or Family Relationship Statutory Guidance Framework; Dec 2015; Home Office
[28] Myhill, A and Hohl, K (2016)

16.4.10 Due to his decline in mental health Adult B had become unpredictable and he exhibited changes in his mood on a daily basis. To friends and family Adult B appeared to have a loving and caring relationship, but it is clear from the accounts provided by Adult D that he could become controlling, violent and aggressive for no apparent reason when he was in the home environment. Declining mental health is known to increase risk in terms of abuse and intimate partner violence[29] and is discussed later in the report.

16.4.11 Adult B's pastor has recalled that he was controlling in that he would not allow Adult D to obtain a driving licence and had convinced her that she needed a Visa (which she did not require) to remain in the country. He had stated that she could not leave him or she would risk being deported. Adult B was also possessive and would check his wife's mobile phone regarding her contacts and had stated to his pastor that his wife would be 'in the gutter 'if it wasn't for him. Adult D was also restricted financially in that the level of debt incurred by her husband meant that she had to work not only to support her family but to pay off the money that they owed.

16.4.12 The level of coercion and control that was occurring within the relationship was not apparent to any agency until reported by Adult D following the breakup of their relationship. Adult D had not considered herself to be a victim which is not unusual as many women due to a number of issues including fear, isolation, shame, denial and trauma often fail to report the abuse that they suffer[30]. It was not Adult D left her husband that she realised that the behaviour of Adult B was unacceptable and she subsequently reported it.

16.4.13 From the information available to the review it is difficult to know how controlling Adult B was in respect of Adult A. Adult A was an independent and strong-minded lady yet she felt it necessary to address her sons every need, even to the extent that she would personally groom him (as witnessed by Adult C and her husband). Whilst this behaviour could have been down to Adult A's personal choice it appeared to family and friends that the level of her attentiveness was on occasions all consuming.

16.4.14 Whilst there were previous recorded incidents of verbal arguments between Adult B and Adult D the first reported crime, involving actual abuse between the two, occurred on the 1st January 2016. There was nothing at that time to indicate that there had been previous physical abuse in the relationship. Whilst professionals working in the agencies in Plymouth acknowledge that the first reported incident is unlikely to be the first time that it has occurred[31] there was nothing recorded or elicited from Adult D to suggest that this was the case in this relationship.

16.4.15 In total there were eight reported incidents of violence reported to the police and on these occasions there was an appropriate response and DASH risk

[29] Rongqin Yu, et al. (2019)
[30] Womens Aid (2020)
[31] On average victim's experience fifty incidents of abuse before getting effective help (Safe Lives ;2018)

assessments were completed in line with policy (D034[32]). Adult D however, when asked about the DASH process, couldn't recall whether the risk assessment had been completed on each occasion. Officers dealing with victims therefore need to ensure that they fully explain the purpose of the DASH risk assessment to victims.

16.4.16 Police action also took place in line with their stalking and harassment policy (D281). When each of the incidents were reported the police appropriately escalated their response and took positive action. As a consequence of this action Adult B was issued with a restraining order and the breaches were investigated. Adult B and Adult D were also the subject of a MARAC referral on the 19th October 2017 which was being processed at the time of Adult A's death. Adult D was also referred to appropriate domestic abuse support agencies.

16.4.17 The PDAS member of the Panel reviewed the information known to agencies and the referrals that were made to their organisation in respect of Adult B and Adult D. On the information known at that time and in view of the agencies that were already involved in Adult D's case it was felt that the risk assessments were graded correctly (medium) and that there were no concerns at the time of assessment that would have warranted a MARAC referral; until the reported escalations in behaviour in the above paragraph.

16.4.18 As stated the true extent of abuse that was occurring in the relationship was not known to professionals until Adult D made a report to the police in November 2016. It was at this point that she detailed the length of time that she had endured the abuse and types that of violence that Adult A had inflicted on her. In a conversation with a DSL in May 2017 Adult D stated that it was only at that point that she had started to acknowledge and understand the abuse that she had been living with. Once Adult D recognised the behaviour as a form of abuse there were no barriers identified from an agency perspective that prevented her from reporting it. The barriers up until that point were her own beliefs, culture and sense of duty.

16.4.19 Adult D had confided to a small number of people within her church and they had chosen to try and provide counselling to the couple in order to address the issues that were raised. The relevant people within the church have since reflected that they were unaware of the domestic abuse services available for victims and their families in the Plymouth area and therefore they did not reach out for advice and help.

16.4.20 The lack of knowledge that Adult D had in relation to the fact that she was a victim of abuse and the issues raised by the church regarding domestic abuse services highlights the continual need for Safer Plymouth and all agencies to maintain an effective communications strategy in relation to domestic abuse.

16.4.21 There were indications that Adult B could be abusive as far back as September 2015 when there had been a report that he had pushed Child B2 out of a stationary car causing them to injure their head. A subsequent home visit also

[32] Devon and Cornwall Police's Domestic Abuse Policy.

identified that Adult B had hit the same child with a sink plunger. These matters were the subject of assessment at the time but were not seen as an indicator of wider abuse in the household due to no other information being disclosed at that time.

16.4.22 Adult D has stated that her husband's behaviour and attitude clearly affected their children and in particular Child B2. Evidence[33] shows that children are not simply bystanders in abusive households but should be considered victims in their own right. Domestic abuse has been shown to lead to adverse childhood outcomes; increased risk taking; anxiety and in some cases death[34]. In this case the impact of Adult B's behaviour on his children manifested itself into Child B2 refusing to go to school. On these occasions Child B2 had to be 'manhandled' back to his school by his parents which resulted in him stating to a DSL that he wanted 'new parents'. Research indicates that 'exposure to domestic abuse is related to emotional and behavioural problems….[whilst] co-occurrence of child abuse increases the level of emotional and behavioural problems'[35] and that these issues often manifest themselves in anxiety, temper tantrums, sleep problems, truancy and physical pain.[36] All of these symptoms were evident in the children but there was nothing reported at the time that would have indicated that they were being exposed to domestic abuse. It is not clear whether the DSL's within the children's educational settings had considered that domestic abuse could be a contributing factor, and therefore they didn't ask the relevant questions that may have elicited this.

16.4.23 Children, like those in this family setting, may also be harmed by non-physical abusive behaviours inherent to coercive control based domestic abuse[37]. and it is inevitable that this would have put additional strain on the family dynamics and further impacted on Adult B's mental health.

16.4.24 There is nothing to indicate that any one professional should have picked up the patterns of behaviour exhibited by the couple or their children. The majority of this behaviour took place within the confines of the household and therefore would not have been apparent to those interacting with the family. Adult B had a strong relationship with his GP and would often confide in him. Despite the strength of this relationship Adult B never disclosed the level of abuse that was occurring in the household. His GP had been trained and was cognisant of safeguarding and on one occasion had asked Adult B if any abuse had occurred in his relationship with Adult D. Adult B had only disclosed that his wife had slapped him. On reflection, and now knowing the extent of abuse that was occurring in the relationship Adult B's GP has stated that it would have been a good idea at that time to have had the ability to contact Adult D's GP. This would have enabled him to see whether they had any further concerns. His GP has however stated that there was no consent to do so from either party and that he did not have those contact details anyway and would not have been able to ascertain them.

[33] Hester (2011)
[34] Devaney, 2008.
[35] (Wolfe et al;2016)
[36] Royal College of Psychiatrists (2018)
[37] Emma Katz (2016)

16.4.25 There is nothing to suggest that Adult B was exposed to domestic abuse in his younger years and it does not appear that he was violent to his mother whilst growing up (which is commonly termed as adolescent to parent violence and abuse (APVA)) ,[38]. There is also no information to suggest that he been violent against Adult A in the weeks prior to her death.

16.4.26 In this particular case, there has been nothing found in either agency records or from speaking to friends, family or neighbours that had Adult A been subjected to abuse that she was prevented from coming forward. There is also nothing to suggest that Adult B prevented her from doing so. Research has however identified that many parents fail to recognise or report abuse as it's a complex social problem where the abuse is excused or downplayed by victims due to the strong feelings that they have for their children[39]. Victims also tend to undervalue or "perceive" certain types of abuse such as psychological abuse as not being "serious enough" to ask for help[40]. The prevalence of this type of abuse is therefore difficult to determine and is likely to be under represented in domestic abuse statistics particularly when it is perpetrated by an individual of trust [41].

16.4.27 Once the domestic abuse had been reported all agencies and professionals were receptive to the information that they were presented with and in the main they followed appropriate procedures and practices. Adult D was also provided with the appropriate signposting to support agencies. The decisions made by professionals were in the best interests of all parties concerned and were based on the information that was disclosed by Adult D and Adult B. Agencies appropriately used this information when completing assessments and offering support. Operational practice will be discussed in more detail at paragraph 16.10.

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

16.5 <u>Adult A's vulnerability and mental health</u>

16.5.1 Adult A was a seventy-six-year-old woman who could be considered vulnerable due to her age; however she was totally independent and had full capacity. Adult A was not in receipt of any services and nor did she need them. During the period of the review Adult A had only had two Emergency Department attendances and these related to orthopaedic injuries.

16.5.2 Whilst Adult A was considered to be optimistic in her outlook, and she lived life to the full, her attitude changed considerably after Adult B had moved in with her.

