Domestic Homicide Review

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

In respect of the homicide of Angela

In December 2017

Report produced for Coventry Police and Crime Board by
Paula Harding
Independent Chair and Author
August 2019

ACRONYMS

AAFDA: Advocacy After Fatal Domestic Abuse
AMPH: Approved Mental Health Practitioner
CSAB: Coventry Safeguarding Adult Board
CCG: Clinical Commissioning Group
CPA: Care Programme Approach
CPS: Crown Prosecution Service
CWPT: Coventry and Warwickshire Partnership NHS Trust
DoH: Department of Health
DHR: Domestic Homicide Review
GP: General Practitioner
IMR: Individual Management Review
IRIS: Identification and Referral to Improve Safety in primary care
OASYS: Offender Assessment System used in probation services
SWMCRC: Staffordshire and West Midlands Community Rehabilitation Company
UHCW: University Hospitals Coventry and Warwickshire
WMP: West Midlands Police

GLOSSARY OF TERMS

Approved Mental Health Practitioners are mental health professionals approved by a local social services authority to carry out assessments and admission to hospital under the Mental Health Act

Coventry Police and Crime Board: Coventry's Community Safety Partnership

Care Programme Approach is a package of care for people with mental health problems that includes a care co-ordinator and a regularly reviewed care plan

Coventry and Warwickshire Partnership NHS Trust provides a range of community, children's and mental health services. Those included in this review were:

- **Arden Mental Health Acute Team (AMHAT)** provides a psychiatric and risk assessment service in acute healthcare settings such as Emergency Departments
- **Crisis Resolution and Home Treatment** Team (Crisis Team) offer 24 hour support and treatment for people experiencing a psychiatric crisis and who are already open to mental health services. Home treatment is offered as an alternative to hospital admission
- **Occupational Therapy** aims to improve health and wellbeing through enabling participation in the activities, roles and routines of everyday life. They are a core part of the multi-disciplinary team within community and in-patient mental health services.
- **Community Psychiatric Nurse (CPN)** is a mental health nurse who offers treatment in the community supporting individuals tin managing their health taking medication.

Depot injection: a slow release, slow acting form of medication

IRIS: Identification and Referral to Improve Safety is a general practice-based domestic violence and abuse training support and referral programme

Parricide: the killing of a parent or other near relative

SWMCRC: Staffordshire and West Midlands Community Rehabilitation Company included the following interventions in this review

- **Rehabilitation Activity Requirement:** includes a combination of appointments and activities, designed to support and monitor the offender's progress through their order and support their **rehabilitation**.
- **Pre-sentencing report:** Probation services are required to prepare a pre-sentence report for the court before a custodial or community sentence is imposed. The report should include an assessment of the nature and seriousness of the offence, and its impact on the victim.
- **Fast Delivery Report** is a type of pre-sentence report that was typically shorter and less detailed and could be completed within a one-week adjournment of the court
- **OASys** is the national risk and need assessment tool for adult offenders in England and Wales. It is used to measure an offender's likelihood of further offending; to identify any risk of serious harm issues; to develop an offending-related needs profile; to develop individualised sentence plans and risk management plans; and to measure progress and change over time.

West Midlands Police provided the following services in this review

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

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PREFACE

Members of the review panel offer their deepest sympathy to the family and to all who have been affected by the victim's murder.

Family members have been provided with the opportunity to provide their personal statements which will be added to the report before publication.

Family members were asked to provide pseudonyms for the victim and her son in line with Home Office guidance. They have chosen the name Angela for the victim.

1. INTRODUCTION

1.1. Background

1. This review concerns the homicide of a 68-year-old woman, Angela, who was killed by her 46-year-old son for whom she cared. Her son had been diagnosed with paranoid schizophrenia. At the time of the killing he was found to be experiencing a period of psychosis with delusions and that there was an extensive history recorded of the evolution of his mental health problems.

1.2. Aim and Purpose of a domestic homicide review

2. Domestic Homicide Reviews (DHR) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the homicide of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom she was related or with whom she was or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the homicide.

3. The purpose of a DHR is to:

" a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) 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;
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency

approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice" (Multi-Agency Statutory Guidance 2016, para 7)

4. As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review should "articulate the life through the eyes of the victim…The key is situating the review in the home, family and community of the victim and exploring everything with an open mind". (*Multi-Agency Statutory Guidance 2016, paras 8 and 9*)

5. Hence, the key purpose for undertaking a domestic homicide review is to enable lessons to be learned where a person is killed as a result of domestic violence, abuse or neglect. 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 Timescales

6. The decision to undertake a review was made in February 2018. An independent chair was commissioned, and the panel began to meet in May 2018, in advance of the conclusion of criminal proceedings in March 2019. The panel agreed the draft of the report initially in March 2019 and a period of engagement and consultation with the family, as well as the advocacy services that supported them, followed before the report was submitted to the Community Safety Partnership, Coventry Police and Crime Board, in December 2019.

1.4 Confidentiality

7. This Overview Report has been anonymised and, where stated, redacted. Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail from the victim's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

2. TERMS OF REFERENCE

2.1 Methodology

8. In Coventry, the management of domestic homicide reviews is undertaken by their Safeguarding Adult Board on behalf of Coventry Police and Crime Board, the area's community safety partnership. The Chair of Coventry Police and Crime Board and the Safeguarding Adult Review Group reviewed the circumstances of this homicide and decided that a review should be undertaken as the criteria set out in Section 9 of the Domestic Violence, Crime and Victims Act (2004) had been met.

9. The Home Office was notified in March 2018 of the decision to hold a domestic homicide review. It was acknowledged that the timescale to conclude the review would be dependent on the criminal processes.

10. All local agencies were notified of the homicide and were asked to examine their records to establish if they had been approached by or provided any services to the family and to secure records if there had been any involvement.

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

12. The Senior Investigating Officer in charge of the criminal investigation from West Midlands Police attended the second panel meeting and was able to provide detail on the findings of the criminal investigation and the conclusions of the court which have been incorporated into this review.

13. The Terms of Reference were drawn up by the Independent Chair together with the review panel incorporating key lines of enquiry and specific questions for individual agencies where necessary. Individual Management Reviews (IMRs) were requested from agencies as well as information reports from agencies with less involvement. Briefings were made available for IMR authors by the Independent Chair in advance of their internal enquiries.

14. The panel met seven times during which, panel members were able to discuss the progress of the review and request further clarification and additional material, where needed. Minutes were taken at all panel meetings and all actions agreed for the panel have been tracked and signed off as completed.

15. The panel considered and agreed the draft Overview Report which was also considered by the Safeguarding Adult Board Sub-Group before being endorsed by the Chair of the Coventry Police and Crime Board on 17.03.2020 prior to submission to the Home Office.

2.2 Involvement of Family and Friends

16. Angela's siblings, ex-daughter-in-law, grandchild and sister-in-law were provided with the dedicated domestic homicide review leaflets from the Home Office and each engaged in the review at different times either by face to face meetings, telephone calls, letter or email. They contributed to the terms of reference and their views have contributed to the final report, wherever possible. The independent agencies, Victim Support Homicide Service, Advocacy After Fatal Domestic Abuse (AAFDA) and Hundred Families, provided advocacy and support to family members during the review.

17. Angela's family described her as kind, caring and funny with a heart of gold and a contagious laugh. She was straight talking and bold so wasn't frightened to tell you how

she felt. At the same time, she was a very good listener and made herself available to listen to whoever might need her and her level-headedness meant that she gave good advice.

18. At the stage of setting the terms of reference, family members questioned:

- Why wasn't his risk to others identified when he had a history of violent outbursts?
- How had the police responded each time that reports were made to them concerning Angela or her son?
- What Whitefriars Housing Group were doing about him living in his mother's one-bedroomed home?
- Agencies appeared to have left all the responsibility of managing the perpetrator with the victim. She had told professionals that she did not want him living there due to his outbursts. He was unable to look after himself and take his medication and why didn't agencies intervene?
- Why didn't professionals recognise the obvious deterioration in the state of the bungalow? Angela had been house-proud, but the walls were discoloured with smoke; chairs in the kitchen had been thrown up the walls and broken, seemingly in his fits of rage.
- Why couldn't agencies see that his paranoia was getting worse and his mental health spiralling out of control?
- Why wasn't anyone looking at the whole picture including the police call-outs?
- Angela asked the mental health social worker numerous times to hospitalise him. Were there times when he could have been hospitalised but wasn't?

