safe & sound

Dudley's Community Safety Partnership

A Domestic Homicide Review
Overview Report
DHR 2

Report into the death of a 78 year old woman

'Annette'

January 2016

Report produced by Malcolm Ross M.Sc.
Independent Chair and Author

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List of Abbreviations

CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CSP	Community Safety Partnership
DASH	Domestic Abuse Stalking and Harassment
DCPSB	Dudley's Community Safety Partnership Board
DDS	Dudley Disability Service
DGNHSFT	Dudley Group NHS Foundation Trust
DHR	Domestic Homicide Review
DNA	'Did Not Attend'
DWMHP	Dudley and Walsall Mental Health Partnership NHS Trust
EPCMHN	Enhanced Primary Care Mental Health Nurse
FAST	Fast Alcohol Screening Test
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
IMR	Individual Management Review
NHS	National Health Service
MBC	Metropolitan Borough Council
MNC	McMillan Nurse Consultant
SAP	Single Assessment Process

Introduction and Background

The members of this review panel offer their sincere condolences to the family of Annette for the sad loss in such circumstances.

The pseudonyms used in this report have been decided by family members.

1. Introduction

1.1 This Review concerns Annette, a 78[1] year old woman, who died as a result of an incident at her home at lunch time on Christmas Eve 2015. There had been an argument late on Christmas Eve between Annette and her son, Phillip aged 38 years, over food he was going shopping for, for Christmas Day lunch. He picked her up to move her towards the front door but Annette and Phillip stumbled near to the front door and Annette injured her pelvis. An ambulance was called and she was taken to hospital and admitted for treatment.

1.1.2 She was seen by police on Christmas Day 2015 and reported that Phillip had been bad tempered with her over the food and that he had shaken her in the past. Annette's Hip operation had been successful. She had overcome a prior chest infection. Rosemary (Annette's middle child) was in discussions with Social Services about Annette's imminent discharge, when in mid-January 2016, Annette's condition suddenly deteriorated while she was in hospital, and she died two days later

1.1.3 A Home Office Pathologist determined that Annette had died from Pneumonia caused by a combination of lung carcinoma, chronic obstructive airways, disease and hospitalisation as a consequence of fractured hip.

1.1.4 Phillip was charged with her manslaughter on the direction of Crown Prosecution Service. He eventually appeared before the Crown Court and was acquitted of all charges.

1.1.5 In accordance with Home Office Guidance[2] a Domestic Homicide Review was commissioned.

1.2 Purpose of the Review

1.2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[3] on 13th April 2011 and reviewed in December 2016[4]. Under this section, a domestic homicide review means 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 was related or with whom he was or had been in an intimate personal relationship, or*

[1] Annette was born in 1937 but stated for years that she was 2 years younger. Her date of birth on her marriage certificate was false. The children confirmed her correct date of birth from her birth certificate.

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

[3] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*

[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death"

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[5], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

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

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

1.2.5 In December 2016, the Government again issued updated guidance on Domestic Homicide Reviews especially with regard to deaths resulting from suicide. The guidance[6] states:

'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.'

1.2.6 The guidance[7] defines coercive and controlling behaviour as:

'Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

[5] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.

[6] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 18 page 8

[7] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 15 page 8

1.2.7 The circumstances of Annette's death meet the criteria under this section of the guidance.

1.2.8 Such Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a review is to:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse: and
- Highlight good practice

1.3 Process of the Review

1.3.1 Safe & Sound (Dudley's Community Safety Partnership) received a notification letter from West Midlands Police on 26th January 2016 in respect of Annette's death. The notification letter advised that Annette's death "may fit the definition of a Domestic Homicide Review, as defined in the Domestic Violence, Crimes and Victims Act 2004". The Community Safety Partnership was asked to consider and discuss the circumstances of Annette's death in line with Home Office Guidance.

1.3.2 In line with Home Office Guidance and Safe & Sound (Dudley' Community Safety Partnership) procedures there was a scoping exercise and a DHR Core Group Meeting was convened for 4th March 2016.

1.3.3 The Core Group considered information that they had at that point in time and concluded that depending on the cause of Annette's death and the charge in respect of Phillip, would determine whether a Domestic Homicide Review would take place or a Safeguarding Adult Review.

1.3.4 The delay in commencing the Domestic Homicide Review was by and large two-fold. First the inquest into Annette's death was suspended. The cause of her death was not made known to the Community Safety Partnership until November 2017. Secondly, the Community Safety Partnership was awaiting the outcome of the trial at the Crown Court. The Home Office were notified on two occasions in respect of the delay.

1.3.5 An independent Chair and Author was commissioned and appointed and a DHR Panel was appointed. At the first review panel terms of reference were drafted. On the 29th April 2019, the Board approved the final version of the Overview Report and its recommendations.

1.4 Independent Chair and Author

1.4.1 Home Office Guidance[8] requires that;

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."*

1.4.2 The Independent Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and since retiring in 2000 he has 18 years' experience in writing over 80 Serious Case Reviews and chairing that process and, since 2011, performing both functions in relation to over 33 Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.5 Domestic Homicide Review Panel

1.5.1 In accordance with the statutory guidance, a Panel was established to oversee the process of the review. Mr Ross chaired the Panel and also attended as the author of the Overview Report. Other members of the panel and their professional responsibilities were:

• Malcolm Ross	Independent Chair and Author
• Sue Haywood	Head Community Safety Dudley MBC
• Katriona Lafferty	Community Safety Officer – Reducing Vulnerability Dudley MBC
• Anna Gillespie (now Walsh)	Chief Executive CHADD
• Tracey Priest	Safeguarding Report Writer DWMHP NHST
• Sharon Latham	Head of Safeguarding DWMHP NHST replaced 18.10.18 by: -
• Sarah Mantom	Head Safeguarding DWMHP NHST
• Judith Page	Named Nurse Safeguarding Adults Dudley Group NHSFT
• Christina Rogers	Head of Safeguarding Dudley Group NHSFT
• Stephen Lonsdale	Head Adult Safeguarding Dudley MBC
• Sam Portman	West Midlands Police
• Raj Lagan	Back Country Women's Aid

[8] Home Office Guidance 2016 page 12

- Jane Atkinson Dudley CCG

1.5.2 The Panel members confirmed they had no direct involvement in the case, nor had line management responsibility for any of those involved. The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.5.3 The Panel met on five occasions on the following dates: 24th April 2018, 14th June 2018, 16th July 2018, 5th October 2018, and the family members attended a panel meeting on 21st December 2018.

1.6 Parallel proceedings

1.6.1 There were parallel proceedings with HM Coroner for Dudley who has concluded the inquest arriving at a conclusion that death was due to Pneumonia caused by a combination of lung cancer, chronic obstructive airways disease and hospitalisation as a consequence of fractured hip.