[38] Condry and Miles (2012; 2015), Coogan, D (2018).
[39] Wilcox, P (2019)
[40] Santos, A(2019)
[41] Midgley, 2017

Adult C and Adult A's best friend have both recalled how this change in circumstances had an adverse impact on her and that she had found Adult B difficult to live with.

16.5.3 Adult A's friend has since recalled how she would find her sons behaviour 'strange' and that on occasions she would wake from her sleep and find him standing over her. Whilst she found this unsettling it would appear that Adult A had put this down to his declining mental health. As mentioned in the previous section her concerns had also increased following the incident where Adult B poisoned her fish. Despite these incidents it would appear that she never perceived herself to be under any risk of physical threat.

16.5.4 There was evidence that on the 22nd March 2017 (Police records) that Adult A had reached a low point in her life and that she intended to take an overdose. Concerns had been raised by Adult B in a text to Adult D and he contacted the Police. On this occasion Police spoke to Adult A and she had stated that she was feeling low and stressed about her son living with her. Adult A stated that following a period of rest she no longer intended to take her life. Police referred the matter to her doctor (which should be seen as good practice). Again on this occasion when discussing her situation through with the Police Adult A had not raised any specific concern about any risk from Adult B. Adult A was seen by her GP on the 24th March 2017 where the two of them explored the reasons behind her presentation. Her GP discussed her current living and the caring arrangements involving her son which she described as a 'bit upsetting'. She felt that she was not sleeping and she was prescribed a low dose of antidepressants. No other concerns were raised at that time about abuse and no other risks were identified. Adult A's comments could have been explored further in order to identify the levels and types of abuse that she may have been experiencing.

16.5.5 The Panel felt that in this case additional training in domestic abuse was required across GP practices to ensure that staff are aware of the impact of domestic abuse and have an understanding of behaviours shown by perpetrators of domestic abuse.

16.5.6 There were however entries in some agencies (Livewell Southwest and Housing) records that seem to contradict this view. The Livewell Southwest IMR has identified that there was evidence in Adult B's records that highlighted that Adult A was concerned about her son. These records state that in telephone conversation between professionals and Adult A that she had stated that she was afraid of her son. On discussing these concerns through with her Adult A had stated that the Police and the family were aware of her concerns and that measures had been put into place to safeguard her. There has however been nothing found during the review to suggest that this was in fact the case and therefore the extent of Adult A's concerns and what she was specifically referring to could not be ascertained. In a letter from a consultant neuropsychologist (dated the 8th June 2017) to a consultant psychiatrist who had examined Adult B they stated that …*'he is not really functioning on a day to day basis and this is placing a lot of strain on his mother who is caring for him. I feel that there is a risk to her in terms of coping with*

him'. On exploring this further it was apparent that the risk to Adult A had been considered and had been seen as a mental not physical risk. The concerns in relation to Adult A were in relation to her ability to cope in view of Adult B's over reliance on her support, his poor behaviour, and his inability to look after himself.

16.5.7 There is also information contained in the records of Housing that when Adult A was contacted to confirm that her son was homeless she had stated that he could no longer remain at her address as she was scared of him. She stated that he had done something bad but didn't elaborate on this. On this occasion Adult A did not divulge why she felt scared of her son (although it is not clear whether she was specifically questioned about this) and there are no other details recorded or information held to say what had prompted this remark. The disclosure that was made by Adult B to Housing regarding domestic abuse occurring within his family (paragraph 15.27) and the comments made by Adult A could have been explored further by staff working within that agency. Had these comments been explored then this may have led to an opportunity to intervene and offer additional support and to signpost both adults to other services. Housing providers in the City need to ensure that all staff are appropriately trained and that they feel confident in managing disclosures. Domestic Abuse Housing Alliance (DAHA) best practice and accreditation would enable appropriate services to work towards a 'Whole Housing Approach.

16.5.8 Whilst the chronology provides a comprehensive overview of the information known to agencies prior to the death of Adult A there are few indicators as to why the events on the day of her death occurred. Likewise there is limited information contained in agency records or gained from the information provided by family and friends that would have indicated that if Adult A felt vulnerable, why this was the case, or that she had perceived that there was a specific risk to her.

16.6 Adult B's vulnerability

16.6.1 The third area for analysis is whether Adult B was vulnerable due to his declining mental health and his exposure to drug addiction. This area will also explore whether Adult B could and should have received additional support that may have addressed his condition and therefore reduced his propensity to become violent and abusive.

16.6.2 Although Adult B did not meet the definition of vulnerability used by statutory agencies[42] it is apparent that the deterioration in his mental health meant that he was vulnerable. Adult B had suffered for years with depression, anxiety and an addiction to diazepam and each of these factors would have made him vulnerable and in need of support. Adult B had also suffered from chronic myeloid leukaemia although the information from his GP has indicated that this was controlled with medication and was not seen as 'a major issue in his health problems'.

[42] Adult at Risk - An adult at risk of abuse or neglect is defined as someone who has needs for care and support, who is experiencing, or at risk of, abuse or neglect and as a result of their care needs - is unable to protect themselves; Care Act (2014).

16.6.3 The accounts that have been provided by Adult C, Adult D and friends clearly show that Adult B's mental health had deteriorated over time. Adult D described how he had become increasingly paranoid (report to Police dated 18th November 2016) and later (May 2017) recalled to a DSL that her husband's mental and physical state had declined further in the months leading up to the incident (Education IMR). Adult D was not alone in these views as on the 17th August 2017 Livewell Southwest records show that Adult A had described how her son had 'gone back to being a little boy'. His continuing decline was also evidenced on the 23rd August 2017 when Adult A and Adult B's step mother attended a police station and spoke to a station enquiry officer about their concerns. On this occasion both had wanted to discuss his deteriorating health, his behavioural issues and his misuse of medication.

16.6.4 There is evidence that it was not only his family that were concerned about his mental and physical health. Agency records clearly demonstrate that professionals were cognisant of the impact of Adult B's mental health both in relation to him personally and in respect to his family. Throughout the period covered by the review Adult B had been supported by health services including GP services, the CMHT and via outpatients. In respect of the Acute General Hospital outpatient's department Adult B had been managed for a period of eighteen years predominantly by the haematology specialist services as well as neurology and neuropsychology with appointments every three to six months. There is clear evidence in Health records that services recognised his vulnerability to mental health related issues.

16.6.5 The review has also identified that other agencies were aware of the difficulties that Adult B had with coping with anxiety and depression. Entries in the Education records of the children show that as far back as 2008 a DSL had considered signposting Adult B for support. This consideration was however not followed through due to the DSL being persuaded by Adult D that her husband was receiving adequate support from his GP and from Harbour. In this particular instance the DSL had demonstrated a good level of awareness and their thinking was in line with the 'think family approach'[43]that is promoted within Plymouth. This should be seen as good practice.

16.6.6 Adult B was also self-aware that his mental state was deteriorating. Adult B informed Health professionals that he was struggling to leave the house due to feelings of anxiety and panic. He acknowledged that he was finding his social situation 'overwhelming' and that this was hugely detrimental to his physical and mental health.

16.6.7 Mental health is a significant issue in homicides and is recorded as the second most common health-related theme in the DHR reports.[44]. The family of Adult A

[43] The 'Think Family' strategy promotes co-ordinated thinking and delivery of services to safeguard children, young people, adults and their families/carers.

[44] Sharp-Jeffs and Kelly (2016)

have questioned whether Adult B should have been detained in relation to his mental health and whether his risk was effectively considered by professionals.

Under Section 2 of the Mental Health Act 1983 a person can only be detained if:

- they have a mental disorder.
- they need to be detained for a short time for assessment and possibly medical treatment, and
- it is necessary for their own health or safety or for the protection of other people.

Under section 3 a person can be detained if:

- they have a mental disorder.
- they need to be detained for your own health or safety or for the protection of other people, and
- treatment can't be given unless the individual is detained in hospital.

A person cannot be sectioned under this section unless the doctors also agree that appropriate treatment is available for that individual.

Under Section 4 a person needs to be detained if:

- they have a mental disorder
- and it is urgently necessary for that person to be admitted to hospital and detained, and
- waiting for a second doctor to confirm that the person needs to be admitted to hospital on a section 2 would cause "undesirable delay".

  Under this section a person can be sectioned by one doctor only (together with the approved mental health professional) and that person can be taken to hospital in an emergency and assessed there.

16.6.8 When those working with the Mental Health Act talk about someone with mental health problems and whether or not they should be sectioned, they often use the term "mental disorder". The Act defines this as "any disorder or disability of mind" (section 1).

Mental disorder can include:

- any mental health problem normally diagnosed in psychiatry
- learning disabilities - if the disability makes you act in a way which may seem "abnormally aggressive" or "seriously irresponsible".

16.6.9 In this case on the occasions that Adult B presented to services they concluded that there was no immediate need of care and control. Every time that Adult B was assessed he was deemed to have capacity and therefore did not reach the thresholds laid down by the Act. Adult B's GP has stated that whilst his agitation and distress was increasing he did not feel that Adult B was certifiable at any point.

16.6.10 On the 22nd August 2017 following concerns that Adult B's mental health had severely deteriorated he was reported missing by Adult A (this incident occurred after the Police issued him with a PIN). Adult B had sent a text to Adult A stating that 'I am going to end my life as I have nothing to live for'. On this occasion the Police found that he was staying with a friend and they attended the address to check on his welfare. At that time he was described as calm and rational. There would appear to have been no specific reason or evidence of vulnerability that would have indicated why he would have sent the text other than to illicit some reaction in Adult A. On this occasion the Police complied with relevant policy and practice. Adult B could not have been detained at that time under the Mental Health Act as he was not in a public place and was not deemed to be in immediate risk of harm.