19. These questions were incorporated into the terms of reference.

20. Family members were able to provide a rich narrative about Angela, her life, experiences and feelings about her son which the review would not have known without them. They were also able to identify those times, from Angela's point of view, where she was frustrated by agencies not responding to her son's needs and how, towards the end of her life, she disclosed being 'at her wits end', not knowing how to summon the help that she thought her son needed. The family's contributions have been included in the body of the report.

21. The draft Overview Report was shared with the family and their comments included.

22. The perpetrator was also informed by letter that the domestic homicide review was taking place and initially agreed that he would like to contribute to the review. However, after the criminal case was heard, he was admitted to a secure psychiatric hospital and his clinicians did not think him well enough to engage thereafter.

2.3 Independent Chair and Overview Author

23. The Independent Chair and Overview Author is Paula Harding, who has compiled the Overview Report, the Executive Summary and co-ordinated the integrated action plan.

Paula Harding has over twenty-five years' experience of working in domestic violence with both senior local authority management and specialist domestic violence sector experience. For more than ten of those years, she was a local authority strategic and commissioning lead for domestic abuse and violence against women for Birmingham. Since leaving the statutory sector she has been an independent chair of both domestic homicide reviews and safeguarding adult reviews and has acted as a consultant to Women's Aid organisations.

24. Ms Harding completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic violence and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office: *Conducting a Homicide Review*[1].

25. Beyond this review, Paula Harding has never been employed by any of the agencies of Coventry Police and Crime Board.

2.4 Members of the Review Panel

26. Multi-agency membership of this review panel consisted of senior managers and/or designated professionals from the key statutory agencies. The Panel members had not had any direct contact or management involvement with Angela's family and they were not the authors of the Individual Management Review reports that their organisations provided.

27. Wider matters of diversity and equality were considered when agreeing panel membership. Refuge, a national domestic violence organisation providing services in Coventry, and Brighter Futures, a regional provider of domestic abuse perpetrator programmes, provided particular expertise on domestic violence and the 'victim's perspective' to the panel.

28. The review panel members were:

- Paula Harding - Independent Chair and Overview Author
- Andrew Errington – Head of Practice Development & Safeguarding Adults, Coventry City Council
- Anneka Steele – Facilitator Co-ordinator, Brighter Futures (Domestic abuse service)
- Claire Cooper – Refuge (Domestic abuse service)
- Craig Hickin – Head of Environmental Services, Coventry City Council
- David Bates – Detective Inspector, West Midlands Police
- Jayne Phelps – Safeguarding Lead, Coventry & Rugby Clinical Commissioning Group
- Kevin Ruddock – (check role) CGL (Substance misuse services)
- Lisa Pratley – Lead Professional for Safeguarding, University Hospital Coventry and Warwickshire

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

- Mandy Braimbridge - Assistant Director of Nursing, replaced Maxine Nicholls as the representative of Coventry and Warwickshire Partnership Trust
- Martina Palmer – Refuge (Domestic Abuse Services)
- Martyn Hale - Director of Care and Support replaced Catherine Collis as the representative from Whitefriars Housing Group
- Rebekah Eaves - Business Manager, Coventry Safeguarding Adult Board
- Tony Kuffa – Regional Manager, Staffordshire and West Midlands Community Rehabilitation Company (Probation Services)

29. The panel was provided with legal oversight and guidance from Coventry City Council Legal Services.

2.5 Key Lines of Enquiry

30. The review sought to address both the 'circumstances of a particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and specific issues identified in this particular case. Individual Management Review Authors were asked to provide a comprehensive chronology and respond to the following questions in respect of their involvement with Angela and her son:

Domestic abuse: risk, threat and needs

- *What was known about domestic violence and abuse in this case? How was abuse identified and how were the needs, risk and threat from domestic violence responded to?*
- *How much information was known and gathered to inform assessments and how formal risk assessment processes were applied?*
- *What **threshold**s were applied to the assessment process and how these were reflected in the service provided?*
- *Whether **mental health or substance misuse** issues affected your agency's response to domestic abuse?*
- *If domestic abuse was not known, how might your agency have **identified** the existence of domestic abuse from other issues presented to you? For example, were there policies and procedures for direct or routine questioning and how well were they implemented in this case?*

Mental Health and Substance Misuse

- *How was* the perpetrator*'s alcohol and drug use understood in relation to his medication, care needs and risk to himself and others?*

Carers

- *Was the victim identified as a carer and what opportunities were there to have a formal or informal carer's assessment or conversation about her needs and responsibilities?*

Engagement

- *How **engaged** were the victim and the perpetrator in assessment processes and services and how much were their views and wishes taken into account?*

How robust was **multi-agency working**? Considerations should include:

- *How effectively did agencies work together to assess, make decisions and respond to risks, threats and needs in this case?*
- *When referrals were made, how did you expect that agency to respond?*

Equality

- *Did **practice** demonstrate the sensitivity of age, gender, disability and any other protected characteristics under the Equality Act 2010 identified in this case? Were any of these factors considered, particularly in relation to caring responsibilities, and if so, responded to appropriately?*

*How **well equipped were staff** in responding to the needs, threat or risk identified for the family. How were staff supported to respond to issues of domestic abuse, safeguarding and public protection through:*

- *Robust policies and procedures?*
- *Sufficient training, supervision and oversight to support them to deliver appropriate services?*
- *Having sufficient resources to meet expected practice?*

*Can you identify any **organisational systems**, in your own or other agencies, that presented difficulties or challenges to your delivery of services to either adult?*

*Can you identify areas of **good practice** in this case?*

*Are there **lessons** to be learnt from this case about how practice could be improved? If these learning themes have been subject to any previous reviews please provide details of actions required and progress against them.*

*What **recommendations** are you making for your organisation and how will the changes be achieved?*

31. In addition, the following agencies were asked to respond specifically in their IMR to the following points.

Adult Social Care and Coventry and Warwickshire Partnership NHS Trust

- *To assess the consideration that was given to the perpetrator's ability to be detained under the Mental Health Act*
- *Whether it was known if family members wanted the perpetrator to be detained under the Mental Health Act and how decisions made in this regard were communicated to them.*

Community Rehabilitation Company

- *The perpetrator received a 12-month community order for criminal damage. How far did the underlying circumstances of that incident impact upon your work with him during the period of his supervision.*

West Midlands Police

- *Following several reports of incidents in relation to his mother and his previous partner, the perpetrator was returned to his mother's address. Had assessments been undertaken or risks identified about this course of action on each occasion?*
- *During 2014 and 2015, the Police received eight reports of domestic abuse from the perpetrator's previous partner. Can you explain the rationale for action being taken against the perpetrator on each occasion?*
- *What opportunities were there to complete a formal DASH risk assessment and what was the rationale if these were not done?*
- *When faced with two potential abusers, how did officers make decisions about who was the primary perpetrator and how much did previous information held within police systems influence that decision?*

Clinical Commissioning Group

- *What was the result of the perpetrator's alcohol screen in February 2015 and how did the practice respond?*
- *The practice was notified of at least five attendances by the perpetrator at the Emergency Department over the most recent 12-month period. In most cases, he discharged himself before being treated. How were these followed up by the practice?*

32. Specific information reports were required from the following organisations:

Whitefriars Housing Group

- *The perpetrator was referred to Tenancy Sustainment by the Neighbourhood Housing Team after they discovered that he had not moved in and mental health concerns were raised. Did the responses comply with the organisation's expectations?*
- *In July 2017, the perpetrator disclosed that he was being abused by his mother and it was noted by the officer had been aware of the victim and her son having a close relationship. Can the officer describe more about how this relationship was observed, how this affected the response provided and whether the follow up visit was made to the perpetrator at his tenancy or his mother's address?*

University Hospitals Coventry and Warwickshire NHS Trust

- *In the times that the perpetrator was seen at the Emergency Department, how was risk, threat and need assessed and responded to?*
- *On several occasions, the perpetrator left the Emergency Department before being seen. Please assess the effectiveness of processes and practices used to enable engagement with vulnerable patients and consider whether any of these contributed to his disengagement on those occasions.*

2.6 Timeframe

33. The panel agreed that the review should focus on the contact that agencies had with Angela and her son during the period between 1st May 2013, when the perpetrator moved into his mother's property, until the end of 2017, when Angela died. Any significant information which might come to light during the review outside the set timeframe, was to be agreed by the review panel for inclusion if determined to be of relevance.