1.6.2 Annette's death was investigated by West Midlands Police and her son was charged with her manslaughter. He appeared before the Crown Court and was acquitted.

1.7 Time Period

1.7.1 The time period for the review is from 1st January 2005, being the date when the Phillip became a carer for Annette, to the date of the Annette's death in January 2016.

1.8 Scoping the Review

1.8.1 The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the DCSP to identify agencies that had involvement with Annette prior to her death. Where there was no involvement or insignificant involvement, agencies were requested to inform the Review by a report.

1.9 Individual Management Reports

1.9.1 An Individual Management Reports (IMR) and comprehensive chronology was received from the following organisations:

1.9.2 IMRs to be produced by:

- Dudley CCG Primary Care
- Dudley and Walsall Mental Health Trust
- Dudley Disability Service on behalf of Adult Social Care
- Dudley Group NHS Foundation Trust - Acute and Community Services

1.9.3 Statements of information were received from:

- West Midlands Police
- West Midlands Ambulance Service

1.9.4 Guidance[9] was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the death indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standard
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

1.9.5 Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the reports. The recommendations are supported by the Overview Author and the Panel.

1.9.6 The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

2 Terms of Reference

2.1 The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed

Generic Questions are:

- Were practitioners sensitive to the needs of Annette and Phillip, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about Annette or Phillip? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse of Annette or Phillip and were those assessments correctly used in this case? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Annette subject to a MARAC or other multi-agency fora?
- Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were Annette's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of Annette should

[9] Home Office Guidance 2016 Page 20

have been known? Was Annette informed of options/choices to make informed decisions? Were they signposted to other agencies?

- Was anything known about Phillip? For example, were there any injunctions or protection orders that were, or previously had been, in place?
- Had Annette disclosed to any practitioners or professionals and, if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of Annette, Phillip, Ann, Rosemary and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard Annette and promote her welfare, or the way it identifies, assesses and manages the risks? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- Did any staff make use of available training?
- Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?
- How accessible were the services for Annette?
- Were agencies cognisant of any care or support requirements for the son as a carer?
- Were agencies aware of any care or support needs for Annette?

Individual Needs

2.2 Home Office Guidance[10] requires consideration of individual needs and specifically:

> 'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'

2.3 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

[10] Home Office Guidance 2016 page 36

- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

2.4 The review gave due consideration to all of the Protected Characteristics under the Act.

2.5 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

2.6 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act. Annette herself refused help from agencies, declined medical treatment but was considered throughout to have the capacity to make those decisions

Family Involvement

2.7 Home Office Guidance[11] requires that:

> "Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

2.8 The 2016 Guidance[12] illustrates the benefits of involving family members, friend and other support networks as:

> a) assisting Annette's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide;
>
> b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises Annette helping the process to focus on Victims and perpetrator's perspectives rather than just agency views.
>
> c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.
>
> d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of Annette and/or the soon in order to see the homicide through the eyes of Annette and/or Phillip. This approach can help the panel understand the decisions and choices Annette and/or Phillip made.
>
> e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information

[11] Home Office Guidance 2016 page 18
[12] Home Office Guidance 2016 Pages 17 - 18

for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

f) revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) enabling families to choose, if they wish, a suitable pseudonym for Annette to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

2.9 Comments made by the family members have been included and referred to in this report. Please see section 'Views of the Family'.

2.10 Family members have been supplied with a redacted copy of the Overview report and the Executive Summary of this report.

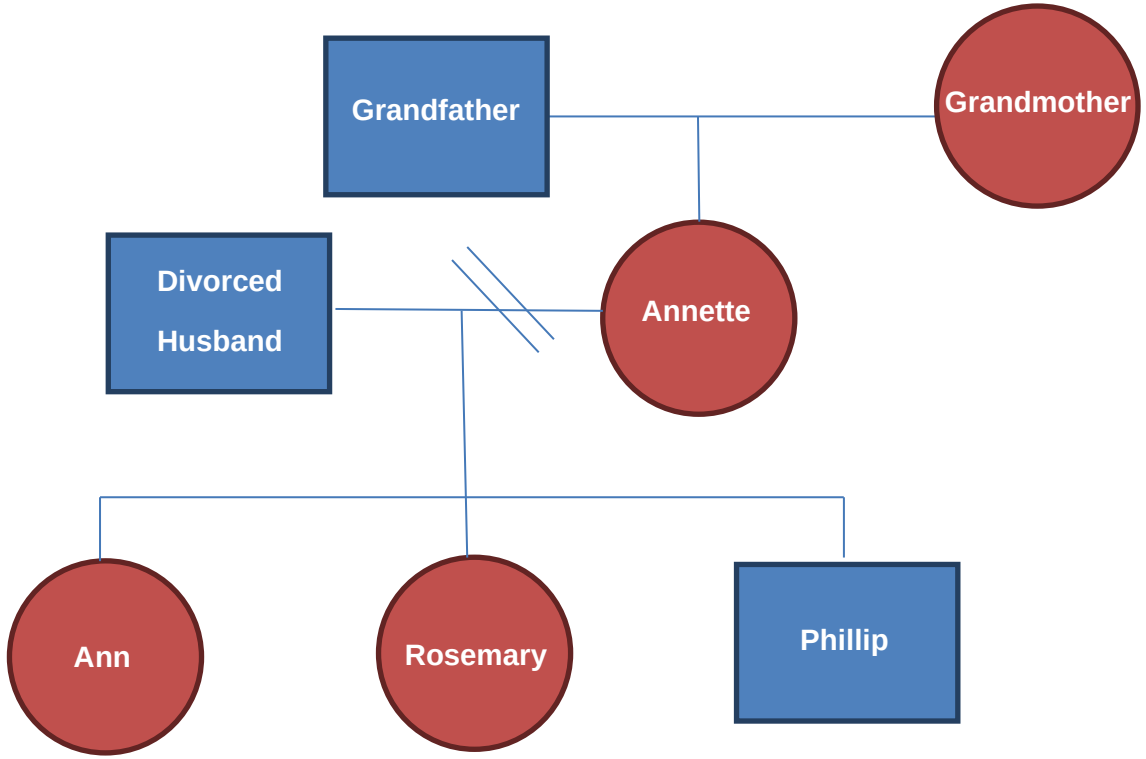
2.11 Family members were informed of the Advocacy After Fatal Domestic Abuse (AAFDA) service and given literature about AAFDA at the beginning of the review when initial contact was made by the Independent Chair and Author

Subjects of the Review

2.12 The following genogram identifies the family members in this case, as represented by the following key:

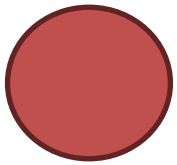
Annette	Female – mother of Ann, Rosemary, and PHILLIP.
Ann	Female - Oldest child of Annette
Rosemary	Female – Middle child of Annette
Phillip	Male – Youngest child of Annette
Ex Husband	Divorced husband of Annette – father of Ann, Rosemary & Phillip

GENOGRAM



Separated /Divorced

Female



Male

3. Summary of events.

3.1 Annette was a 78 year old woman. She married her husband in 1963, but divorced him in the early 1990's. She has three children referred to in this report as Ann, Rosemary and Phillip. Phillip is the person that stood trial and was acquitted.