16.6.11 On the 23rd August 2017 Adult B was arrested for harassment following a further incident involving his family. On this occasion he was seen in custody by a health professional and he was the subject of a pre-release plan where no issues were identified regarding risk. Adult B was signposted to his GP for help in relation to his deteriorating mental health which demonstrates good interagency working.

16.6.12 On the 26th September 2017 Adult B was seen in the presence of his step mother by a mental health nurse. On this occasion it was felt that Adult B answered all of the questions that were put to him in a thoughtful and reflective manner. The outcome of this meeting was that Adult B was not suffering from psychosis but experiencing 'significant life challenges, [and] his motivation was poor and he was struggling to see a way ahead'. On this occasion no specific risks were identified.

16.6.13 On the 19th October 2017 following a breach of the restraining order which prevented him from contacting his wife, Adult B was subjected to a further risk assessment whilst he was in custody. On this occasion he stated that he was depressed but that he did not want to be referred to any mental health worker. Whilst in custody he was seen by a health care professional who deemed him fit to be interviewed. Crucially there was no indication that Adult B presented a risk to any other person or that he lacked capacity. The fact that Adult B was seen on each occasion that he was arrested and detained by a health care professional should be seen as good practice.

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

16.6.15 As can be seen from the assessments that were carried out Adult B did not reach the threshold for being detained and presented as lucid and having capacity. As a result Health services continually concluded that whilst Adult B was suffering from 'psychosis type symptoms' he was not psychotic. There has been nothing identified through the review process that would contradict this view. There is evidence recorded in Health records that Adult B's symptoms were being treated

by the CMHT in liaison with his doctor and therefore to have deprived him of his liberty on the occasions when he was assessed would have been inappropriate.

16.6.16 Adult B was extremely clever in the way in which he presented to professionals, friends and family. Friends and family have recalled how manipulative he could be in order to achieve his own way. An example was given by Adult C's husband who recalled how, when homeless, he had played on the sympathies of family members and one minute presented and being mentally unstable and extremely vulnerable, and the next he was lucid and capable of filling out complex forms to enable him to get access to benefits. On this occasion Adult C's husband states that he was clearly being manipulative and deceitful, and that this was would occur on a regular basis.

16.6.17 On the 5th April 2017 the initial child protection conference (ICPC) documented that Adult B had made previous threats of taking his own life but concluded that he was known to be manipulative and used these threats when things weren't going as he wanted them to. This behavioural trait was seen on the 21st August 2017 when he was reported missing after threatening to end his life and on many occasions when he used to text his pastor and his friends with similar threats. Whilst the review process has not found any indication that agencies or professionals became intolerant of this behaviour it did make risk and mental health assessment, which are both complex processes, difficult to undertake.

16.6.18 In terms of Adult B however it is difficult to assess from agency records the true extent of his mental health deterioration, whether he had fluctuating capacity, or whether he was just manipulative. Friends and family have identified that he would use his vulnerability to his own advantage and this enabled him to manipulate people, including professionals. This was apparent on a number of occasions, when he would often present to professionals as rational and with capacity in order get his own way and then conversely as vulnerable when he wanted something such as medication. Issues regarding fluctuating capacity and mental health due to drug/alcohol addiction and its impact on conducting accurate mental health assessments, has been the subject of national research[45].

16.6.19 GP records show that they were frequently concerned about Adult B's physical and mental wellbeing but that on each occasion that he presented, he always had capacity. Adult B was described as an intelligent man who '*was able to understand and was able to weigh up and retain information in order to make decisions'*. His GP stated that at no stage did he feel that he was certifiable but felt that he needed an enormous amount of support and help.

16.6.20 Adult B attended consultations or had contact (letters etc.) with GP services numerous times over the period specified in the terms of reference and was treated for such issues as anxiety, depression, insomnia and general pain.

[45] Sakar, J (2008); Community Care (2008)

16.6.21 There were however numerous occasions where Adult B failed to effectively engage with professionals (Harbour and Children's Social Services, Health services) and his attendance at appointments was sporadic. This is evidenced by Adult A calling the Mental Health Team (MHT) to report her concerns and to advise them that despite Adult B being well enough to have attended appointments he would often choose to cancel or miss them. This lack of engagement therefore made any attempt to help Adult B difficult to manage. His GP has also described how he became exasperated as Adult B failed to comply with agreed plans and '*instead he (Adult B was] subtly sabotaging me at many opportunities, not keeping appointments and not following up on things which [the GP] felt was essential to his recovery'*.

16.6.22 His GP has further stated that he '*gradually formed the impression that he [Adult B] felt that if he recovered then he would no longer have an excuse to lean on my support or the support of ancillary health professionals and therefore he became enmeshed in a system of dependency and need for medical care*.' He described how he saw him as a 'pathetic and broken man' and that he had tried hard to influence his positivity to life and instil hope in him but had not succeeded. Adult B demanded huge amounts of time, energy and resources. From the chronology and from the information provided by the GP it would appear that he was afforded the time to discuss his issues through and often a ten-minute appointment would be extended to twenty to thirty minutes. This level of service was beyond that offered to other patients and was unsustainable in the end due to his GP's own high workload. The GP has stated that he had referred Adult B to appropriate support agencies at every opportunity. This included referrals for four neurological reviews, mental health team intervention and talking therapy.

16.6.23 Adult B's GP has stated that he had tried to act as a friend to Adult B. This level of commitment should be seen as commendable but from entries within the records it would appear that this level of familiarity could have also left him vulnerable to the manipulation that was experienced by friends and family.

16.6.24 There is additional evidence recorded in agency records that despite the demands that Adult B placed on services he was afforded the time that he required despite his non-attendance at arranged appointments services continued to actively try and engage with him (Children's Social Care were offering monthly appointments to provide updates on his children all of which he failed to attend). This level of support was also seen in the efforts made by the lead research nurse who worked within the haematology services. This individual had long conversations with Adult B and clearly showed sensitivity and patience. Despite her persistence offers of advice and support or informal signposting were always declined by Adult B. The level of engagement that this professional had with Adult B should be seen as good practice.

16.6.25 From the information that was available to the review panel it would appear that at the time of the incident appropriate mental health teams and psychiatrists were working with Adult B. The level and appropriateness of this interaction has also

been reviewed through a serious incident requiring investigation (SIRI) review[46] which also concluded that the level of support that had been offered was appropriate.

16.6.26 Adult B was also receiving active support from his family, particularly his mother, his step mother, and his network of friends. This was seen as a stabilising and protective factor as professionals have recalled how these individuals exhibited 'kindness and care for his mental health needs' (IMR – University Hospitals Plymouth NHS Trust). There is no evidence to suggest that this level of support clouded the views of professionals or prevented Adult B from accessing services.

16.6.27 During the latter part of his life Adult B would appear to have sought solace within the church. During that period those within the church offered him and his wife a great deal of support although they too became increasingly frustrated by Adult B's attitude and behaviour. Adult B's family, pastor and a number of his friends felt that he would often fail to take responsibility for himself, despite him having the capacity to do so. His pastor had tried to discuss this with Adult B on a number of occasions and yet on doing so Adult B would become increasingly angry and agitated. His pastor stated that as a result of his reaction he often found that he would have to step 'very lightly around this area'.

16.6.28 There were periods in Adult B's life when, due to his fluctuating mental health, he would require and seek additional and constant support and attention. At one stage when those around him considered that he was at his most vulnerable he was provided with weekly support from his church. This included one to one counselling with his pastor. Despite the advice given Adult B would fail to listen to what was being said or to take the suggested steps to improve his mental and physical health. On one occasion Adult B told his pastor that despite everyone thinking that his issues were related to his mental health his needs were actually spiritual. It would appear that Adult B would constantly try to seek attention on one hand but then dismiss it when he didn't receive the reaction that he wanted.

16.6.29 Despite Adult B's apparent ability to control parts of his life and manipulate professionals, friends and his family, he was nether the less vulnerable in many respects. This is clearly demonstrated in his desire to constantly seek attention, the high level of contact that he had with Health services, his addiction to drugs and his irrational thought processes.

16.6.30 Adult B believed that at one point that his life had been touched by the spirit of death. When his son had become ill in February 2017 he sent a text his pastor stating; 'Before I joined [the church] I had a prophecy…. at that time, I was just like [Child B2] I couldn't eat and drink, the prophecy said it was because of a spirit of death'. Adult B had made the same statement to a number of Health professionals. Again due to the level of deceit that he had previously shown it is difficult to tell whether he truly believed this, or whether it was an additional attempt to gain attention. Adult B had asked his pastor to cast the demons out of

[46] A national standard of review conducted by Livewell Southwest following the death of Adult B.

him on one occasion which was refused as it was felt to be unwarranted and unnecessary.

16.6.31 Further evidence of his vulnerability was demonstrated when Adult B moved out from Adult A's home address. On this occasion he was initially housed by the Salvation Army. Within hours of this placement the Salvation Army had contacted Community Connections stating that they could no longer accommodate Adult B due to 'his vulnerability and risk from others' stating that he "appears to have no understanding or ability to protect himself'. Alternative accommodation was found for Adult B on this occasion. Whilst the Salvation Army had identified that Adult B could pose a wider risk to himself this was not acknowledged by other agencies or disseminated further by Community Connections.