2.7 Individual Management Review Reports (IMRs)

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

- Coventry and Rugby Clinical Commissioning Group
- Coventry and Warwickshire Partnership NHS Trust
- Staffordshire and West Midlands Community Rehabilitation Company
- West Midlands Police

35. Chronology and/or information reports were requested from:

- The Recovery Partnership Coventry
- University Hospitals Coventry and Warwickshire NHS Trust
- West Midlands Ambulance Service
- Whitefriars Housing Group (hereinafter referred to as Whitefriars Housing)

36. All reports were authored by professionals who had not had any direct contact or management involvement with Angela or her son.

37. The National Probation Service presented a pre-sentence report to court on behalf of Staffordshire and West Midlands Community Rehabilitation Company and their involvement was considered under the latter's IMR.

38. During this period, mental health social workers from the local authority's Adult Social Care were seconded to Coventry and Warwickshire Partnership NHS Trust under a legal agreement[2] between Coventry City Council and the NHS Trust. Their involvement was therefore considered under the Trust's IMR.

2.8 Agencies without contact

39. The following agencies were contacted but confirmed that neither the victim nor her son were known to them

[2] Under section 75 of National Health Services Act 2006 between local authorities and an NHS body

- Refuge – domestic abuse services
- Fry Accord Housing Association - domestic abuse perpetrator programmes
- West Midlands Fire Service

2.9 The definition of domestic violence

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

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

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

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

    Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." (HM Government, 2016a)

2.10 Parallel Reviews

41. As the perpetrator had been in the care of mental health services when he killed his mother, Coventry and Warwickshire Partnership NHS Trust reported the 'Serious Incident' under the NHS Serious Incident Framework[3]. It was determined that the need for a single agency 'serious incident review' was superseded by this multi-agency domestic homicide review.

42. The inquest was postponed pending the criminal trial and not resumed as the coroner was satisfied that the criminal process had determined the cause of homicide.

[3] Further information on this framework can be found at https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

2.11 Equality and Diversity

43. The review gave due consideration to the victim's vulnerabilities alongside each of the protected characteristics under Section 149 of the Equality Act 2010. Both the victim and her son were of White British ethnicity. The panel considered that the victim's sex and age were relevant to this review as well as the perpetrator's long-term, disabling mental illness.

44. In the year that the victim died, 8.5% of women killed within the context of domestic abuse[4] were killed by their sons and this was double the number of the previous year (Femicide Census, 2017, p.26)[5]. Bows (2018) recent and first known study to specifically examine domestic homicides involving older people in the UK found that the majority of parricide perpetrators were adult sons and the majority of parricide victims were female and concluded that "the risk factors for domestic homicide in later life are gender specific." (2018:2)

45. Sex and gender plays a further role in this review as the victim was a carer to her son. Sharmer (2016) recognised that women are the predominant providers of informal care for family members with chronic medical conditions and adults with mental illnesses. In this way, there are societal and cultural expectations of women to adopt the role of a caregiver, but these norms and demands do not protect women from the emotional, physical and financial stress that may ensue.

46. The Equality Act 2010 defines a disability as a "physical or mental impairment which has substantial and long-term adverse effects on your ability to carry out normal day to day activities". Under this definition, the perpetrator would be considered to have a protected characteristic. His mother could also be affected by 'discrimination by association' which is defined as someone "being treated less favourably because of their link or association with the protected characteristic of someone else".

47. Consideration of these issues of equality are addressed in the body of the report below.

2.12 Dissemination

48. The following organisations will receive copies of this review:

- Coventry Police and Crime Board, Coventry Safeguarding Adult Board and their agencies
- West Midlands Police and Crime Commissioner
- All agencies involved in the review and beyond through publication on the Coventry Police and Crime Board website

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

3. BACKGROUND

3.1 Persons involved in this review

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

Designation	*Relationship*	*Age at the time of homicide*	*Residing with victim at time of homicide*
Angela	The victim	68	---
The perpetrator	The victim's son and perpetrator of the homicide	46	Yes
The perpetrator's ex-wife	Ex-daughter-in-law of the victim	Not relevant	No
Adult 3	The perpetrator's ex-partner	Not relevant	No
Grandchildren	The victim's two grandchildren	Not relevant	No

50. Angela was 68 when she died and is survived by her sisters, her sister-in law and their families with whom she was close. She also maintained a close relationship with her son's ex-wife and her two grandchildren who are now young adults.

3.2 The homicide

51. Angela was killed in December 2017. When the police arrived at the scene, the perpetrator said that his mother had threatened him with a knife, and she was accidentally stabbed whilst he was trying to take it off her. A post-mortem revealed that she had been stabbed seventeen times and received a fatal injury to the aorta.

52. He was arrested and charged with her murder but later pleaded guilty to manslaughter on the grounds of diminished responsibility. The court heard how, at the time of the killing, the perpetrator was suffering with paranoid schizophrenia; experiencing a period of psychosis with delusions and that there was an extensive history recorded of the evolution of his mental health problems. Judge Andrew Lockhart QC, presiding, agreed with expert opinion that the perpetrator's responsibility was diminished on the grounds of his mental health.

53. For the offence of manslaughter, the perpetrator was sentenced to sixteen years imprisonment, extended by a period of five years to be served on licence. Although he had been assessed as fit for interview and later trial, his mental health deteriorated after his conviction. After sentencing, he was to continue in a secure mental health facility until he was found well enough to serve the remainder of his sentence in prison.

54. During sentencing, the Judge referred to the perpetrator's diminished responsibility due to his mental illness but also to the perpetrator's responsibility for his actions stating,

> *"I am clear that whilst you have longstanding mental health problem it is also plain that you felt great anger towards your mother; this had built up over time. You were exhibiting that anger on ... [date redacted] … December not long before you killed her in this violent and sustained attack. In my judgement anger was the primary and driving reason why you killed her …. your culpability whilst diminished remains high".* (Regina v [redacted] Sentencing Remarks)

4. CHRONOLOGY

55. The sections below have been based on information provided from agencies' records and interviews with staff; agencies' analysis in IMRs; summaries of the criminal trial and interviews and contributions from close family members. It would not be possible to detail the full extent of the perpetrator's involvement with mental health services as they include more than a thousand entries. The chronology therefore represents the Independent Overview Author's view of significant information and events about the victim.

4.1 Background

56. Angela had one son from her marriage and had cared for her husband for several years before he died in 2012. Her only son had been born in 1971 and, by family accounts, had been a "beautiful child and teenager and a decent lad". He married in 1995, worked conscientiously, started buying their home and had two sons who are now young adults.

57. However, four years into his marriage, when he was in his late twenties, he started taking drugs which had a profoundly adverse effect on his mental health, his employment and his marriage. He separated from his wife in 2001 and they divorced two years later. His GP recorded that his divorce featured behaviours including jealousy and domestic abuse.

58. The perpetrator was diagnosed with schizophrenia and went to live with his parents. His mental health stabilised, although he continued to find that going to work made him anxious. Some years later, he went to work and live in a nearby area, shared a house and appeared relatively stable.

59. When his father died, in 2012 the perpetrator was described by a family member as "being a rock to his mother" and was very supportive. Family members recalled how he had adored his mother and did not think that he had ever been violent or abusive to her during these times. Although he had divorced, he saw his children often and they regularly stayed with their grandmother over weekends.

4.2 [Perpetrator]'s relationship (2013 – 2015)

60. In 2013 the perpetrator met a new partner and they began drinking heavily together with both being inebriated most days. The couple had explosive arguments and the police became aware of several reports of the perpetrator's domestic abuse towards her over the two years that they were together.