3. 2 For reasons set out in the section of this report entitled the 'Views of the Family', both girls left home at quite an early age leaving their brother, Phillip, at home.

3.3 Phillip is a single man and employed in the HMRC industry. He had a settled quite responsible job which suffered in the latter years due to him taking responsibility to looking after his mother whose health was poor. Phillip says he has been away from work with depression due to caring for his mother.

3.4 Annette and her husband, before they divorced, moved from Birmingham area to Dudley to be near her parents who lived close by. Again, details of Annette's life are within the Views of the Family section and are provided by Annett's children on interview with the Author of this report

3. 5 The timeline for this review starts in January 2005, the time when Phillip became the carer for his mother. Phillip has given his consent for his medical records to be provided to the review process.

3. 6 The following chronology has been split into two sections, one for Annette and one for Phillip to ensure, as far as possible, that Annette's voice is heard and not lost among a mixed chronology which includes a large amount of information about Phillip.

Annette

3.7 There are Police records regarding both Annette and her ex-husband dating back to the 1970's but none related to domestic violence or abuse between them. The records mainly concern problems with neighbours, anti-social behaviour by others but nothing that can be attributed to any form of domestic abuse between Annette and Phillip.

3.8 With regard to the medical history of Annette, the medical chronology is extensive due to her numerous medical conditions. Mention is made of a number of relevant entries, the remainder being routine checks, appointments and blood pressure tests. It is known that Annette suffered from a stroke in 2005, prior to the scoping dates of this review. In August 2005, following her stroke, Annette had an Access Visit from an Occupational Therapist. It was identified that there were tripping hazards in the house and the son was advised to remove the carpets downstairs. Annette had previously fallen due to a trip over the carpet. It was also noted that Annette was prone to hoarding and the room was cluttered.[13] Annette self-discharged from hospital.

3.9 On 29th August 2006, records indicate that Annette attended her GP complaining that she was stressed but did not give a reason. Her blood pressure was elevated and she

[13] In 2005 there was not a Self-neglect Policy in Dudley and staff would not have received any training in regard to self-neglect or hoarding. Self–neglect has been included in Safeguarding Adults Training since 2010 following two Serious Case Reviews in Dudley where self-neglect was a feature. This was further strengthened when The Care Act 2014 was introduced in April 2015 and Self-Neglect was identified as one of the ten types of abuse.

was prescribed medication. There is nothing to suggest that she was asked what was causing the stress.

3.10 In March 2007, Annette was prescribed anti-depressants as she was grieving over the loss of her brother. In September of that year records indicate that Phillip expressed a wish to purchase a blood pressure monitor out of concern, to keep an eye on Annette's blood pressure as it was often high & serious risk of heart attack- Annette also wouldn't attend appointments & would refuse to go.

3.11 There are several missed appointments when Annette failed to attend to her GP surgery. In March 2008 she failed to attend for a breast screening – no reason was recorded.

3.12 In September 2008, Annette was referred to speech and language therapy associated with her stroke. In November 2008, a discussion was had with Annette and Phillip about general medicine and elderly care.

3.13 In March 2009, Annette failed to attend four appointments at the speech therapy, two because she was reported to be too ill to attend and two more cancelled without notice. The family note that Phillip was always willing and able to take her to her appointments. She was discharged from that service. The GP was informed of this by letter and Annette copied in.

3.14 On 3rd June 2009, Annette telephoned the GP surgery stating she had cut her arm and was unable to attend at the surgery because Phillip was at work. There is no record of what had happened but she was advised to go to the walk in centre that evening and to 'self-care' the arm injury.

3.15 During an outpatient's appointment in 2010, it was noted that Annette required a walking stick to assist her with her mobility. However Community Nurses gave the picture of Annette would rather 'furniture walk' whilst at home rather than use her stick. She would usually sleep downstairs, again rather than negotiate the stairs. Records indicate that at that time Phillip was her main carer who helped her getting in and out of the bath although she managed with her personal hygiene herself. Phillip was also responsible for the shopping, cooking, cleaning and kitchen tasks.

3.16 On 11th November 2010, Annette attended at the General Medicine/ Elderly Care Clinic and found to be well but she insisted that she should not be discharged.

3.17 On 14th November 2011, Annette refused a Home Visit, assessments, continence assessments and blood pressure checks.

3.18 On 26th October 2012, Annette's GP received a letter from FAST[14] indicating that Annette had completed a questionnaire on alcohol consumption where she stated that she consumed 6 or more drinks in one session less than once per month. All other questions were recorded as a negative response. The family are of the view that Annette did not consume alcohol after her stroke in 2005.

3.19 In June 2013, Annette declined a referral to see a dietician and in July 2014 she declined a dementia screening. It was noted that she was at risk of dementia.

3.20 In November 2014, Annette disclosed details of numerous fractures over her lifetime to the Rheumatology clinic. She did not specify how they had happened which Phillip, who was with her, stated that it may be connected to her heavy drinking in the past.

[1414] FAST – Fast Alcohol Screening Test

Annette denied that statement. There is nothing in the GP records from 2005 that confirm that other than a referral letter for an X-ray in 2014 which stated that she had a history of falls and chronic pain and the investigations were to identify if she had osteoporosis.

3..21 Later in November 2014, Annette was seen in the Respiratory Clinic where she stated that she lived with her son and that she had no other family. She had two daughters whom she rarely saw.

3.22 In November 2014, the GP received a letter from the Respiratory Services to the effect that Annette had been diagnosed with a probable condition of cancer. Phillip had expressed his concerns to the Respiratory Services about his ability to care for her and enquired about a package of care. Annette had already decline the offer of help from a local Day Hospice. She also refused a referral to Social Services and indicated she would not accept care from them.

3.23 In December 2014, Annette declined an offer of a referral to a dietician. She did not attend for an urgent scan in February 2015, and she was discharged from the Rheumatology Service again for failing to attend. The following week she failed to attend an appointment with palliative care. She was unable to have any radiotherapy due to her COPD condition and she did not attend for another re-arrange appointment in March 2015.