16.6.32 In this case no one organisation was party to all of the information in relation to Adult B's decline or the totality of his vulnerability. Much of the information was only known to family and friends and to his GP (although he was unaware of the abuse that was occurring in the household and has only reflected upon how manipulative he was post incident). What was clear is that Adult A and other family members were frustrated with regards to the services that were available to help them support Adult B at the time when they considered him to be most vulnerable. His family were confused about which services could assist them at their time of need, particularly with regards to Adult B's mental health. Family members had sought help from a number of mental health settings and support services in the city, but many stated that they couldn't help him as he didn't reach their threshold for intervention. Health and adult care services in Plymouth therefore need to review their communications strategies in order to ensure that there is increased awareness amongst staff and the general public in relation to the mental health services that are available in the City.

16.6.33 Adult B's GP retired in September 2017 and it his genuine belief that this event and the withdrawal of a further source of support may have been a relevant factor in Adult B's mental deterioration.

16.7 <u>Alcohol and Drug Abuse</u>

16.7.1 The fourth area for analysis relates to the impact of alcohol and drugs on Adult B as family and friends felt that Adult B's behaviour had become increasingly difficult to manage due to the deterioration in his mental health and his addiction to prescribed medication.

16.7.2 The extent to which Adult B drank alcohol and its effects on his personality and behaviour are difficult to assess. He had admitted to drinking alcohol but had stated to a GP that it was only two glasses of port a day (18, 11.2016). There is information, however, from Adult D (18th November 2016) that he was 'drinking and taking diazepam to excess', and the combination of the two would have affected his mental and physical state and increased his propensity to become

violent. There is clear evidence nationally[47] of the effect that these can have on the behaviours of individuals and the increase in risk that they can pose. There is also research[48] that substance abuse coupled with mental health issues also increases the risk of domestic abuse.

16.7.3 There is conflicting information available regarding the amount of diazepam and other medications Adult B was taking. Information from Adult D, friends and agency records appear to show that he was addicted to diazepam but his daily or weekly intake of the substance could not be accurately ascertained. There was also an indication from Adult D and friends that he was purchasing medication over the internet. His GP when asked about this stated that he was not surprised that he had resorted to this in order to supplement his supply of drugs which professionals were trying to reduce. The quantities that were purchased via the internet and the level of consumption of these types of medications could not be determined. This picture was further complicated by the fact that Adult B would allegedly not take his medication (27.06.2017/ 21.08.2017) and it is believed that he would stockpile his tablets. The fact that he was not taking his medication was reiterated by Adult B to his pastor, who over a three-month period had seen him on a weekly basis, and also to a GP during an outpatient's appointment.

16.7.4 Adult B had been placed on a programme by his GP which was designed to reduce his dependency on prescribed drugs. This programme included a referral to the Harbour centre for specialist help and support in reducing his addiction to substances. There was evidence in records of effective communication between his GP, Social Services, the Harbour Centre and his Consultant Psychiatrist.

16.7.5 It is clear that Adult B would try to circumvent this programme at every opportunity and despite repeated efforts by his GP he would often fail to engage with support services that were offered to him (Harbour). It is also clear that he was extremely manipulative and that he adopted a number of methods in order to obtain the drugs that he desired. These methods included seeing a number of GP's, arranging out of hours appointments and presenting in crisis. It was felt by Adult B's GP that many of these methods were adopted in order to ensure that he didn't see him. Adult B would also typically request prescription drugs after detailing a 'long series of complaints' at appointments (GP information). His GP on reflection has also concluded that Adult B '*realised that running late added extra stress to a doctor and therefore he was more likely to get what he wanted at the end of an exhausting consultation'.* When asked to qualify whether this was within practice guidelines his GP has stated that whilst tablets were prescribed at times of crisis these would only be reinstated in small quantities (22nd December 2016 when seven tablets of diazepam were prescribed).

16.7.6 The prescription regime adopted in this case has been reviewed by an independent GP. In their view the approach taken by Adult B's GP was entirely appropriate and the reductions that were achieved (from 28mg to 11mg) was seen

[47] Schumacher et al (2001)
[48] Brecklin (2002), Bennett & Williams (2003).

as being an achievement in view of the circumstances. Maintaining the relationship in the way that Adult B's GP did was seen as key to achieving benzodiazepam reduction and the independent GP states that the controlled prescribing in this case would fit with best practice in this area. The independent GP has also stated that for a person addicted long term to diazepam the dose of 11mg a day was very unlikely to have had an impact on Adult B's social functioning as he was likely to have developed significant tolerance of the medication.

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

16.7.8 As a result of his addiction to diazepam Adult B had two very brief episodes of engagement with Harbour which consisted of four weeks in 2008 and a further four weeks in 2009. On both of these occasions these periods of engagement were initiated as a result of Adult B's GP trying to make reductions in his prescriptions. On these occasions Harbour staff liaised with Adult B's GP to ensure that any reduction was proportionate and manageable so as not to compound Adult B's issues. Adult B was supported by Harbour staff throughout these periods.

16.7.9 Whilst there is clear evidence of the affect that these substances had on Adult B and Adult D their impact is less evident in terms of his relationship with his mother. There has been nothing found to suggest that drugs or alcohol was a direct factor in the death of Adult A.

16.8 <u>Risk Management – Adult B</u>

16.8.1 In this case there was clear evidence of adult mental health, substance abuse and domestic abuse. The presence of this these factors is recognised as a clear indicator of increased risk to both children and adults.

16.8.2 Adult B's level of risk would appear to have increased as his mental health deteriorated his addiction to prescription medicines increased, and at significant times in his life such as the separation from his family. Triggers to him becoming aggressive included situations when others tried to give him advice about his behaviour or attitude. His pastor has stated that despite him having regular contact with Adult B, and repeated attempts to help him, he would become increasingly angry and resentful. During his interaction with Adult B his pastor had become increasingly concerned about his own safety to the extent that he would not see Adult B alone. In the end the pastoral help that was being offered to Adult B was withdrawn as a consequence for Adult B's behaviour and attitude. At no time were specific risks identified during this period of interaction with his pastor that would have indicated that Adult B was a risk to others other than his wife.

16.8.3 There were numerous risk factors apparent in the relationship that Adult B had with his wife. Adult B would have been clearly aware that Adult D had wanted to end their marriage. This is a particularly vulnerable time for victims and research[49] shows that the risk of increased violence and homicide is greater on these occasions. In this case there was also a history of Adult B stating that he wanted to take his own life, an addiction to prescription drug abuse, and financial worries. As a consequence of these factors the DASH risk assessment indicated that Adult D was at risk of continued abuse, and that there were a number of high risk factors present in their relationship including coercive control which is often a "golden thread" running through risk identification and assessment for domestic violence[50]. Research[51] has shown that when looked at holistically many of the risks that were present in Adult B's relationship with his wife could have indicated that he had the propensity to commit fatal domestic abuse. In her research in relation to the 'Homicide Timeline' (2020) Dr Jane Monckton Smith identifies that there are distinct stages in the escalation process that can assist professionals in predicting risks (many of which are documented in the DASH risk assessment). In this case there were clear triggers to Adult B's behaviour including his fear that he was losing control through his life experiences and separation, and that there was an increase in controlling patterns of behaviour.

16.8.4 Following disclosures made by Adult D to the Police and other agencies (Education/PDAS) it was acknowledged that Adult A posed a risk to his wife, but not to others outside of this relationship. On the facts that were known at the time this would have been an accurate assumption. All of the domestic abuse incidents that the Police were called to, and which involved Adult B and Adult D, were risk assessed and graded using the DASH process and the support that was put in place was proportionate. None of these risk assessments identified that Adult B was a risk to others at the time when they were completed. Adult A also never identified this risk during her contact with the Police and therefore the final two stages of Dr Jane Monckton Smith's model in terms of risk (planning and homicide) would not have been evident or could have been foreseen by professionals or family members at that time.

16.8.5 Adult B had been risk assessed by numerous agencies and none of them identified any significant risk of harm to others outside of the marital home and especially his mother. It is important to recognise that matricide (the murder of a mother by her child) is an extremely rare event[52] and the information provided by Adult A would not have led professionals to believe that her son would have murdered her. Research has shown that there is a recognised vulnerability of individuals, mostly older people, when they undertake a caregiving role[53] but family ties often prevent them from recognising the abuse or reporting it. The risks to these groups are therefore underestimated by professionals who may come into contact with them through the lack of information shared with them.

[49] Riggs et al (2000), Kimmel (2002)
[50] Myhill, A and Hohl, K (2016)
[51] Monckton Smith, J (2020)
[52] Bourget et al (2007), Holt, A. (2017)

[53] Morbey, H (2002)

16.8.6 Adult B had been subjected to a risk assessment as part of the detention process by the Police on the1st January 2016. On this occasion it was identified that he had capacity and that he was suffering from leukaemia. Adult B also stated that he was taking his medication (which contradicted what he told his pastor, Housing and Health professionals). Adult B also stated that his mental health problems were related to panic attacks. On that occasion a pre-release risk assessment had been completed which identified that there were no specific issues of concern or risk in relation to Adult B.