61. The first report from Adult 3, in May 2013, sought police assistance because the perpetrator was drunk and smashing up her home. On arrival the police could find no signs of disorder or indicators that a crime had been committed as Adult 3 provided no further information aside from saying that she was a "bit uneasy" around the perpetrator because of his size. She declined to complete a DASH and the perpetrator, who displayed no signs of mental illness, was compliant and removed from the property.

62. On the second police report, in August 2013, Adult 3 called saying that she had been assaulted but when the police attended, she initially refused them entry, was abusive and gave them multiple versions of events. The perpetrator was also claiming to have been assaulted but did not elaborate. In the absence of any further details or indication that a crime had been committed, the police again felt that they had few options available to them and so Adult 3 was removed from the perpetrator's home and taken to her own. No DASH was undertaken, nor record made of 'domestic abuse non-crime' report in line with the national recording standards which require that police offices record both crimes and non-crime incidents of domestic abuse.[6]

63. In September 2013, the perpetrator's psychiatric care was transferred from his previous area to Coventry. His schizophrenia was considered to be relatively well controlled, but he had already missed a couple of review appointments with the psychiatrist and went on to miss a couple more. As a result, he was discharged back to his GP and this pattern of missing appointments, discharge from mental health services and discontinuity of care continued for a couple of years.

64. In October 2013, Angela complained to her GP that her son was being aggressive towards her and that this was contributing to her low mood following her husband's passing the year before. She was referred for bereavement counselling.

65. On 2nd June 2014, the perpetrator had a review with the psychiatrist who provided information to the GP detailing how he was stable on his injectable medication that he had fortnightly. It was noted that the perpetrator reported hearing voices which disturbed his sleep, experienced panic attacks and anxiety around people. He was having particular difficulty with crowded places and public transport.

[6] Home Office Counting Rules for Recorded Crime are available online at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721595/count-general-jul-2018.pdf

66. The next call to the police on 19th June 2014 again provided no indication that any crime had been committed. Adult 3 was intoxicated and wanting the perpetrator removed from her home. However, police had been advised on the call log that "the caller lies when the police arrive, as she doesn't want any trouble." As the perpetrator refused to leave, he was arrested to prevent a breach of the peace, taken to his mother's address and de-arrested. Adult 3, who had not had the opportunity to complete a DASH with officers, complained that the perpetrator had not been arrested for an assault on her. It is not known whether her inebriation dissuaded the officer from completing a DASH but subsequently grading this incident as standard risk on the non-crime domestic abuse report had the effect that it would not be picked up by a safeguarding officer thereafter.

67. On 26th September 2014, the police responded to a call where on arrival, both the perpetrator and his partner were heavily intoxicated and abusive to them. Neither were making any allegations and the perpetrator was again removed and returned to his mother's home. It was not possible to complete a DASH on this occasion, due to Adult 3's demeanour, but a non-crime report was completed and graded as standard risk.

68. Three days later, the police located an anonymous call as coming from Adult 3's home and found them both intoxicated and the perpetrator holding a hammer behind his back and initially being aggressive to officers. He was calmed down, surrendered the hammer, was arrested for breach of the peace and taken into custody. Whilst in custody he disclosed that he had stopped his anti-psychotic medication partly at his partner's request. The medication made him lethargic and over sedated him. Later he would go on to say how it made him drool and affect his sexual functioning. He also stated that he was drinking six pints of 7% cider per day and using cocaine daily.

69. Adult 3 was contacted by phone and, whilst angry that the police had not taken a statement from her, refused to provide any further information. Once sober, the perpetrator was released without charge.

70. The police attend the next call on 11th October 2014 where both were intoxicated and arguing. Adult 3 only wanted them to remove the perpetrator without wanting to give any other information. Again, this was recorded as standard risk on a non-crime report with no DASH undertaken

71. Four days later, the perpetrator spoke with his psychiatrist about some of the difficulties that he was having with his partner, saying that she was very domineering, would not let him have contact with his sons and dissuaded him from having medication by injection.

72. On 13th December 2014, Adult 3 called the police saying that "he has thrown me on the floor". The police found her unconscious and the perpetrator heavily intoxicated. Paramedics were called and Adult 3, who regained consciousness, was taken to hospital. A child of Adult 3's friend was at the address being babysat whilst her mother was on a night out and the perpetrator and the child were taken to his mother's home. Whilst actions were taken in respect of sharing information and convening a conference in

respect of the child, there appeared not to be any action taken in respect of the original allegation.

73. On 1st January 2015, Adult 3 called the police again to say that "he is battering me" and that the police had not taken any action previously other than take him to his mother's address. Although Adult 3 was too intoxicated to give a statement when the police arrived, she signed their copy book to say she had been repeatedly assaulted and the perpetrator was arrested. After being assessed as fit for interview, the perpetrator denied assaulting his partner and made counter-allegations against her. At the same time, she stated that she did not want to support a prosecution and, because of past experiences, did not have confidence in the police. The perpetrator was released without further action.

74. At a psychiatric review on 17th February 2015, the perpetrator reported having been split up with Adult 3 for nearly a year, which is inconsistent with the five calls that his partner had made to the police during that time alleging his violence or threat. He described how she had drained him mentally and had been very violent towards him. He no longer wanted to see her because she affected his mental health. He also complained about poor sleep, increased fatigability, loss of interest in activities, irritability, anxious mood and paranoid ideation about people looking at him. At the same time, he was trying to reduce his medication to doses which would have been insufficient to help with his symptoms. He was assessed as being at very low risk of harm to himself or others. He went on to miss appointments with mental health services for the next three months during which time he stopped taking his medication and drinking alcohol. Whilst the perpetrator was screened for alcohol at the GP Practice that month, there is no record of the findings being available although it is known that the findings were not followed up.

75. On 6th April 2015, Adult 3 called the police saying that the perpetrator had kicked and punched her and refused to leave. When the police arrived, the perpetrator went to pick up a large kitchen knife and hammer that were lying on the living room floor. As an officer attempted to prevent him doing so, the perpetrator punched the officer to the head. He was then tasered and arrested. The incident resulted in a caution for the assault of the police officer, but the original allegations on that day were not investigated and no statement was taken from Adult 3, missing an opportunity to take action for domestic abuse. Officers returned the perpetrator to his mother's address.

76. On 28th June 2015, neighbours reported the perpetrator was attempting to kick his partner's door in and repeatedly shouting abuse at her. The perpetrator was found to be intoxicated having consumed six litres of cider and ten diazepam tablets, which constituted an overdose. He was arrested and subsequently pleaded guilty to using violence to enter premises (Section 6, Criminal Law Act 1977).

77. A pre-sentence, 'Fast Delivery Report' was prepared by the National Probation Service to aid sentencing during which the perpetrator disclosed his mental health diagnosis as paranoid schizophrenia. He also disclosed increased alcohol consumption and historic

cannabis use. He was referred for an Alcohol Treatment Requirement assessment but failed to attend.

78. The Court imposed a fine and a twelve-month community order and required him to complete twenty-five days of a rehabilitation activity. Adult 3 had not supported the notion of a restraining order and no such order was issued. This was the final report to the police in respect of domestic abuse against his ex-partner.

79. During this period, he began to miss health appointments and resisted taking his medication because of the side effects which affected his relationship. He said that his partner had not wanted him to take the medication.

80. Family members reflected that he also neglected his mother during this period, contacting her only for money or staying only after his girlfriend had kicked him out of her home. Angela, who had little money, borrowed a large sum in the region of £4000 to pay off the debts accrued by her son and his girlfriend with a loan shark who had been threatening them in connection with money for drugs that they owed. This may be seen as an indicator of coerced debt and economic abuse.

4.3 Moving into a one-bedroomed bungalow: 2015-2016

81. The perpetrator's two-year relationship with Adult 3 ended and he came back to live with his mother full-time. One family member said that he was never the same again after that period in the relationship. Angela tried to get him back onto his medication, but it was not until a year later that he stopped resisting and started taking it regularly again.

82. By this time, Angela had developed arthritis and was constantly in pain. She had trouble climbing stairs and for this reason, was very pleased to have been offered a bungalow by Whitefriars Housing which she moved into in April 2015. She was very house-proud and enjoyed tending her small garden. However, the bungalow was only one-bedroomed and so her son had to sleep on her sofa and for two people, this led to very cramped conditions.