3.24 Annette was first known to Dudley MBC Social Care Falls Service in February 2015 when there was a requirement to complete an assessment due to her repeatedly falling at home. The assessment was made and a referral for a provision Tele-Care (pendant alarm) and a dossett box for the management of her medications. As both Annette and Phillip were smokers, referrals were also made to the Fire Service for smoke detectors. Following this, the Falls Service failed to reach Annette by letter or telephone and there was no further contact.

3.25 On 12th February 2015 Annette disclosed to her GP that her son gets angry and has depression and that he cares for her. Social Services had attempted to assist but Annette had declined their offer of support. Annette stated that she thought her son was upset at her diagnosis and the District Nurse was going to speak to him about it. She also stated that she had declined support by the Macmillan Nurse. Phillip was under his GP for depression which at that time was considered stable. The GP record states that Annette was declining all additional support being offered to both her and Phillip.

3.26 In September 2015, she refused her B12 medication on two occasions and in October she had to be reminded to take her blood pressure medication. This resulted in her being advised to go into hospital in November 2015, due to her high blood pressure but again she declined to do so. On the same day it is recorded in GP notes that ‘she had a new stress in her life but didn’t want to talk about it’. This was the unexpected death of a relative.

3.27 Christmas Eve 2015, Phillip was compiling a shopping list for Christmas Day lunch items. Annette started to criticise his choice of branded bagged potatoes he was planning to buy & cook with on Christmas Day. Phillip states that her criticism was relentless and he lost his temper with her and picked her up to put her out of the front door. They fell near to the front door and injured her hip. Phillip immediately called for an ambulance and the police. She was taken to hospital where she was admitted. She was advised that she needed surgery on her hip but she declined because of all of her other medical

conditions. Five days later she agreed to have the surgery. Her condition deteriorated and she died in hospital later in January 2016.

3.28 A police investigation commenced and following a forensic post mortem it was determined that her injury had led to her death together with her other medical conditions. On 25th December 2015, Phillip gave 'No Comment' interview on the advice of his solicitor. However, on 22nd July 2016 he gave a full account saying that his mother was verbally abusive towards him and that she acted in a physical and aggressive manner towards him. He moved towards her to put her outside to allow him to have some time to himself. At this point she slipped through his fingers as he took hold of her and she slipped to the floor causing the injury. The Crown Prosecution Service decided there was sufficient evidence to charge Phillip with the manslaughter of his mother but after a trial at the Crown Court he was acquitted.

3.29 Phillip's medical information commences in February 2005, where there are numerous entries on the GP records of Phillip presenting with a variety of conditions including numerous chest infections throughout 2005, feeling stressed (15.12.05) because of work and home, In October 2007, he reported that he was having problems sleeping. His sleeping problem continued into April/May 2008 when he also reported feeling depressed.

3.30 Phillip's depression continued into 2010, when in April, his GP referred him to Primary Care Mental Health Services. In May 2010, he disclosed to Mental Health incidents of historical abuse within the family when he was younger and that he was the carer for his mother. He described how his parents were violent towards each other, and that his grandfather sexually abused his sisters (this is expanded upon in Views of the Family). He planned to marry and have a family.

3.31 In 2011, Phillip bought the family house from his mother knowing that as her health deteriorated she would want the security of somewhere to live. Phillip would be her carer but this purchase caused financial problems for him.

3.32 Phillip's' depression continued during 2012 when he was being prescribed medication.

3.33 In January 2013, Phillip's aunt (Mother's sister-in-law) died and he presented again to his GP with depression. He was prescribed medication for his anxiety and stress. Phillip was left to deal with his Aunt's will. In April of that year Phillip underwent cosmetic surgery after which he was prescribed medication for a wound infection.

3.34 On 5th January 2015, Phillip's GP made a referral to Social Services advising that Phillip had been having thoughts about harming either his mother or himself. He presented himself to Social services in his pyjamas. He could not cope with caring for his mother. He was offered support in his own right but no further referral was made. The GP advised Social Services that Phillip would not be going home that evening and that he had booked himself into a hotel for the night. There was an urgent referral to mental health services.

3.35 On the 8th January 2015, Phillip had an initial assessment with a Primary Care Mental Health Worker, where Phillip had disclosed that he had been suffering from depression for the last 4 years but felt that this was increasing with each episode getting longer. He had been the main carer for his mother for 10 years. According to Phillip his mother had been verbally and mentally abusive towards him when he was young. He had left home at 15 years old due to his mother. His sisters had no contact with her. He had previously seen a counsellor at his school when his parents split up and at the aged of 17 he had overdosed. Phillip stated that he would not do this again because he loved

his family and wanted to live. He stated that he felt his job was at risk. The clinician thought that the trigger for his depression was him being a carer for his mother. He had become quieter and isolated with every day being the same. He avoided people and lacked motivation. The Patient Health Questionnaire (PHQ-9) and General Anxiety Depression (GAD-7) score sheets that were completed indicated that his depression was severe.

3.36 Phillip was referred to Improving Access to Psychological Therapies (IAPT) for Cognitive Behavioural Therapy (CBT) and he was content to go along with a care plan from his Mental Health Clinician about which he was positive. His case was discussed at a South Locality Meeting on 12th January 2015, where it was decided that it would be beneficial for Phillip to attend a Self-Management Carers Workshop run by Dudley Public Health. The Enhanced Primary Care Mental Health Nurse offered to see Phillip again once he had completed the course to which Phillip agreed. He advised the Primary Care Mental Health Nurse he was taking his medication and that he had been signed off from work for a further two weeks. There were no other concerns recorded and the clinician's case was discharged.

3.37 On 26th January 2015, Phillip reported to his GP that he had been to Social Services for help in managing the care for his mother. He had problems sleeping, he was angry, he had apathy and was worried about being laid off work due to sickness. Earlier that month Phillip had self-referred to Social Services, as he wanted a carer's assessment being the main carer for his mother.

3.38 On 9th February 2015, Phillip contacted the Primary Care Mental Health Worker by email advising that the course had run and there would be a delay of a few months before it would commence again and he asked if he could commence his CBT in the interim.[15]

3.39 In February 2015, Phillip reported to his GP that he had been to CBT. He felt that he could not carry on as his mother's carer. He had no thoughts of self-harm. He said that his mother does not leave the house and she had been assessed by social services and he was waiting to hear back from them. GP notes stated he "needs to look into a referral to Age Concern/Age UK and see if they can be of any help." There is nothing to indicate that he self-referred to these agencies.