16.8.7 Adult A's family have raised concerns that their mother was not informed of the risk that Adult B posed when he was asked to leave his home address by Children's Social Services on the 5th April 2017. Children's Social Care have clarified that the role of the children's social worker at that time was to protect to the children and in this instance, asked the Adult B to leave the home. A question would have been asked about whether any new address that he was intending to go to had children living there as this would have been the primary concern. The social worker would only be empowered to share other information where it was considered that there may have been a risk of significant harm to a child. In cases where there is a significant risk to an individual, then agencies have policy and practice in place to disclose such information. In this case all the presenting evidence pointed to the fact that Adult B was a risk to his wife. Adult B hadn't made threats, nor had he been violent to any other adult person. Adult A was a calming influence in Adult B's life and had willingly taken him into her home at that time and there was no previous history of abuse between them.

16.8.8 On the 27th June 2017 Adult B was seen as an outpatient and the examining doctor recorded that; 'There is no risk of suicide or self-harm behaviour'. There is a risk of self-neglect. There is no risk of violence'. Adult B's GP also stated that he never identified any risks that would have given him cause for concern about the safety of others and has stated that he had never heard him express any suicidal or homicidal thoughts. Research[54] has shown that health care professionals often find it difficult to identify and determine elder abuse due to its definition and prevalence varying significantly. There was nothing identified in the review that would indicate that health care professionals involved in the care of Adult A or B would not have acted if they had become aware of any risk to Adult A.

16.8.9 The review has identified that the risk management of Adult B was actively considered by the CMHT in relation to the challenges that he had reported concerning his anxiety and mental health. On the 9th September 2010 Adult B had been assessed by a consultant psychiatrist and the risk of him taking his own life, both in the immediate and long term, was considered to be low as was his risk of violence. His GP has stated that in later years this risk management process was however increasingly difficult to undertake accurately due to the fact that Adult B's presentation fluctuated, and at times even his demeanour was in opposition to his reported anxiety and mental health difficulties. The GP has confirmed that risk

[54] Hurd, D (2020)

management practices were in existence and followed and it was felt that on the information presented Adult B did not pose a risk to anyone.

16.8.10 Community Connections also risk assessed Adult B when he moved into shared accommodation as part of their internal procedures. This risk assessment was conducted to ensure that Adult B was a suitable tenant to be placed in the property. The focus of this risk assessment (which was comprehensive and should be seen as best practice) and the homeless approach appears to be based on Adult B's primary physical health condition (Leukaemia). At that time the BCHA Team and Plymouth Community Connections were under the impression that the house that Adult B was being interviewed for was a 'low support' scheme. This meant that in order to access the scheme, and the housing that they were looking to provide, Adult B would first have to be homeless and he would have also needed to be able to manage his own day to day affairs. This assessment included the ability of Adult B to be able to undertake such tasks as being able to contact the GP, collect his medication and manage his income. The support that would have been offered to Adult B was therefore minimal but proportionate to his needs. During the process of moving Adult B into the property Adult A indicated that she wanted to be actively involved in the care and ongoing support of her son. At the time of completing the assessment no other specific risks were identified.

16.8.11 The only incidence of note with regards to risk to Adult A was where he had poisoned his mothers' fish. This was an isolated incident and even though it was reported to the Police this would not have led them to believe that Adult A was in immediate danger. On this particular occasion Adult A (recorded in the DASH) stated that she was not frightened of Adult B, and that she was not afraid that he would kill or cause injury or violence against someone else. She also stated that he had never threatened to kill her and that his behaviour was due to his mental health. The officers who had received the information considered the risks but had concluded that there would appear to have been no immediate threat to anyone else. The fact that Adult B had then moved out of his mother's house would have also decreased the risk further. The officer attending the scene would appear not to have recognised the link between cruelty to animals and the increased risk of violence[55] but as this was the first incident involving both Adult A and Adult B, and due to the nature of what had been divulged, they would not have been expected to take any additional action. On this occasion Adult A had not wanted to make any complaint about this incident and the matter was risk assessed as low. This was appropriate in the circumstances.

16.8.12 In May 2017 Adult D had discussed her concerns about Adult B with a DSL. On this occasion it was recorded that she was 'very honest about her fear of Adult B and his unpredictability' and that she considered that she and her family were 'more vulnerable now that in his [Adult B] eyes he has nothing to live for'. Nationally it is recognised that this is a particularly vulnerable time[56]. By this stage however the matter had already been reported to the police and appropriate

[55] Gullone, E (2012)
[56] Salari, S (2007)

intervention had taken place. At that time Adult D was also receiving ongoing support from all relevant services. Again the risk appeared to be towards Adult D and her family, not to Adult A.

16.8.13 As a result of the information available to agencies there would have been no apparent reason to inform Adult A that her son was a specific risk to her, or to inform her of the abuse that Adult D had disclosed. There was information recorded within the Livewell Southwest notes that were recorded as part of the SIRI process that Adult A was aware of the risks that Adult B posed to his wife but there is nothing further that has been identified, as part of the review process that would substantiate this.

16.9.14 In hindsight an escalation point for agencies in terms of Adult B's vulnerability and risk could have been the point at which he stated to Adult D (Education IMR) that he had nothing to live for which is a recognised high-risk factor. The Education IMR identified that the DSL saw this as a concern but not one which warranted any immediate action as it was taken in the context of what was happening to Adult B and his family. The threat was directed towards himself and there were no other concerns raised in relation to other people. These remarks and any subsequent threat were mitigated by the fact that agencies were intervening and support was being offered to all parties. Even if escalated at that time it would have been unlikely that any additional services would have been identified to support Adult B due to the level of intervention that was already taking place.

16.10 Operational Practice

16.10.1 The sixth area for analysis was whether professionals had a good knowledge of relevant policy and practices and whether this was reflected in operational practice. This analysis includes the knowledge and policies relating to domestic abuse in view of its impact on Adult B's family in the years leading up to the death of Adult A and the management of his risk as a consequence of his history of abuse. This part of the review will also consider whether services were available to Adult D, family members, and whether appropriate safety advice was provided.

16.10.2 From the detail recorded in the IMR's and through the collective assessment of the panel it has been identified that whilst the majority of professionals had a good understanding of domestic abuse there was still learning required to fully embed practice. This has been highlighted in the report and in the IMR's submitted by schools and the police. Current policy and practice would also appear to be robust and fit for purpose.

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

16.10.4 The panel reviewed whether Adult D had received the appropriate support and advice in relation to the abuse that she had suffered. According to agency records Adult D had been given the appropriate advice in each of the incidents involving Adult B. There was nothing recorded in agency records that would indicate that different decisions or actions may have led to a different course of events.

16.10.5 On those occasions where the Police were involved with Adult D and Adult B they did complete the relevant DASH risk assessments and graded the incidents as domestic abuse in line with their policy and practices. There was evidence of good practice by the Police with respect to this process. On occasions the risk assessment made by officers attending incidents was reviewed and re-categorised in light of the holistic information concerning Adult B's previous behaviour. On the 18th November 2016, following a report by Adult D regarding an incident of abuse the DASH was graded as low/standard. This DASH was reviewed by a DV risk assessor who later spoke to Adult D due to the nature and length of time that she had been victimised. This contact would have been outside of normal process as risk assessors would only normally become involved in high risk cases. Consideration was also given to the welfare of the children within the risk assessment process and the appropriate documentation was completed and submitted.

16.10.6 The review has also considered whether the death of Adult A was an isolated incident or whether there were any warning signs that would indicate that there was previous history of abusive behaviour towards her. It is clear that agency involvement specifically relating to Adult A and Adult D was limited. There is no specific evidence of physical abuse between Adult A and Adult B or risks identified. On the one occasion that a risk assessment processes was completed it was appropriate and graded correctly. Thresholds for intervention were appropriate and correctly applied in this case.

16.10.7 From the information known to agencies and from the information provided by family members there wouldn't appear to be any barriers to Adult A reporting abuse if she had suffered from it. She had a strong family network and close relationship with Adult C and friends. The sudden escalation in violence that led to Adult A's death could therefore not have been foreseen by professionals.

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

16.10.9 In undertaking this DHR it became apparent that Adult B's mental health had a substantial impact on his children. Whilst this DHR has rightly focused on Adult A the Education IMR in this case identified a number of operational practice issues

which were worthy of mention. One aspect of the DHR process is about improving practice across all agencies and on discussion it was felt that the issues raised needed to be recorded and followed up by those agencies involved. The welfare of the children in family settings that are affected by issues such as mental illness and domestic abuse is of paramount importance and therefore the following paragraphs have been included in this report.

16.10.10 The impact of Adult B's mental health and his behaviour on his children was substantial. Education records clearly document the emotional and psychological affect that they were suffering as a result of witnessing their fathers declining health and as a direct result of his actions towards them and his wife. This included Child B2 refusing to go to school and periods when they would mimic their father's behaviour by staying in bed and refusing to eat. Despite these difficulties there was however good evidence recorded within Education records that demonstrate that the children received support and guidance during a period in their life which must have been extremely difficult for them to comprehend. This level of support went beyond the standard policy and practice within the schools and this should be seen as good practice. National research has shown that experiencing adversity, trauma and complexity in childhood has a significant impact on the mental health and wellbeing of children and adults[57]. This is why it was essential that the children received the support that they did.