83. In 2015, the perpetrator consistently missed appointments with mental health, and he had to be re-referred back into mental health services by his GP twice. His mother agreed with the GP to give him his medication daily.

84. In the meantime, he was required to comply with the terms of his community order and on 10th August 2015 he attended an induction appointment with Staffordshire and West Midlands Community Rehabilitation Company (SWMCRC) who provide probation services for standard and medium risk offenders. He was assessed as presenting a medium risk of harm and a low risk of reoffending.

85. Despite having a requirement to attend regular meetings, he failed to attend the next six weekly meetings with probation, sometimes ringing to say that he was struggling

with his mental health. Indeed, on 22nd September 2015, the GP requested a psychiatric assessment for the perpetrator who was showing signs of relapse and needed to return to having his medication by depot injection.

86. Faced with breach of the perpetrator's community order for failing to attend appointments, the probation officer liaised with agencies and found that the perpetrator's mental health had deteriorated, and he was no longer engaging with substance misuse services.

87. On 28th October 2015, the social worker made a visit to Angela's home to find that her son had disengaged from services; had stopped having his depot injection; appeared agitated and was hearing derogatory voices but denied suicidal or thoughts of self-harm. Two days later, he was assessed by an Approved Mental Health Practitioner (AMHP) and psychiatrist at home with Angela present. They found that his psychotic symptoms had re-emerged. He disclosed that he had stopped his depot injections to see if he could stay well without it. He felt unable to leave the house because of his psychotic symptoms and his auditory hallucinations included voices telling him that people, including family members, were plotting against him, but said that they were not telling him to do anything suicidal or homicidal. He denied that he had misused alcohol or drugs for years.

88. It was concluded that a Mental Health Act assessment was not required but his depot medication was to be re-introduced and he was to receive twice weekly visits from the Crisis Team. His mother shared no concerns regarding risk and stated that she would continue to support him until he became well. Although it was not documented whether she was asked whilst on her own, this would have been normal practice. She was given out-of-hours contact numbers for the Crisis Team should she need them and regular home visits from the CPN continued. After this period, the perpetrator had frequent contact with mental health services.

89. In November 2015, the perpetrator was taken by ambulance to the Emergency Department with cardiac symptoms that were later determined to be anxiety. After seeing the mental health team on site, he was discharged for a review with the psychiatric nurse the next day.

90. However, during November 2015 the psychiatrist noted that Angela was making decisions about her son's medication, such as altering his medication to prevent his low mood in the afternoons. Angela told the CPN that her son disturbed her during the night. She said that they argued daily and both her and her son stated that the arguments were caused by them 'being on top of each other'.

91. By the January, the psychiatrist had noted that, as the perpetrator had become more stabilised on his medication, he was becoming bored and his relationship with his mother was deteriorating into disagreements, "bickering and snappiness".

92. In January 2016, the probation officer visited the perpetrator at home and his CPN, who was present, confirmed his diagnosis of agoraphobia. The perpetrator asked the

probation officer for help in finding his own accommodation. The CPN was also encouraging him to attend the library to electronically bid for properties from the local authority as he had identified that his future and his re-housing was important to him. However, at the end of January, he overdosed on his medication and was taken to hospital where he was seen by mental health services. He had no suicidal ideation at this time and was discharged for follow up by the CPN. He thought that the medication (Sertraline) had disrupted him. Indeed, his mother had advised the psychiatrist that Sertraline was having a poor effect on him.

93. In February 2016, during a home visit, Angela spoke to the probation officer complaining that little headway had been taken on her son finding his own accommodation. She was also concerned that his medication did not seem to suit his personality. Probation service continued to visit on a monthly basis until June 2016.

94. During that month Angela told both the psychiatrist and the CPN that her son's behaviour had become worse. She said that he was constantly picking arguments and continually talking to himself and swearing under his breath. Both the CPN and psychiatrist noted that the perpetrator presented no risk to himself or others at that time.

95. By April 2016, he had left the psychiatric day care halfway through admission. His notes demonstrated a further escalation of tension, recording that the perpetrator had taken an overdose three months before because of his home situation. The perpetrator advised that his mother

    "was now becoming violent to him. She prevents him from watching the TV and playing music and says that he sits in the kitchen all day doing nothing. He says she also sometimes prevents him from eating and drinking because she has bought the shopping. He came to live with his mother 6 months ago following a breakup from his then girlfriend. There was domestic abuse in the relationship, and they were both violent towards each other. He says his mum begged him to return to her house but now abuses him and is stealing his money" (Mental health notes)

96. Meanwhile, his fortnightly depot injections continued. The Occupational Therapist was visiting the house regularly during this time and Angela confided in her that she was worried about her son's drinking whilst he disputed that there was any problem.

97. On 30th June 2016, the probation officer made a final home visit under the community order, concluding that the perpetrator consistently lacked motivation to engage with agencies that could assist with his ongoing accommodation and mental health issues. Angela commented that she felt mental health services had "washed their hands" of her son. Nevertheless, the probation officer did not return or follow up on remaining concerns, including accommodation, despite there being six weeks left of the order.

98. The circumstances escalated to the point where Angela called the police regarding her son on 2nd July 2016. She said that he had schizophrenia, was drunk and was threatening her but if he would calm down then she would be happy for him to stay. When

approached by police officers, he displayed a lot of anger towards his mother and was rambling. He also refused to leave the property and so was arrested to prevent a breach of the peace.

99. Whilst he was in police custody, his mother phoned several times, concerned about how her son would get home. Officers advised that she was under no obligation to have him back home, but she maintained that she wanted him to come home and, there being no indications of an offence, he was released from custody and returned home. Although a DASH was not completed, Angela was considered to be facing a standard level of risk. She declined referrals to other agencies and a non-crime domestic abuse report was recorded. However, Angela disclosed the incident to the visiting occupational therapist whom she had confided in previously. The occupational therapist advised her to call the police if he was aggressive again but also missed the opportunity to complete a DASH.

100. At the perpetrator's next scheduled psychiatry appointment on 7th July 2016 he stated that he regretted drinking alcohol a few weeks prior and that he had not taken illicit drugs for eight months. Nonetheless, he agreed to be referred to substance misuse services. He complained that the medication was making him like a "zombie", drooling and sleeping most of the time.

101. Later that month, a neighbour reported to housing services that the perpetrator was urinating in their porch. They said that it was very unusual because he was normally "a very nice man who usually sits outside drinking tea". The housing officer visited Angela who was deeply apologetic and pointed out that her son lived elsewhere but spent a lot of time during the day with her. She was reminded that he could not live with her as hers was a one-bedroomed property but that he was welcome to spend as much time as he liked as long as he did not cause a nuisance. The nuisance matter was considered to be resolved amicably.

102. On 10th September 2016, the perpetrator attended the Emergency Department but left before being treated. The hospital attempted to contact the patient and his mother as next of kin by telephone, leaving messages requesting them to call back.

103. On 15th September 2016, Angela's neighbour called the police stating that the perpetrator was drunk and aggressive, and they were worried about Angela. Within ten minutes the Ambulance Service requested police assistance as the perpetrator had fallen briefly unconscious after having been aggressive with paramedics and 'family' and they were worried that he would be aggressive when he awoke. The perpetrator was taken to hospital and both police logs were closed without further enquiry or recording a non-crime report. The perpetrator stayed for observation and treatment and was discharged.

104. On 7th October 2016, the GP received a letter from the consultant rheumatologist saying that Angela had banged her head before and developed intermittent temporal pain as a result. There was no evidence that further enquiries were made of how the head injury had occurred.

105. In November 2016, the psychiatrist diagnosed the perpetrator as having a mixed personality disorder with obsessive, compulsive and paranoid traits, exacerbated by alcohol and cannabis abuse. It was concluded that this diagnosis may account for much of his behaviour at the time.

4.4 A new tenancy is provided to the perpetrator: December 2016 onwards

106. On 21st December 2016, Whitefriars Housing, a social housing provider, gave the perpetrator keys to his new home around the corner from his mother. The tenancy sustainment officer visited the new property twice when the perpetrator was not at home. Not having had a response from a subsequent telephone message, the tenancy sustainment officer closed the case in March 2017.