3.40 Six days later on 17th February 2015, Phillip again presented at his GP and again stated that he was tired of looking after mother and that he was angry and frustrated. He did not want to be her carer. He did not want to harm himself or mother. The GP increased his medication.

3.41 On 23rd February 2015, an assessment of Phillip's mental health was conducted by telephone with Phillip's agreement. The assessment suggested a Self-Management programme for Phillip, who had already contacted them and had been told that there was a waiting list several months long. The assessment recorded that Phillip was feeling low, stressed, lacked motivation, and he was struggling to cope with being a carer. He said he felt worthless and a failure and he may lose job. Phillip requested help with his daily coping skills and with his lack of motivation. He was re-referred on to IAPT for low intensity psychoeducation work. The risk Phillip posed to others was determined as being low. He was waiting to start a Self-Management programme. It was determined that the risk to harming himself of others was low.

[15] An incident report was filed by the Primary Care Mental Health Worker due to a service user being given a Trust employees email address.

3.42 On 13th March 2015, Phillip reported to his GP that his attention 'comes and goes'. He had good and bad days, felt very angry and had the shakes at home. The GP discussed with Phillip how to deal with his mother and warned him to hold his emotions.

3.43 In April 2015, Phillip reported that he was sleeping better but by July 2015, he stated he was unable to sleep as he was stressed caring for his mother who is refusing help from outside agencies. He was prescribed sleeping medication. He was offered low intensity group sessions for his depression but he did not attend. The following month he again failed to attend without giving a reason and he was discharged from the Mental Health Services.

3.44 In July 2015, Phillip was offered a Wellbeing Pre Group appointment for 22nd July and a letter was sent to him confirming those details. The aim of the Pre group meeting is for the person running the group to familiarise the service user with the course. Phillip attended the group and explained that his main frustration was that of having to look after his mother, which meant that there was little else in his life to improve his mood.

3.45 Phillip attended the group session in August 2015 and reportedly got on well and enjoyed the session. He was tasked with completing 5 aspects of the CBT[16] model for the next session however he failed to attend that session and contacted the office to say that he would be attending the following session. He was discharged due to non-attendance at two group sessions.

3.46 In October 2015, Phillip reported to his GP that he was fed up living with his mother and had applied to rent a house to live separately from her. At that time he was living with his mother.

3.47 On 18th December 2015, a referral from Phillip's GP was received by Social Services expressing concern that Phillip was saying that he was going to leave his mother and he was her only carer.

3.48 In January 2016, Phillip admitted to his GP that he had injured his mother by picking her up and putting her out of the house. He stated she was very abusive, difficult and verbally aggressive towards him. The respite from his mother had lifted his mood slightly but he did not feel proud of what he had done.

4. Views of the family and associates.

4.1 On 14th June 2018, the Overview Report Author spent a considerable time with the family members, Ann, Rosemary and Phillip. They described their childhood with their parents as being chaotic. Annette and their father married in 1963 and divorced in the early 1990's. They describe their mother, Annette, as being a very controlling, violent and abusive person who controlled their father. He was 7 years younger than the mother and the children said they were opposites. Annette gambled, drank alcohol, smoked and described as being 'racy', out partying all of the time. The father did not drink, was an intellect and an academic and well educated. He used to sleep in his car to get away from Annette. The family lived South of Birmingham for some years and then moved to the Black Country to be nearer their mother's family. They describe life after that as going 'down-hill'. Annette and the father separated in 1982. The father could no longer tolerate his wife's behaviour. He was of the opinion that Annette had a mental health problem. Once the father had left the marital home, the children describe

[16] CBT - Cognitive Behavioural Therapy

that things were worse for them. Annette was violent to all of them and she would tell them that their father would drown them in the sea. Phillip was protected somewhat because he was the youngest but Annette's treatment of the girls was extreme.

4.2 The father did not marry again but his new long term partner wrote to the employers of the children alleging all sorts of untrue allegations about them which resulted in them losing their jobs due to the contents of the letters. The children believe that their father is no better off with his second partner than he was before he divorced from their mother.

4.3 Both Ann and Rosemary allege they were physical abused by Annette and sexually abused by a relative. They were not aware that the other was being abused until Ann was 17 years of age and Rosemary was 14 years of age, when one disclosed to the other what had been going on. Their mother told the rest of the extended family that the girls were liars and making the allegations about sexual abuse up and called them trouble makers within the family. Both girls were sexually abused from an early age until they were Secondary School age. There are also allegations of sexual abuse by a second male relative. All three described how their mother would use the father's belt to beat them.

4.4 As the girls grew into teenagers, they describe how their mother would dress them up to make them look older and take them to night clubs in the Black Country area of what is now West Midlands. The mother would be looking for male company and would encourage men to go home with the girls along with the mother and men she had found. The girls describe having to make excuses so not to have sex with the strangers. The girls would have to say they were 18 years of age but in truth they were 13/14. In later years, once the girls had left home, when Annette arrived home with her current male companion, she would turn Phillip out of his bedroom because it was the tidiest bedroom in the house for her to use. Phillip was 11/12 years of age at that time.

4.5 They stated that Annette would leave Phillip and Rosemary in the house alone for weeks at a time while she was staying with her boyfriend. Ann had left home by then. Annette had taken the house keys with her so Rosemary and Phillip had to climb in and out of the house through the living room window. Annette would often leave them without money. They all describe them having their birthday and Christmas present taken off them and the mother would sell them for money for cigarettes.

4.6 Rosemary left home at the age of 14 years. Phillip stayed at home and their mother 'kicked' Ann out because she stood up to her mother and she was pregnant. While Phillip was too young to leave, he stayed with Annette until he was 15yrs old then left. He returned later that year and stayed with Annette caring for her until her death. Phillip lost his job because he had to look after his mother on a full time basis.

4.7 The children recall that their mother met a man and moved in with him, sending £15 per week to the two youngest children who were left alone in the family house. They were all school children at that time and were unable to get themselves to and from school so they were absent. Phillip described how he once wrote his mother a note saying 'Please leave me alone' and included a list of things that he wanted to change with his mother. Ann said that her mother would flirt with boys from her school class if he ever brought any friends home. They also stated that their mother would stage burglaries at the family home alleging that the meters had been broken into for the cash, but she had done it herself. The mother also taught the children to steal from shops. Annette also stole from shops.

4.8 They told the Author that their mother required psychiatric treatment but would not accept treatment. She always thought that she was fine and not in need of treatment. Annette would send Ann to the GP to collect Annette's medication.

4.9 The physical abuse inflicted on the children was described as including throwing alcohol, hot tea and hot soup at them, kicking, punching, slapping them around the face and hitting them with ash trays as well as using bread knives to threaten the children. A lot of this abuse was when they were in public. When Rosemary was 15 years of age and Phillip was 9, they were made a Ward of Court.