16.10.11 There was however evidence that one particular school failed to follow practice and policy in relation to safeguarding. On occasions the behaviour of Adult B towards his children was not recognised as being inappropriate and consequently was not challenged or the appropriate referrals made. On the 3rd December 2012 Child B2 had refused to go to school and had locked themselves in a bathroom. Adult B had forced his way into the bathroom and 'manhandled' the child, carrying them out, against their will to the car of the DSL who then took the child to school. On this occasion Adult B was assisted by Adult D. The Education IMR documents that this was considered 'normal' parenting behaviour at the time and within the realms of the parent's authority. On this occasion Child B2 was in his pyjamas and was given an option to get dressed in the car or in the school. On arrival at school Child B2 got out of the car and walked towards the school with no shoes on. He then became agitated, lashed out at the DSL and ran off. His parents were contacted, and they eventually returned with Child B2 and carried him into the school staff room. Child B2 was spoken to and he stated that he was being bullied by his brother (Child B1). He also stated that he felt isolated and that he wanted 'new parents'.

16.10.12 On the 11th December 2012 following a report that Child B2 had again refused to attend school a DSL had carried out a further home visit. During this home visit it was disclosed that there had been a disagreement in the family which had resulted in Adult D losing her temper and she had then 'grabbed Child B2 by the hair and slapped him across the face'. The Education IMR has identified that the school did not make a referral to Children's Social Care on this occasion as they considered

[57] Young Minds (2018)

that this 'incident to be a one off and that it occurred as a result of everything else going on in the family'.

16.10.13 On the 30th January 2013 a meeting was arranged through the school in relation to Child B2's behaviour as they were described as becoming 'rebellious and stubborn'. On this occasion Adult B stated that on one occasion he and his wife had taken Child B2 to a DIY store and upon arrival he had refused to get out of the car. Adult B stated that he had no option but to 'manhandle his son' out of the car which left him feeling very stressed. He also admitted to kicking Child B2 up the backside whilst walking along with him. Records indicate that a DSL would have normally informed the head teacher of Adult B's actions but that they did not 'feel that Child B2 was in danger'. Again, no referral was made to children's social care and the behaviour was explained by the stresses that the family were under.

16.10.14 On the 5th February 2013 a member of school staff witnessed Adult B carrying his son into the school grounds. Child B2 was seen kicking and struggling and was described as 'obviously distressed about coming to school'. Child B2 later stated that Adult B had hurt him whilst taking him into school and pointed to his lower back. A DSL checked the child's back but they could see no marks.

16.10.15 On each of the afore mentioned occasions the school failed to consider the child and the family from a holistic perspective and they should have acted in accordance with their own policy and the South West Child Protection Procedures[58]. This is poor practice and should not have occurred. There is nothing to suggest that the failure to follow established policy and practice came from poor training or a lack of knowledge; however those involved would benefit from refresher training.

16.10.16 On the 16th September 2015 a DSL phoned and spoke to Adult B and Adult A. The DSL noted that in their belief Adult D presented as the disciplinarian for the children and Adult B was seen as being 'too kind' and that he was often over the top when talking about Child B2. The DSL felt that Adult B didn't always come across as sincere. That same day Child B2 stated that he was afraid of Adult B because he was hitting him hard on a very frequent basis. He then went on to say that Adult B hit him with a plunger and belt and that this happened at least once a week. Child B2 also stated that Adult B had caused injuries which had kept him off of college during the previous year. On this occasion the DSL correctly referred the matter to children's social care.

16.10.17 On the 17th September 2015 a social worker spoke to the DSL and Child B2 in school. Child B2 was asked whether they wanted to make a formal complaint against their father. The fact that Child B2 was given such responsibility was considered an issue by the school, although there is no evidence of escalation recorded. The Education IMR has identified that following this initial contact

[58] South West Child Protection Procedures is a tool used by the South West Local Safeguarding Children Boards. The procedures aim to provide the most up to date information about policies relating to safeguarding children. It contains both shared procedures as well as more specific local guidance.

children's social care failed to keep the child updated as to what was happening with their case. This worried the child and it is recorded that Child B2 appeared to be struggling with this lack of contact. Again, there would appear to have been no escalation or attempt to contact children's social services to rectify this issue.

16.10.18 During this period Child B2 started to complain of stomach issues and again refused to go to school. When spoken to at the school Child B2 stated that they 'wanted to be dead'. Child B2 was eventually updated on the 6th November 2015 and the social worker apologised for the lack of previous contact. The social worker provided an update that following a home visit it had been identified that there were no safeguarding concerns. The DSL asked the social worker to contact the child's GP before closing the case and they promised that they would do this. In the following weeks the DSL attempted to contact the social worker on a number of occasions and on the 26th November 2015 a message was left for the DSL stating that no further action would be taken. The social worker also stated that the family had been referred to other agencies. A referral had been made for a parenting programme and confirmation of receipt of referral was received by the social worker on 26/11/18. The programme would then have made direct contact with parents but unfortunately there was a waiting list for these services. The DSL tried to call the social worker back to find out if they had spoken to the GP only to be told that the social worker was not allowed to return her call as the case had been closed. The DSL was advised that she could make a further referral if she had other concerns[59]. The DSL stated that they had put in an official complaint at this stage but there is no documentary evidence to verify this claim. Children's Services have checked their records but from the detail recorded it is not possible to ascertain whether the DSL was advised that the call would not be put through or whether the social worker was not available. This episode demonstrates poor practice in the communication between the two agencies and a failure to escalate.

16.10.19 The IMR for Education has recorded the frustration of DSL2 with regards to the fact that that it had taken so long for the case to be considered as a child protection issue and that it had only been escalated due to the concerns about Child B3's well-being. They stated that Child B2 had disclosed a number of times and there had been significant concerns about his well-being for a number of years, and yet it appeared that his cries for help had not been heard. The IMR concluded that had Child B2 had been assessed through the Resilience and Vulnerability Matrix[60], used in many local authorities nationally, including Plymouth then the threshold for intervention may have been assessed differently. The DSL believed that Child B2 would have been seen as a vulnerable child living with high adversity and that they displayed behavioural traits such as poor attachment, being a loner, isolation, early childhood trauma which were all signs of inconsistent neglectful care' and abuse[61] . In these circumstances the Education IMR highlights

[59] Children's Social Services have confirmed that the practice would be that When a case is closed, a caller is usually directed to a duty social worker, who can usually provide a more immediate response to the caller.
[60] A vulnerability and resilience tool to support analysis and decision making for children. The tool can be used by social workers and all professionals working with children and families. The resilience and vulnerability tool support analysis and decision making, without replacing professional judgement.
[61] Grotberg (1997), Barnardo's (2014)

that Child B2 would, in the view of the DSL and the IMR author, most definitely have been viewed as a child in need or even a child in need of protection.

16.10.20 Despite the issues raised in respect of safeguarding practices in the school and escalation processes there was clear documentary evidence recorded in the IMR submitted by Education of good interaction between the schools and the children within the family. The DSL's were in personal contact and home visits were conducted. There was also good interaction between the head of year and Child B2. The level of interaction organisation was evident in the records scrutinised as part of this review.

16.10.21 There is also evidence that DSL3 had good knowledge of domestic abuse services as they discussed through with Adult D options for support including safe houses and referral to PDAS. They later stated that they intended to accompany Adult D to her PDAS appointment and they were also present when she telephoned a solicitor for advice. Again this demonstrates a good level of support.

16.11 Information Sharing and Communication

16.11.1 Evidence of poor communication between schools and children social care has been documented at paragraph 16.10.18.

16.11.2 In their IMR, PATH identified that prior to them housing Adult B there was no exchange of information relating to any risk assessments that Bournemouth Churches Housing Association (BCHA) [62] and Plymouth Temporary Accommodation (PTA) had completed. PATH have stated that had they known this information then they may have refused to house Adult B or asked that support or monitoring was put into place by the relevant service. They concluded that information sharing between partner agencies and professionals should be implicit and that any assessments from the referrer should be referred to PATH and vice versa.

16.11.3 In the earlier years covered by this review, there were examples where ineffective information sharing procedures were in place, for example, the missed opportunities to seek assessment through children's social care. It was clear in more recent years that information sharing within the City has improved through the use of the 'Plymouth Gateway'[63]. Agencies report that they are now sharing information at an earlier stage. There were also clear examples of good information sharing practice between multiple agencies, for example where DSL 3 shared information with the Police, the solicitor and PDAS to ensure the safety of the family resulting in proactive police action.

16.11.4 There was evidence of good practice regarding interagency communication between the DSL and the GP for Child B2 (11th January 2016). Conversely there would appear to have been poor communication between the GP and children's

[62] BCHA are a major provider of a diverse range of housing, support and learning services for socially excluded people.
[63] The Gateway can be used for any general information and advice question that relates to a child pre-birth through to 18 years of age (or 25 in relation to SEND matters).

social care as on this occasion the GP stated that they were not aware of any safeguarding concerns and that they had not been contacted by any social worker. The GP has also stated that they had not received the minutes from the Case Conference held in respect of Adult B's children.

16.11.5 An additional area where practice could be improved is the relationship between the three schools. The Education IMR has stated that somewhat surprisingly given the issues identified at School 2, neither Child B2 nor Child B1 were subject to anything other than a standard transition into secondary school. The IMR concluded that this was most likely correct in relation to Child B1 given the limited information that was held in relation to them. In relation to Child B2 however significant issues had been identified at the primary school and yet no safeguarding concerns or other information was shared between schools. This information may have helped to establish patterns of behaviour. Although information was clearly shared once concerns were identified (there appeared to be a good relationship between the safeguarding leads in all three schools), it appeared to be shared reactively rather than proactively. The Education IMR therefore concluded that it could be argued that as there had been no concerns identified in over twelve months before Child B2 left School 2 and issues were no longer deemed 'live' there was a clear rationale for not sharing safeguarding records at the earliest opportunity. The IMR identified that historical information is however crucial, particularly in cases where there are indicators of domestic abuse.