107. When the perpetrator was provided with his own accommodation, Angela was looking forward to being able to have her grandchildren to stay again. To settle her son into his new flat she bought him a bed and furniture and became very frustrated when he failed to make the move.

108. In the months after receiving the keys to his flat, the perpetrator became more demanding of services and reported increased levels of distress in coping with social changes.

109. On 22nd December 2016, the perpetrator was referred by the CPN to The Recovery Partnership who provided substance misuse services in Coventry at the time. The referral was made under the Dual Diagnosis [mental health and substance misuse] Joint Working Agreement and featured the perpetrator's binge drinking. However, the perpetrator did not wish to take up the referral and no explanation was given.

110. The third incident reported to the police whilst the perpetrator was with his mother was on 4th January 2017 when Angela contacted the GP to say that her son had threatened to kill her. The police were present with Angela for the duration of the call and mental health services were contacted. The Crisis Team also contacted the police independently to say that the perpetrator had contacted them for support and disclosed that he wanted to murder his mother. He also disclosed that he had already pushed her and hurt her ribs and was going to put his head in the oven. The Crisis Team were aware that Angela had reported not being able to cope with him anymore.

111. A Triage Car, which included a police officer as well as a mental health nurse, attended to find the perpetrator calm but stressed about having to move into his new flat. The triage nurse had no concerns and Angela, contrary to the Crisis Team's understanding, reported that she was happy to have him home as he had not threatened or hurt her. She was encouraged to contact the police if things changed. The perpetrator had an appointment with the Crisis Team the next evening and the police case was closed with no offences recorded. The Crisis Team went on to assess that "both… [the

perpetrator] … and his mother appeared to be easily agitated with each other at times when arguing."

112. Three days later he attended the Emergency Department saying that he had violent thoughts towards others. Although he left before being seen, he was contacted by phone and reported feeling calmer and agreed to contact the Crisis Team for ongoing support. The Crisis Team were aware that alcohol abuse was on ongoing issue and questioned why he had declined support from specialist services, having previously agreed to a referral. He stated that, "I am not an alcoholic" (Mental health record)

113. On 7th February 2017, the Ambulance Service requested police attendance as the perpetrator was having a psychiatric episode and threatening to harm people. He was taken to hospital but left before being seen. Hospital staff consulted with Arden Mental Health Acute Team who said that he was low risk and would be seen the next day for his depot injection.

114. On 8th March 2017 during a psychiatric review, the CPN advised the perpetrator that services would not intervene between him and his mother. Mental health service considered that this had been a missed opportunity to undertake a Domestic Abuse, Stalking and Harassment (DASH) risk assessment with Angela, particularly as she had disclosed to them that she felt that she could not ask him to leave her home. A fortnight later, the perpetrator told the Crisis Team that his mother had hit him and stated that he had to hold her around the neck in order to stop her form hitting him. However, a different risk assessment was undertaken regarding the self-harm that the perpetrator had attempted earlier in the day which It was recorded that he did not voice any thought plan or intent to harm himself again, nor thoughts to harm his mother.

115. On 23rd March 2017, Whitefriars Housing became aware that the perpetrator's flat was insecure and had minimal furnishing inside. They changed the locks and referred him back to their Tenancy Sustainment section. The perpetrator told them that he was still moving his belongings from his mother's but had been broken into twice and wanted an emergency move. The tenancy sustainment officer advised him how to go onto 'Coventry Homefinder', the online social housing allocation system, as well as how to get home contents insurance and then closed the case. The alleged burglaries were only one of a number of reasons that the perpetrator was giving for not moving into the flat.

116. On 3rd May 2017, the perpetrator called the police saying that he wanted to report himself for domestic violence and that a week previously he had argued with his mother over money and grabbed her by the throat. A woman could be heard shouting in the background and the call handler tied this to the previous incident involving his threats to kill his mother. When police arrived, both were calm, but the perpetrator agreed to be taken to hospital and the officers updated the log to show that this was a mental health issue and not domestic abuse.

117. Within 3 hours, Coventry University Hospital requested that the police undertake a safe and well check as the perpetrator had left the hospital before being seen. Officers attended the home and spoke with mother and son separately and Angela said that she was happy to have her son home. The perpetrator said that he was feeling fine and had booked an appointment with the GP for later that day. Police officers left without further involvement.

118. In June 2017, an urgent appointment was arranged with psychiatrist as the perpetrator was becoming anxious and contacted the Crisis Team wanting to change his medication or go onto anti-depressants. The perpetrator advised the psychiatrist that his mother was forcing him to increase his doses of his injection, that she was stealing from him and that he wanted to live independently but the boiler in his flat was not working. His mental health keyworker was to help with his housing issues and possibly an appointee for his money so that he could live independently. He continued to attend for his bi-weekly depot injections for the rest of the year.

119. Over the next month, the perpetrator's anxiety and difficulty sleeping increased and his medication was increased in response. He attended the Emergency Department three more times over following months in relation to his mental health, each time leaving before treatment.

120. The police received two further calls that month concerning the perpetrator's thoughts of suicide but found him safe and well when they responded. On the 9th July 2017, a further call regarding suicidal thoughts and hearing voices lead to the Ambulance Service being called and the perpetrator being taken to hospital. As he had been taken to a suitable location for treatment, officers did not consider that they needed to make any referrals to relevant agencies for mental health or safeguarding.

121. On 17th July 2017, the perpetrator phoned Whitefriars Housing customer call-centre to say that his mother was abusing him. The neighbourhood housing officer who had visited him and his mother before, contacted the Vulnerable Adults Team, was directed to the mental health team and was called back by the perpetrator's support worker who would take up the issue and make any necessary referrals thereafter. In the meantime, the neighbourhood housing officer contacted the perpetrator back. He confirmed that he was fine, and he had merely had an argument with his mother and there was no reason to make a referral for safeguarding.

122. On 18th August 2017, the perpetrator stated that he had taken an overdose of his mother's heart medication. Angela had gone to visit a close relative. Unbeknown to the police, her infrequent times away from her son were usually spoilt by his insistent telephone calls and attempts to get her to come home. The police attended and phoned Angela to say that her son had made a suspected suicide attempt by taking her tablets. They asked her whether she would come home but she suggested they send him to hospital instead. Her relative said that Angela described herself at this point at her 'wits end'.

123. When paramedics arrived ninety minutes later, they found that the medication the perpetrator had taken would not have been harmful. He turned out to be fine and refused an ambulance. Nonetheless, the police officers contacted the perpetrator's support worker and took him to his GP for an emergency appointment.

124. A couple of months before Angela's homicide, the perpetrator had started harassing his ex-wife by phoning her 20-30 times per day. She had to block his number but would phone him once a week to help calm him down as she was worried about the effect his behaviour was having on his mother.

125. On 23rd August 2017, mental health services discussed planning for discharge with the perpetrator and it was agreed that the CPN would work with the perpetrator around his discharge from their services. His mother was present at the meeting. However, there was insufficient information recorded regarding the rationale behind the decision to discharge him at this time.

126. On 1st September 2017, Angela contacted the police to say that her son was behaving in a threatening manner and would not leave. She said that he had been calling her names and threatening to go out and stab someone. Whilst she was not frightened for herself, she was worried for the safety of others. Ten minutes later, the perpetrator phoned the police to say that he was being assaulted by his mother. When police attended, they found that there had been an argument over money and the perpetrator had not been taking his anti-depressants.

127. Angela, for the first known time, took his keys so that he could not return. She told a close relative that she had been greatly angered when her son had told the police that she was abusing him. Police officers took him to the railway station from where he took a train into the city centre, got drunk and returned to his mother's bungalow, asked her to pay for the taxi and convinced his mother to let him in. The police graded the risk as medium and considered that both had been safeguarded on the basis that they had been separated and that Angela had taken his house keys off him.

128. The police supervisor revised the grading of risk to 'standard' on the basis of no identifiable factors of serious harm. Unlike the previous incident where officers took a holistic approach to the perpetrator's needs, no referral or signposting was made for either Angela or her son, despite him behaving erratically and not having taken his medication.