4.10 Phillip told how he was stuck in the house when his mother had a stroke. In 2010 he bought the house off her so that she would have a roof over her head when her health deteriorated. Annette's treatment of Phillip when he was left to look after him her became unbearable and he contemplated suicide and he had a nervous breakdown spending time rocking backwards and forwards in his bed. He said that he walked to Brierley Hill Social Services with his jeans over his pyjamas sobbing saying that he could not cope any more. Social Services said that Annette needed a Care Plan but Annette said that Phillip was being a 'drama queen' and refused a Care Plan.

4.11 Phillip needed a stomach operation but he didn't have it because there was no one to look after his mother. He said that Annette was lazy and constantly running Phillip down, which took its toll on his self-esteem and confidence. He said that Social Services offered no help whatsoever not even respite for him.

4.12 Phillip described how a nurse came to the house to do an assessment but Annette was so rude to her that the nurse left. Phillip described the house as a 'hoarder's house'. Annette hoarded everything and if he tried to move anything or tidy, Annette would get extremely angry at him, call him names, swear at him and demand that whatever he had moved he returned to its original place. She treated him as a child all of his life. Phillip said Annette was offered a place in a nursing home but declined. She was offered a visit from Social Services but refused to be seen. Phillip gave the Carer's Allowance that was paid to Annette who spent it on cigarettes or save it to buy gifts. She stopped smoking 3 months before her death. She accused Phillip of stealing the benefit money on numerous occasions.

4.13 During the panel meeting on 21st December 2018 when the family attended, it was clear that all of the family members had lasting and ongoing issues stemming from their formative years. The meeting was an emotional experience for both the family members and the panel, and resulted in panel members being able to offer advice and assistance to each of the family members and the commitment to help each of them with their particular issues of concern. The family wrote to the Overview Author expressing how helpful the experience of meeting the panel had been and were grateful for the advice and support they had each received.

4.14 The argument that preceded Annette's injury and subsequent death was, according to Phillip, not out of the usual and was typical of everyday life with his mother. Phillip would also like to have the following statement included in this report after speaking to other carers or communicated with on line:

> *'There should be refuge facilities made available to carers who are at risk of either killing themselves or harming the person they care for. The current system assumes that the person who needs care is considerate to the wellbeing of the carer and will co-operate in anything to make the carer's life easier. I can guarantee you this is rarely the case. No doubt they love them but the care recipient gets tunnel vision and before long familiarity breeds*

contempt and they begin to take the carer for granted. The carer stays put due to a combination of fear, obligation and mostly guilt. They are then subject to constant and ever changing demands that drive carers to breaking point and in some cases suicide.

There needs to be an option where the carer when reaching breaking point can frankly hit the panic button, go to a short term refuge and the care of the individual short term overtaken by agencies before violence erupts.

No doubt government agencies would initially baulk at the potential expense of this, but bearing in mind the expense occurred just in my case alone. The costs of prosecution, legal aid and court time only to lead to an acquittal must be considerable. This could be saved if carers are invested in before the situation reaches boiling point rather than penalising them later.

Thank you for your time and any efforts taken to support carers who are currently in the position I was, I would not wish it on anyone'.

4.15 The family were asked about friends, associates and other family members in the process of this review, however all three children stated that Annette was a recluse and did not have any friends and suggested that this is why she was so possessive about Phillip.

5.0 Analysis and Recommendations.

5.1 There is strong evidence within this review of how abusive Annette was to her children during their childhood. There is also evidence to suggest that her abuse towards Phillip in particular extended until the day of her injury on Christmas Eve 2015 that led to her death. It is unusual to find a parent abusing their adult child and there is limited research to be found on the subject. However Amanda Perl[17], describes the abusive parent, which resembles the description of Annette's behaviour given by her children and Phillip especially.

5.2 Perl states that:

'Spiteful, jealous and resentful, the abusive parents mocks the child, comparing then with a (fake) image they hold of themselves. The child feels unacceptable in basic ways. Belittling, condescending and hurtful actions with exaggerated and extreme responses for the lightest misdemeanour results in projection of the parents' shadow side so they can avoid feeling inferior.'

'Any verbal or physical violence by the parent creates bodily trauma that results in the adult child becoming accident prone, extremely vulnerable leading to susceptibility to harm or illness, depression and anxiety. The beaten and broken child is spiritually bereft and emotionally confused.'

'Poor frustration tolerance, tantrums, jealousies and breaking boundaries, e.g. flirting with, seducing the child's partner or friends is the parents' game.'

and finally:

[17] Emotionally Abusive Relationships; Survivors of narcissistic parents. Amanda Perl M.Sc. Psychotherapist Counsellor May 2017

> 'Fearing abandonment, feeling sad, guilty, frightened, inferior and deeply ashamed, this anxious, angry enraged child becomes even more dependent, reliant and attached to the brainwashing parent. Alternatively, the child may rebel leaving home during teenage years, Suffering premature maturity, they face a lifelong struggle with acute anxiety.

5.3 All of what Perl states was and is still being experienced by Annette's three children in their adult hood

5.4 The agency that had significant dealings with both Annette and Phillip was Dudley Disability Service (DDS) who saw both during a period of twelve months. The DDS IMR indicates that there were incidents whereby Phillip made his concerns known about his inability to care for his mother and there was an incident where an opportunity was missed to open a Safeguarding Referral after Phillip had disclosed thoughts of harming his mother in January 2015. It has to be stressed however that he followed that comment up with another to the effect that he would never hurt his mother and that he loved her. Nonetheless the IMR indicates that consideration should have been given to submit a Safeguard referral.

5.5 The DDS contact with Annette revolved around Social Services offering to provide support to Annette which was designed to alleviate the tasks Phillip was undertaking in relation to his mother. Social Services efforts were hampered by Annette constantly refusing services and wanting her son to undertake the caring role despite his inabilities to cope.

5.6 The DDS IMR indicates that Annette had capacity to make decisions although there was no evidence of a capacity assessment being conducted. It was thought that she had capacity to make decisions with regard to her constantly declining services and according to her GP, there was no diagnoses of any mental health illness.

5.7 Mention has been made of the carer's assessment that Phillip applied for. There was a delay of two months in arranging that assessment which was predominantly due to difficulties in contacting Phillip to engage in the assessment process because of his mother being uncooperative. The DDS IMR indicates that perhaps a more timely assessment may have led to the family having support at an earlier opportunity. The Dudley Disability Service identifies three area of learning;

- More timely carer's assessments to be arranged especially in instances whereby carers have expressed stress, distress or inabilities to cope with their caring role.
- To take allegations of harm to others seriously and raise these as safeguards in the first instance when we are made aware of any concerns
- Collateral checks to be made with other agencies, family and background information sort to inform our safeguarding investigations and threshold decisions on raising cases to a safeguarding investigation.