16.11.6 Even when the case was live, information sharing with external parties, such as the Police and PDAS appeared to be more rigorous then the information sharing between schools on a day to day basis. A greater acknowledgement of the link between all three children may have helped establish clearer patterns of behaviours not just of the children, but of Adult D and Adult B and in particular their interactions with the schools. For example, Adult B phoned the primary school on one day and the secondary school a few days later. There are no reports indicating their either school was aware of Adult B contacting the other, whereas a 'red flag' alert could have been issued to the other schools caring for siblings. This would have ensured that there was a consistent response to Adult B on each occasion. In other examples, both Child B2 and Child B3 experienced mental health difficulties whilst in primary school, however both cases were seen in isolation and no links firmly established. A better use of chronologies would have been beneficial, but a wider consideration should perhaps have been given to developing 'live' combined family chronologies across the education system where siblings are enrolled in different schools. Two of the schools, for example, used the CPOMS[64] online system and the third was considering it.

16.11.7 Consideration has already been given to the tracking of siblings more effectively throughout a single school, as a result of this review, and therefore there could be further potential for tracking siblings across schools in 'real time'. This would provide a comprehensive and accessible record to safeguard children. Although

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

there is evidence of the schools communicating with each other at certain points, formalising this process would make it more effective and ensure consistent communication through the critical points of a child's journey within the education system.

16.11.8 There was also evidence of good practice relating to information sharing through the use of the ViST by the Police. This process, which has not been adopted nationally, offers the ability to consider the vulnerability of adults and children. A good example of its use was in March 2017 when Adult A was feeling low and a ViST was completed prompting a letter to her doctor. A further example was shown on the 22nd August 2017 in relation to Adult B's mental health. Often these concerns would not have met the statutory threshold for intervention, required by other agencies and such incidents would previously have resulted in no action being taken and safeguarding issues left unresolved. There was also evidence of the voice of the child being effectively recorded in Police records (16th September 2015) and this should be seen as good practice.

16.11.9 There was good evidence of the use of the Child at Risk Alert (CARA) process by the Police (school 1 on the 5th January 206) to ensure that the schools attended by the children were notified of incidents of abuse in the household. That said there were also occasions where these reports were not received (school 2), although the review has not been able to ascertain why this occurred. This would appear to have been an omission and not a reoccurring issue requiring a recommendation in this case as quality assurance practices are in place to prevent a repetition of this from occurring in the future.

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

16.12 Agencies Policy and Practice

16.12.1 Whilst the majority of agency policies at the time (in respect of domestic abuse) would appear to have been robust (many have since either been refreshed to reflect changes in National policy) there were some discrepancies in practice which will be discussed later in this section.

16.12.2 Panel members scrutinised the period between the 2nd October 2017 and the 19th October 2017 to look at whether this could have provided an intervention point where Adult B could have been placed in custody and which may have prevented Adult B from unlawfully killing Adult A. The initial breach was reported on the 2nd October 2017 and an appointment made for Adult D to make a complaint. This was completed on the 5th October 2017 and this process adhered to policy. The crime was allocated for investigation and there was evidence that the officer in the case, in between other commitments, had attempted to locate Adult B. A further breach was reported on the 16th October 2017. This incident was initially allocated for a further appointment to be made with Adult D. On this occasion the control

room sergeant intervened and upgraded the incident. This should be seen as good practice and effective supervisory oversight. There was then a period when a resource could not be found to attend and take a complaint from Adult D. An appointment was then made with Adult D to take a statement of compliant on the 18th October 2017. Once completed and a high-risk DASH being submitted the crime was allocated for the arrest of Adult B. Adult B was then arrested on the 19th October 2017. Adult B was interviewed but made limited comments so additional evidence was required to provide sufficient evidence to progress a prosecution. A gatekeeping decision was made to release Adult B to enable a forensic download of his mobile phone.

16.12.3 There has been a change in the law which has affected the way in which the Police deal with bail and pre-charge bail conditions. The Police and Crime Act 2017 changed the circumstances and set timescales when pre-charge bail conditions could be imposed. The new laws came into effect on the 3rd April 2017. This change has resulted in a position where suspects are being released under investigation (RUI) and are therefore not being given bail conditions. On this occasion the Police had to make further inquiries in order to obtain the evidence (phone contact) to prove the offence. Without this evidence, and due to the nature of the offence, there would have been insufficient evidence to warrant a remand in police detention. Even if this had occurred experience shows that the courts would been unlikely to have passed a custodial sentence on Adult B [65].

16.12.4 Whilst the focus of the report remains on the interaction between Adult A and Adult B the review process has highlighted a number of specific issues in relation to the way in which domestic abuse was responded to concerning Adult D. As the ethos of the review is to improve the provision of domestic abuse services and interagency working these have been included within this report.

16.12.5 In respect of domestic abuse, the incidents prior to 2016 were dealt with by the Police in accordance with the domestic abuse policy at the time. On review all of the reports had been risk assessed and referred to support services, so bar the high risk domestic report in February 2006 (which was before the introduction of the MARAC process) these incidents would have stood up against today's standards.

On review there were two compliance issues relating to the recording of incidents (16th September 2016 and the 2nd May 2017) against the National Crime Recording Standards. These were human errors and ultimately had no bearing on the outcome of this case. From an organisational perspective similar issues were raised during a HMIC Inspection (2016)[66]. In response the Force has delivered a

[65] Figures from the Ministry of Justice identify that the number of restraining orders imposed by courts in England and Wales rose from 20,356 in 2013 to 23,057 in 2015, up 13%. Just over a third of these – nearly 8,500 – were breached. Penalties for breaching an order can result in a prison sentence of up to five years. MoJ figures reveal that almost two-thirds of those who breached their orders received a non-custodial sentence. Even when the offender had committed multiple breaches, a custodial term was unlikely. (Guardian 2017).

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

training programme in May/June 2017 to all relevant staff and has initiated a quality assurance and compliance regime to improve practice.

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

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

16.12.8 In this case Adult D was allowed to continue to work in a school which was a positive experience for her and the school. This allowed her some level of normality and access to peer support. Whilst this should be seen as good practice any associated risks were not considered by the school, or if they were they were not documented. The school had not considered the risk to Adult D, her children and others, whilst she was at the school. This was particularly important as Adult B knew about the routines followed and how to access the school. Policy and procedures should ensure that, in cases of domestic abuse, the risk to others is clearly reviewed and documented. An effective risk management plan is essential in minimising or negating risk and should have been put into place at the point of disclosure. In this case Adult B had attempted to make contact about his wife and children and whilst the staff present were able to delay his request, a structured plan would have ensured a consistent response and provided staff with the clarity of instruction that they required to mitigate such events.

16.12.9 The Education IMR also clearly identified that the school where Adult D worked did not appear to have considered whether Adult D's duty to safeguard children in her work capacity was impaired due to her experiences. They also failed to consider whether she fully understood the impact of domestic abuse on her own children, and whether there were concerns about the care of her children. This could have impaired her judgement in her work capacity. In this case there had been a disclosure that Adult D had slapped her own child and pulled his hair. No referral had been made to either a Local Authority Designated Officer (LADO) or children's social services at the time and therefore the school failed to follow their own procedures. In this case the actions of Adult D appear to have been minimised due to the disclosures that she and her children had made within the school.

16.12.10 All education settings as far back as pre-school knew that Adult B suffered from some kind of illness, however there was no documented detail as to the nature of

the illness or its potential impact. Schools 1 and 2 held unconfirmed information that suggested that Adult B suffered from leukaemia, but staff appeared to be dubious about the accuracy of this information.

16.12.11 The Education IMR has further identified that there would appear to be a lack of clarity about how schools use the CARA, its purpose, how it is monitored, and how concerns are escalated. All of the CARAs' that were received by the schools were logged in their child protection files but the level of action taken as a result of them was variable. The CARA was only openly discussed with the victim once all parties were aware of the level of domestic abuse occurring (following Adult D's disclosure to the Police in November 2016). Prior to this date, the CARA was not discussed with the victim or in any detail with any of the children. This may be the right approach for some, however in the Education IMR, it is argued that more emphasis needs to be put on professional curiosity and asking the right questions.

16.12.12 In terms of CARA's the Education IMR identified that there needs to be a clearer understanding of what is expected and how to respond. It is suggested that schools would benefit from guidance on:

- whether or not to speak to the victim.
- whether or not to approach the child, and if so, what questions to ask.
- how to ensure the safety of the victim and the child (including determining the need for a risk management plan).
- how to manage the perpetrator if still having contact with the family.
- how to respond to an escalation in CARAs' relating to the same family.

16.12.13 When the question of CARA was broached with the schools by the Education IMR writer, none of them appeared to have considered their role in monitoring the reports and managing any concerns about escalation. Their expectation was that someone else would be doing the monitoring (and escalation where needed). The implied position from the schools was that a CARA is dealt with in the same way as an Operation Encompass Alert[67]. The CARA and its central role in safeguarding children have perhaps been lost and may require some additional training and guidance from the Police and the local authority to ensure it reaches its full potential.