129. On 4th October 2017, the perpetrator contacted his CPN to say that he felt victimized and paranoid and felt that his medication should be increased. He stated that his mother wanted him to move out of her bungalow and that he had no money or food and had lost five stone in two years. Two weeks later he took an overdose of his anti-depressants and was taken to hospital but left after his initial medical assessment of routine observations which were satisfactory but before an assessment could be undertaken of his mental health. The hospital attempted to contact him by phone but, as it was known that mental health services were already aware of his suicidal

thoughts and his presentation was not as concerning as previous times, there was insufficient reason to call the police for a safe and well check to be undertaken on this occasion.

130. On 25th October 2017, the CPN and the support worker visited the perpetrator to review his mental health and discuss discharge from their services. Despite having attended the Emergency Department following a suicide attempt two weeks earlier as well as requiring an increase in his medication because of paranoia, the perpetrator said that he was doing very well, attending his GP surgery each week for his depot injection and felt well on the medication and did not want to stop it. He stated that his mental health was good but asked if he could remain 'on the books' and be seen whenever he wanted to be. He was asked about moving and supported to contact the gas supplier for his heating to be fixed.

131. On 31st October 2017, the perpetrator called the Crisis Team stating that he had raised his fist to his mother but had not harmed her. He called seeking advice as to whether he should take his prescribed medication as he preferred to stay awake all night due to paranoia that "the police may enter and kill me" and that he would "hold [the Crisis Team] responsible if he fell asleep and was killed by the police." (Mental health records)

132. Towards the end of her life, relatives advised the review that Angela appeared to have given up. Her ill-health was getting worse and she could no longer cope. Once described as a fighter, they thought she had been worn down. She described having been let down by agencies and how she would phone and phone them and weeks would pass without any support. She described how lots of different people were involved but none for long enough. Relatives went on to describe to the review how they felt that, two weeks before her homicide, Angela was "screaming out for help". This was not evidenced in mental health records. Indeed, by contrast, mental health services noted that the decision to work towards the perpetrator's discharge from mental health services had been made four months previously and had been agreed by both mother and son and discharge planning continued through this time.

133. On 29th November 2017, the perpetrator received his antipsychotic medication by injection at the GP Practice as scheduled, although he later denied that he had received it.

134. Shortly afterwards, mental health services agreed that the perpetrator was to be discharged from their service the following week. Unbeknown to agencies, local residents had seen him erratically walking barefoot around in circles outside his mother's home the night before the homicide. They also witnessed him being aggressive with his mother when she tried to get him in and raising his fist to her and they warned him to calm down. The perpetrator killed his mother that afternoon.

5. OVERVIEW

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

5.1 Coventry and Warwickshire Partnership NHS Trust

136. Coventry and Warwickshire Partnership NHS Trust (CWPT) delivers secondary mental health care in the area through inpatient, community mental health and mental health services within acute hospitals through Arden Mental Health Acute Team (AMHAT).

137. The perpetrator had a diagnosis of paranoid schizophrenia. His initial engagement with mental health services in 2013 was sporadic and he would frequently fail to attend arranged appointments. His compliance with medication was equally sporadic.

138. The psychiatric review in November 2016 revealed that the perpetrator had been prone to alcohol abuse since his teens, later using cannabis frequently and had a history of aggression including arrest for wounding and affray. The review noted an inclination towards obsessive behaviour and a controlling disposition.

139. From CWPT's perspective, Angela was understood to be a kind and caring parent who wanted the best care for her son. She displayed concern about her son's alcohol use, his inability to manage money and perceived lack of compliance with medication. CWPT were aware of initial mutual affection between mother and son but that there went on to be a deterioration in their relationship, exacerbated by over-crowded conditions and his reluctance to move into his own flat. This also provided his mother with worries that this overcrowding may put her tenancy at risk.

140. CWPT records displayed numerous references to discord between the two with evidence of increased and escalating tension culminating in incidents of reported physical aggression from the perpetrator. Between December 2015 and November 2017, there were at least seventy-seven entries in the perpetrator's mental health file relating to arguments, disagreements or physical incidents between mother and son. At one point, Angela said that she had considered phoning the police and getting an injunction to keep him away from her flat, but she went on to say that she did not want it to come to that. After her son had been offered his flat, he became very agitated and Angela said that she could not cope with him anymore and if it continued, she would move to her sister's and lock the bungalow up. Each of these occasions could be seen to have been prompts to ask more about her experiences.

141. Records also revealed domestic abuse in her son's previous relationships. Although the organisation started to use DASH in response to disclosures of domestic abuse, there was a missed opportunity to complete the DASH when the perpetrator disclosed that his girlfriend was being violent towards him. This may have given insight into their

relationship and help determine the primary aggressor which in turn could have informed future risk assessments.

142. Despite emerging themes of aggression, it is clear that the perpetrator's history of violence with his partner and others was not recognised or considered to be a risk factor for his mother. Angela disclosed to a visiting mental health practitioner that her son had been aggressive towards her and she had had to contact the police. No DASH was undertaken with her as the violence was not considered in the context of domestic abuse.

143. CWPT were aware that persistent, if not always excessive, alcohol use was an issue for the perpetrator which he minimised when asked by mental health professionals. His mother reported being worried about his alcohol abuse and provided contrary accounts of the quantity of his alcohol intake. Nonetheless, risk assessments were based upon the perpetrator's own unreliable assessments of his alcohol use and they failed to take into account his mother's concerns or increased risk in relation to domestic abuse.

144. Despite his unreliable accounts of his alcohol intake, the perpetrator was given advice against drinking excessively or drinking at all on the days that he had anti-psychotic medication through his bi-weekly depot injection. He was also referred to substance misuse services and encouraged to engage with these services on a number of occasions. On one occasion he initially agreed to the referral only later to turn it down.

145. CWPT Dual Diagnosis Policy covers circumstances when a patient has both a mental health and substance misuse issue. The policy requires that "if a service user is unwilling to access treatment, their care needs in relation to substance misuse should be revisited at every appointment and strategies employed to increase their motivation to change." The IMR author considered that staff should have sought advice from substance misuse services to help them work with the perpetrator to address his alcohol misuse as well as sought information from his mother about services to support her.

146. Arguments over money between mother and son dominated mental health records and it was clear that practitioners had proposed practical responses to the lending and borrowing arrangements. The possibility of financial abuse was considered but a safeguarding concern was not raised as Angela, although complaining that her son borrowed money from her, also said that she did not mind and had a system for recording the money that she was owed. At times she was explicit in saying that she was not afraid of her son and did not feel coerced into giving him money. On several other occasions, however, she disclosed that she did not feel able to refuse her son's demands for money. Having said that, practitioners had the advantage of being regularly in the home. It was clear that her son was pestering her repeatedly and waking her in the middle of the night for money for cigarettes and, in the absence of Angela appearing fearful, it was understandable how this was viewed as an issue of mental health rather than domestic abuse.

147. Likewise, the perpetrator's claims that his mother was stealing from him and controlling his money were explored and it transpired that the agreement was beneficial to him because his mother, whilst managing his bank account, would lend him money regardless of whether or not his account was in credit. However, safeguarding concerns for either party over the finances were not clearly documented and so it would have been difficult to see if they changed over time or whether practitioners were becoming tolerant to any escalation of tensions.

148. There were also numerous entries over the years relating to disagreements between mother and son over his medication. There were times when the perpetrator struggled with his mental health diagnosis and wanted to come off the medication altogether, but his mother provided ultimatums that he would have to move out if he did not take it regularly. There were other occasions when the two disagreed about which was the best medication: the perpetrator wanted the medication with the least side effects and thought that his mother wanted him "dosed up to sleep all the time".

149. The conflict over medication was well documented but not considered a risk factor, despite the fact that, on occasion, Angela was asked to manage her son's medication on a daily basis. Moreover, there were also at least two occasions when the psychiatrist altered the perpetrator's medication after talking with his mother indicating that her voice, as a carer, was being taken seriously.

150. CWPT were very aware of Angela's caring role for her son. Her emotional, practical and financial support were well documented within her son's mental health record. A carer's assessment was offered to her on more than one occasion but refused each time. Staff reflected that Angela may have been reluctant to state that she was a carer for fear of her landlord finding out that her son was living there. At the time, mental health staff thought that there was a degree of co-dependency whereby she relied upon her son for companionship and a 'need to be needed'. Unbeknown to mental health staff, these judgements were not consistent with the views of close family who were confident that Angela would not have accepted help for herself: she just wanted her son to get the help he needed to be able to live independently and safely. The issue of support for carers will be considered in the analysis below.