5.8 The IMR from the Dudley Group NHS Foundation Trust mentions the admission of Annette in 2005 following a stroke. She chose to self-discharge and there is very little documentation as to why she chose to do this. There had been an assessment of her mobility and personal care and it was noted that Phillip helped her with meal preparation. Other than asking Phillip to refit the downstairs carpet because of a trip hazard, there were no other concerns recorded. In retrospect, at that time in 2005, there was not a self-neglect policy in Dudley regarding self-neglect and hoarding which would have been pertinent from 2010 onwards.

5.9 The IMR indicates that there is limited information available about Annette and her home circumstances from the Halesowen Community Nurses due to the Single Assessment Process (SAP) folder, which is usually kept at the patient's home, being unavailable for review. The author has contacted family members asking if any medical papers relating to Annette are still within the household, Community Nursing records have been found by Phillip, examined and incorporated into this report.

5.10 Records indicated that the Community Nurse's main concern when she visited Annette was persuading her of the importance of seeking medical attention, (preferably going to hospital due to her high blood pressure), but it is recorded that Annette was stubborn in relation to her health care. It is also recorded that Phillip was concerned and frustrated that his mother would not seek medical attention. The nurses' visits were usually monthly but would increase when Annette's blood pressure was high. On the occasions the nurse saw Annette and Phillip it is recorded that there were no concerns raised and indeed they both appeared caring towards each other.

5.11 It appears that the fact that Phillip was not coping with caring for his Mother's needs had been discussed at the GP's Integration Meeting. It also appears that no one identified the negative impact Annette's ill health was having on Phillip.

5.12 In November 2014 the MacMillan Nurse Consultant (MNC) saw Annette in the presence of Phillip. She described them as being well presented, smartly dressed and had no concerns about their appearance or behaviour towards each other. It is also recorded that at the very end of the consultation as Annette and Phillip were walking out of the door of the clinic Phillip turned and mentioned to the MNC that he was not able to cope any longer and was not well in himself. The MNC advised him to speak to this GP about his own health and to contact Social Services about getting some help at home, but at that Annette said she didn't want anyone in her house and she refused any help. The IMR points out that this was a potential missed opportunity to take Phillip aside and explore his concerns further. The IMR indicates that 'every contact counts' when recognising concerns and more could have been done by the MNC to support Phillip irrespective that Annette was adamant she did not want any support or care. It appears that Phillip was calling out for help but no one brought all of the information from all agencies together.

5.13 The IMR further considers the number of appointments Annette did not attend as well as her refusal to see community nurses. There is nothing recorded as to why she chose to DNA, despite letters being sent to her by the GP. The policy of DNA's advises staff that where a person is vulnerable the Safeguarding Adult Policy should be referred to but this did not happen as staff did not recognise Annette as a vulnerable person. Another area of comment in the IMR is the recording of who Annette attended the hospital with which was subject to comment in a previous DHR of 2016. Safeguarding Adult Training now emphasizes the importance of these facts.

5.14 Throughout this IMR there are no indications of identified domestic abuse by any of the professionals involved with either Annette or Phillip. There were however, indications of a degree of self-neglect on behalf of Annette and this could have been explored further especially in respect to the issue of hoarding, constantly missing treatment and failing to attend appointments. The lack of self-care and self-management of her health was obvious. There is also no evidence of any discussion with Phillip regarding the impact of Annette's self-neglect and hoarding on him. Finally the IMR identifies a lack of awareness in relation to the role of the Carer Coordinator who could have supported Phillip.

5.15 The Dudley Group NHS Foundation Trust (DG NHSFT) IMR identifies ten areas where learning could be improved:

- From April 2018 domestic abuse and self-neglect/hoarding are explored in more detail during level 2 safeguarding training.
- A Domestic Abuse Guideline is being developed.
- A training programme (12 sessions) for domestic abuse is being delivered in Trust. This is jointly delivered by the Trust Safeguarding Team and CHADD.
- A multi-agency training programme for Domestic Abuse is also being delivered through the CCG
- A level 3 Safeguarding Adults training is being developed. Self-neglect and domestic abuse will be explored in more detail.
- Greater emphasis to be placed on 'missed opportunities' and 'every contact counts' in both level 2 and level 3 training.
- The DHR to be shared at the Trust's Internal Safeguarding Board meeting and lessons learnt to be cascaded to staff.
- Lessons learnt from the DHR will be included in safeguarding training.
- The Trust needs to raise the awareness of the role of the Care Co-ordinator at Dudley Group
- Continue to emphasise the importance of documenting who a person is seen with or if seen alone at each contact.

5.16 The IMR also makes three formal recommendations:

- Develop a level three Adult Safeguarding Training Programme which will include an in depth look at a domestic abuse and self-neglect/hoarding
- Raise the awareness of the role of the Carer Coordinator in the Trust
- Complete the Domestic Abuse Guideline that is being developed.

5.17 In conclusion, the DGNHSFT IMR considers that professionals may not have been able to predict the incident preceding Annette's death but Phillip could have received more support as a carer whilst looking after his mother. Strands of self-neglect and how that can impact on family members and the dynamics in that household were not recognised. The IMR states: 'Potentially if he had received the appropriate support as a carer he may not have assaulted his mother'.

5.18 Dudley and Walsall Mental Health Partnership NHS Trust IMR indicates that following the assessment with the Enhanced Primary Care Mental Health Nurse (EPCMHN) on 8th January 2015 Phillip completed a Patient Health Questionnaire (PHQ/9) and a General Anxiety Depression (GAD/7) score sheet that measured his severity of his depression. The result showed he had severe depression and he was referred to Improving Access to Psychological Therapies (IAPT) for Cognitive Behavioural Therapy (CBT). A care plan was suggested to which Phillip was positive however Phillip cannot recall being given this advice.

5.19 Phillip was discussed at a Multi-Disciplinary Team Meeting on 12th January 2015, the outcome of which indicated he would be better supported by a self-referral to a self-management Carer's Workshop provided by Dudley Public Health.

5.20 Phillip remained in contact with EPCMHN throughout February and in March he was invited for an assessment for his suitability for a one to one or a group psychological intervention. Whilst Phillip agreed, he was unavailable for the first appointment but he

attended an alternative appointment in July 2015. In August 2015 he attended the first session of the Mental Health and Wellbeing Group which Phillip indicated he had enjoyed and got a lot from the meeting. No risks were identified at that time. He failed to attend the following meeting but did attend on 26th August but he did not attend any further sessions. His GP was made aware and the GP was told that if there was further work needed with Phillip there would have to be a further referral. Phillip states that at this time he was very ill and he was unaware of what he was doing and unable to recall appointments.