16.12.14 The Education IMR has also identified that the family most likely would have benefited from a co-ordinated early help programme of support. Although there were models for early help intervention available at the time (Common Assessment Framework) take up by families and professionals tended to be sporadic. With the introduction of the Early Help Assessment Tool; the Gateway process, and the Plymouth Assessment Framework (and Threshold Document), it is argued that had these concerns been identified today they would have resulted in an Early Help Assessment or even statutory intervention (due to the allegations of physical abuse). Whilst the family as a whole may have benefitted from such an

[67] An Operation Encompass Alert is an early warning system used in Plymouth to notify schools that a student may have experienced a domestic abuse incident the night before and therefore may need some extra support coming into school.

intervention it is unlikely that this alone would have been sufficient to have addressed Adult B's declining mental health.

16.12.15 In respect of Livewell Southwest their domestic abuse policies have been re written since the incident date. A protocol has also been put into place to support staff that are experiencing or are the perpetrators of domestic abuse and it highlights the responsibilities of Livewell Southwest as an organisation. A new MARAC policy is also with the Executive with overarching responsibility, currently for ratifying.

16.12.16 Within their IMR PATH identified that they do not have a specific domestic abuse policy and this is therefore the subject of a recommendation later in this report.

16.12.17 The family of Adult A had raised concerns as to why the Police had not been contacted when paramedics attended Adult B's address. Adult B had apparently dislocated his thumb during the attack on his mother and her family have questioned whether this should have raised concerns amongst the ambulance crew that attended. The Panel were able to establish that when the paramedics attended the scene their primary concern was the welfare and treatment of Adult A. The paramedics were aware that CPR had been commenced and they commented that 'it was poor'. Health representatives on the Panel confirmed that this was not an unusual observation as if performed by an untrained person and can often result in injuries to the individual concerned. In this case the CPR performed had not resulted in any improvement in Adult A's condition and her appearance was that expected of someone who had undergone the procedure. No concerns were raised that a criminal offence had been committed and the priority was to transport Adult A to hospital. The operational practice in this case adhered to policy and there has been nothing found as part of the review to suggest that police should have been contacted.

16.13 Supervision

16.13.1 Effective supervision was demonstrated by the majority of agencies involved with the family and was evidenced within IMR's. There was evidence that records were reviewed and that staff had supervisory input and support when making decisions. In the Police IMR examples were provided of supervisory intervention in respect of DASH risk assessment and the upgrading of logs to ensure an appropriate response.

16.13.2 In respect of the DSL involvement with the family and the issues raised with respect of child protection referrals there would appear to have been a lack of supervisory support and oversight. Active and qualitative supervisory practices would have identified the information that was available, risks to the children and the opportunities for intervention and referral.

16.14 Training

16.14.1 All agencies involved in this review have demonstrated their commitment to

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

16.14.2 Within Livewell Southwest staff were and continue to be trained to the appropriate levels of safeguarding training as per the intercollegiate document [68] which correlates with their job description, and the organisational training needs analysis of each of the organisations at the time. Domestic abuse is an integral component of that training.

16.14.3 Staff within the Livewell Southwest are now being offered the DASH risk assessment training so that routine enquiry can be introduced throughout the organisation as a whole. Some service lines already ask the domestic abuse questions and there is an aspiration for this to be rolled out to capture all individuals who access services from Livewell. There are current policies in place that are in the process of being re written to reflect changes in domestic abuse reporting using the DASH assessment.

16.14.4 The GP in this case had received regular safeguarding training (last trained in November 2016)

16.14.5 In respect of the Police almost the entire compliment of response staff in the City have been trained in domestic abuse. This training remains ongoing, due to staff turnover. The Police are also currently developing a document which sets out the minimum training standards for officers in relation to safeguarding. This will increase the knowledge of officers and staff and ensure a consistent approach to risk factors. The force is also awaiting a new DASH which is likely to be released by the College of Policing and when this is done they are looking to retrain all officers and appropriate members of staff.

17.0 Conclusions

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

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

17.3 Although Adult B exhibited significant risk factors (due to his declining mental health and previous violent behaviour) there was insufficient information

[68] Safeguarding children and young people: roles and competences for Health Care Staff – Intercollegiate. Third Edition; March 2014.

available to individual agencies to suggest that Adult B posed any specific threat to Adult A on the days prior to her death. Adult B had not made any direct/indirect threats or intimated violence towards his mother.

17.4 Adult B's violence was perpetrated against Adult D and there was no evidence from the risk assessments conducted that he posed any additional risk outside of his immediate family setting. He had never demonstrated the intent to commit such a crime and had never threatened to kill anyone. No one agency had a holistic overview of all of the information in relation to this case and consequently there was no true appreciation of the risks that Adult B could have posed to others in the community.

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

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

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

17.8 The controlling behaviour demonstrated by Adult B in relation to his mother and others is known to be a key marker for fatal domestic violence but in this case the professionals working with the family did not have any specific indication that Adult B was going to commit a homicide. The risks associated with his behaviour were being managed through health intervention supported by those working with people suffering from addiction.

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

17.10 In the main agencies are confident that should an individual present themselves then their staff are trained to identify the signs of domestic abuse or coercive and controlling behaviour. There was evidence presented at panel documenting that all agencies continue to train their staff in this area of safeguarding and progress in relation to this should be continually monitored.

18.0 Lessons Learned

18.1 This part of the report will summarise the lessons which have been drawn from the case and how those lessons are to be translated into recommendations for action.

18.2 The learning opportunities identified in this case are listed by number and these correspond with the recommendations in section 19.0. As previously stated some of the learning and the recommendations relate to issues specific to the education and welfare of children. These have been included in the report as they were identified as part of the DHR process and the Panel did not want these issues to be lost as they will benefit the lives of children living with parents with complex needs in the future.

Single Agency Learning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Multi Agency Learning

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

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

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

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

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

The review identified that whilst the GP for Adult B had been trained in relation to domestic abuse further awareness was required. At the time of the review Safer Plymouth had been working on a concurrent DHR set of recommendations where actions were wholly focussed on work with GP surgeries. DA awareness raising training was undertaken with all local GP surgeries by the local CCG during the timeframe of this DHR. There is also a business case being developed with Devon CCG to look at rolling out IRIS[69] to all local primary care networks. As a consequence this recommendation was not duplicated in this review.

19 Recommendations

19.1 This section of the Overview Report sets out the recommendations made by the DHR panel and then the recommendations made in each of the IMR reports.

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

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

Single Agency Recommendations

- Recommendation 1.

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

- Recommendation 2.

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

- Recommendation 3.

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

- Recommendation 4.

  PATH to implement a domestic abuse policy within the organisation.

- Recommendation 5.

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

- Recommendation 6.

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

- Recommendation 7.

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

- Recommendation 8.

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

- Recommendation 9.

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

- Recommendation 10.

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

- Recommendation 11.

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

- Recommendation 12.

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

- Recommendation 13.

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

- Recommendation 14.

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

- Recommendation 15.

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

- Recommendation 16.

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

- Recommendation 17.

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

- Recommendation 18.

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

- Recommendation 19.

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

- Recommendation 20.

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

- Recommendation 21.

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

  <u>Multi agency recommendations</u>

- Recommendation 22.

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

- Recommendation 23.

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

- Recommendation 24.

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

Glossary

121A – Child notification form used by Devon and Cornwall Police (this form has since been superseded by the ViST).
AAFDA - Advocacy After Fatal Domestic Abuse.
A&E - Accident and Emergency.
BCHA - Bournemouth Churches Housing Association.
CARA - Child at risk alert.
CCG - Clinical Commissioning Group.
CFT - Chronic Fatigue syndrome.
CIN - Child in Need
CMHT - Community Mental Health Trust.
CPOMS - Child Protection online Management System.
CPR - Cardiopulmonary resuscitation
CPS - Crown Prosecuting Service.
CSP - Community Safety Partnership.
CSW - Community Social Worker.
CYPS - Children and Young Person Services.
DAHA – Domestic Abuse Housing Alliance
DASH - Domestic Abuse, Stalking and Harassment and Honour Based Violence risk assessment.
DHR - Domestic Homicide Review.
DSL - Designated Safeguarding Lead.
DVO - Domestic violence Officer.
ED - Emergency Department.
GP - General Practitioner.
GSC - Government Security Classifications.
HTT - Home Treatment team
ICPC – Initial Child Protection Conference.
IDVA - Independent Domestic Abuse Adviser.
IMR - Independent Management Review.
IPCC - Independent Police Complaint Commission.
IRIS - Identification and referral to Improve Safety.
LADO - Local Authority Designated Officer.
MARAC - Multi Agency Risk Assessment Conference.
MDT- Multi Disciplinary Team Meeting.
MHT - Mental Health Team.
NHSE - National Health Service England.
OOH - Out of Hours.
OPA - Out Patients Appointment.
PATH - Plymouth Access to Housing.
PCC - Plymouth City Council.
PCT- Primary Care Trust.
PDAS- Plymouth Domestic Abuse Service.
PHNT - Plymouth Hospitals NHS Trust.
PIN - Police Information Notice.

PIP - Personal Independence Payments.
PTA - Plymouth Temporary Accommodation.
SHA - Strategic Health Authority.
SIO - Senior Investigating Officer.
SIRI - Serious Incident Requiring investigation.

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