5.21 In summary the Dudley and Walsall Mental Health Partnership concludes that there were no risk factors identified or disclosures made around domestic abuse whilst dealing with Phillip and that the main trigger for his depression was linked to the stress for caring for his mother and an emphasis was placed on providing coordinated support in order to reduce his stress level. The partnership also identified a lack of professional curiosity which may have led to opportunities for further enquiry of Annette's problems and a full understanding of Phillip's living experience.

5.22 There was no evidence found as to the reasons for his absence or late attendance at the group sessions and nothing to indicate that this had been explored or whether it was linked to his role as a carer to Annette, or whether the fear of losing his job was a barrier to him attending.

5.23 The Dudley and Walsall Mental Health Partnership makes six formal recommendations:

- To ensure that all professionals continue to access the safeguarding practitioners for advice and/or supervision on complex cases, request attendance at multi-disciplinary discussions and reflective practice.
- To ensure that professionals continue to work with the MDT following agreement of the information pathway and make sure it is embedded within our workforce.
- To continue to ensure all professionals complete required mandatory training enabling them to play a key role in the early identification and response to domestic abuse and coercive and controlling behaviour.
- For the Trust to produce further education for staff with the development of a Top 10 Safeguarding Tips including professional curiosity and voice of the adult.
- To ensure lessons learned are embedded in the Trusts learning lessons process.
- To ensure that any recommendations from the DHR case are included in the safeguarding newsletters, domestic abuse training and bulletins which are circulated to all staff.

5.24 All three Health IMR's also suggest Multi-agency recommendations, which are for the overview report to make.

Recommendation 1

Dudley's Community Safety Partnership works with Dudley Safeguard Adults Board to ensure that Dudley's Multi-Agency Hoarding Framework and the DSAB Self Neglect Policy are launched and implemented as soon as is possible in 2019 and that further multi-agency Self Neglect and Hoarding Training is commissioned by DSAB.

Recommendation No 2

Dudley's Community Safety Partnership should work with Dudley Safeguarding Adult Board and Dudley's Safeguarding Children Board to re-establish multi-agency training in respect of domestic violence and abuse.

5.25 One of the main issues identified in this review was the difficulty experienced by professionals who tried to persuade Annette that she needed treatment and care. It was deemed that she had capacity to make decisions and her word was accepted. It also appears that at these moments, Phillip was telling professionals that he could not cope and that his mother did require treatment. This situation is difficult for professionals, especially health professionals as they cannot compel anyone to undergo treatment if they make a decision not to do so. However, it appears that Phillip's view was not considered and the effect of his mother's decision making was having in his physical and mental health was not significantly recognised. Phillip was also experiencing 'round the clock' verbal and mental abuse from Annette and he needed respite for a while as opposed to coping skills for an hour every week. There was a lack of professional curiosity by all concerned.

Recommendation No 3

Dudley's Community Safety Partnership to receive assurances from all agencies that professional curiosity is included within training and the CSP is assured within 6 months from the date of publication of this report.

5.26 With regard to the information contained in paragraphs 4.3 and 4.4 above which concern the experiences of the children when they were school age, extensive investigations have been made by Children's Social Care into records for that period of time. This was done to explore if anything existed that would support the family's accounts of those years and to see what action was taken. However, with systems changing a number of times and the passage of many years, no trace of any record could be found. However, as the years have passed by procedures have developed, and practice has changed and the "voice of the child" is very much embedded into social work practice and one would expect such records to now be made available.

5.27 With the passage of time policies and procedures within education settings and Children's Services have significantly improved. The borough has a dedicated Multi-agency Safeguarding Hub (MASH) with a dedicated safeguarding education lead. Settings also have Designated Safeguarding Leads (DSLs) who are placed and specifically trained to identify safeguarding concerns and ensure that children in similar circumstances are able to access appropriate support.

5.27 When professionals attended at the family home it was noted that the house was cluttered and had the potential of being a trip risk. The identification of hoarding as a

potential self-harm/neglect was not as prominent as it is today but the guidance on hoarding has now been incorporated into policies and procedures.

5.28 West Midlands Police have researched records for the family members and whilst there are incidents recorded when police were called to assist the family, none of the incidents recorded as domestic abuse within the family or anything else significant to this review. The only incident that is relevant was the response to the allegation made by Annette around the circumstances that lead to her death and the subsequent investigation.

List of Overview Report Recommendations

Recommendation 1 **Page 27**

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Recommendation No 2 **Page 27**

Dudley's Community Safety Partnership should work with Dudley Safeguarding Adult Board and Dudley's Safeguarding Children Board to re-establish multi-agency training in respect of domestic violence and abuse.

Recommendation No 3 **Page 27**

Dudley's Community Safety Partnership to receive assurances from all agencies that professional curiosity is included within training and the CSP is assured within 6 months from the date of publication of this report.

List of IMR Recommendations

Dudley Disability Service

More timely carer's assessments to be arranged especially in instances whereby carers have expressed stress, distress or inabilities to cope with their caring role.

To take allegations of harm to others seriously and raise these as safeguards in the first instance when we are made aware of any concerns.

Collateral checks to be made with other agencies, family and background information sort to inform our safeguarding investigations and threshold decisions on raising cases to a safeguarding investigation.

Dudley Group NHS Foundation Trust

Develop a level three Adult Safeguarding Training Programme which will include an in depth look at a domestic abuse and self-neglect/hoarding

Raise the awareness of the role of the Carer Coordinator in the Trust

Complete the Domestic Abuse Guideline that is being developed.

Dudley and Walsall Mental Health Partnership

To ensure that all professionals continue to access the safeguarding practitioners for advice and/or supervision on complex cases, request attendance at multi-disciplinary discussions and reflective practice.

To ensure that professionals continue to work with the MDT following agreement of the information pathway and make sure it is embedded within our workforce.

To continue to ensure all professionals complete required mandatory training enabling them to play a key role in the early identification and response to domestic abuse and coercive and controlling behaviour.

For the Trust to produce further education for staff with the development of a Top 10 Safeguarding Tips including professional curiosity and voice of the adult.

To ensure lessons learned are embedded in the Trusts learning lessons process.

To ensure that any recommendations from the DHR case are included in the safeguarding newsletters, domestic abuse training and bulletins which are circulated to all staff.

Bibliography

Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 www.homeoffice.gov.uk/publications/crime/DHR-guidance

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