151. In considering their engagement with the perpetrator and how his views and wishes were taken into account, CWPT observed that engagement was 'on his terms', often requiring immediate appointments and contacting other services when his demands were not met. He was not always forthright and there was evidence that he frequently tried to manipulate professionals. The possibility that he was also manipulating his mother did not appear to have been considered.

152. CWPT concluded that despite evidence of a gradual breakdown in the relationship between mother and son, the relationship was seen as a difficult one rather than a domestically abusive one. Factors such as substance misuse, financial issues and a known history of aggression were all documented but not considered risk factors in

the context of domestic abuse. The lack of recognition of domestic abuse meant that domestic abuse policy and procedures were not followed, and opportunities were missed to safeguard the victim.

153. The Trust has made the following recommendations for itself and how it intends to implement these actions features in the appendices:
    - To increase front-line worker's understanding and recognition of familial domestic abuse and how it may present in client groups and in carers
    - To ensure that supervisors have the knowledge and skills to identify domestic abuse in the context of familial abuse and recognise the need to address domestic abuse in relevant cases presented for supervision
    - For staff to recognise the importance of considering known risk factors, including information provided by relatives/carers and historical factors when assessing risk to self and others posed by patients.

5.2 West Midlands Police

154. West Midlands Police provided the review with an analysis of the actions available to them on each occasion when a report had been made. During the earlier period, the Police had received ten reports of domestic abuse between the perpetrator and his partner (Adult 3) between 2013 and 2015.

155. Most incidents in this period were characterised by an absence of injury or disorder; both parties being intoxicated; neither party disclosing any offence and Adult 3 generally wanting the perpetrator removed from her home. There were also occasions when Adult 3 was hostile or abusive to officers. In such circumstances, it is indeed difficult for the police to proceed with positive action and it was not until the ninth report when there was a threat to officers, that he was cautioned and the tenth episode when he was charged and convicted. At other times, he was either taken back to his mother's home or arrested for breach of the peace without further action. In several of the incidents this was because no criminal offences were disclosed and so the options available to the attending officers were limited.

156. The Police identified that there were missed opportunities for them to have made a positive approach to Adult 3 after incidents when she was sober. This would have given her an opportunity to talk to her about the relationship, the risks that she faced, undertake a DASH and be referred to domestic abuse or substance misuse services. However, on the one occasion that they did return she confirmed that she had been assaulted but did not want to support the prosecution any further. It seems that her close relative had had a poor experience with prosecution in this kind of circumstance. It is not known whether positive attempts to engage with Adult 3 when sober, on certain identified occasions, may have strengthened her confidence in the police. Nonetheless, on the occasion that they did return, the perpetrator had made a counter-allegation and, where one person's word was conflicted against the other,

there was no other evidence available to support either allegation for an evidence-based prosecution.

157. There were a couple of occasions where Adult 3 was angered by what she saw as police inaction: in September 2014 she was angry that the police hadn't taken a statement; in January 2015 she complained that the police kept taking the perpetrator back to his mother's address but he kept returning and had beaten her up, but they were not doing anything about it. Indeed, the incident in April 2015 appears the most significant missed opportunity when the perpetrator was drunk, refusing to leave and the officers had to prevent him picking up a large kitchen knife and hammer that were lying on the living room floor beside him. The incident, which involved an officer being punched in the head, resulted in a caution, but there was no follow up with Adult 3 who had made the initial complaint of being assaulted on this occasion. She may have given both an account of her own experiences as well as an account of the perpetrator's treatment of officers.

158. Hammers had also featured on an earlier occasion when the perpetrator was drunk, behaving aggressively and holding a hammer behind his back. He had to be calmed down by officers before he was prepared to surrender the hammer. Note that a hammer is not itself an offensive weapon unless there is an intention to use it to cause personal injury and officers did not perceive an immediate threat from the perpetrator or else, they would have taken immediate physical action as they did in the later episode. A warning 'SIG' marker was placed on Adult 3's address because of the threat to police officers. This marker did not follow the perpetrator to his mother's home address or appear to have been taken into account when returning the perpetrator to his mother's address on each later occasion. Indeed, whilst the police identified that it was understandable that it had been missed as there were no accompanying offences, it would have been best practice to attach a weapons marker to the perpetrator's record on the Police National Computer.

159. Indeed, in five of the ten domestic abuse incidents reported during this period, the perpetrator was removed from his partner's home and taken to his mother's address where he was sometimes living. Whilst his mother did not pro-actively indicate at that time that she had any concerns about her son being returned to her after he had been drunkenly violent or abusive to his partner, the extent to which she was asked by police, and any risk to her assessed, is not known.

160. As well as not completing a DASH in any of these ten reported incidents, there were also missed opportunities to record 'non-crime' domestic abuse and one occasion missed to record a crime. The effect of failing to record 'non-crimes' would mean that there would be gaps in the perpetrator's history which could disguise the level of risk that he posed and restrict the chance to observe patterns or escalations in his behaviour.

161. There were a further ten reports to the police during the period from 2015 onwards when the perpetrator had returned to live with his mother full-time. Whilst all

previous reports to the police had featured the perpetrator being inebriated, after 2016, the perpetrator's mental health and suicidal thoughts became recurrent issues and five out of the ten reports were solely concerned with his mental health. The other five reports made included domestic abuse: two were made by Angela; one by a neighbour; one by the Crisis Team and one self-report.

162. The IMR author considered the perpetrator's thoughts about killing his mother and putting his head in the oven which he disclosed during a call to the Crisis Team in January 2017. After the mental health nurse in the Triage Car assessed him, it was concluded that his thoughts were not considered to be of the nature that would have constituted an offence of Threat to Kill[7] but were an indicator of disturbed thoughts. Mental health services were to see him the next day and Angela herself stated that she was happy to have him at home and had not been threatened or hurt by him.

163. Until the last report, Angela had always stated that she was willing to have her son stay or return home. However, from a policing perspective, there were no indications of having completed a DASH with her and missed that opportunity to discuss risk in any meaningful way. Where the level of risk was recorded, it was identified in 'non-crime' domestic abuse reports.

164. This eleventh and final reported incident in September 2017, was the first time that Angela had not been willing to allow her son to return home and had taken his keys off him. The downgrading of the level of risk from medium to standard was a missed opportunity to safeguard Angela. It is understandable why risk was downgraded, as the perpetrator's history had not been consistently recorded or risk assessments undertaken. However, had the level of risk not been downgraded, this would have been an opportunity for police safeguarding teams to review the case and talk with Angela, who, unbeknown to agencies at that time, was at her 'wits end'.

165. Since this time, completion of the DASH has been made mandatory for domestic abuse, including familial abuse and is systematically audited for compliance. Moreover, response officers now carry hand-held electronic devices enabling them to access information, complete more in-depth checks and complete the DASH electronically at the scene. West Midlands Police have been able to demonstrate significant improvement in response officers' compliance with DASH and are monitoring this on a monthly basis: an activity which is supplemented by dip sampling of cases.

166. In respect of the reports concerning the perpetrator's mental health, there were two occasions where police relied upon other agencies to raise safeguarding alerts or make referrals to mental health. Officers have been reminded that they have a duty to make those referrals directly themselves.

[7] For an offence of 'Threat to Kill' to be committed, a person has to make a threat to kill that person or a third party and intend that person would fear that threat would be carried out (Section 16 of the Offences Against the Person Act 1861)

167. In addition, West Midlands Police has since introduced, a Vulnerability Referral Form which has been made available to officers' mobility devices. This enables them to gain consent from an individual and refer them to other agencies, such as mental health services, directly at the scene.

5.3 Staffordshire and West Midlands Community Rehabilitation Company

168. The perpetrator was referred to the organisation (SWMCRC) following his sentencing at court for domestic abuse related criminal damage. The induction appointment is considered to be crucial for offenders in order for a specific and structured plan of interventions to be designed with the aim of reducing the risk of harm and reoffending.

169. Risk would normally be assessed over the initial few weeks using the Offender Assessment System tool which considers a comprehensive set of factors which may affect an offender's risk. In this case, staff were being directed to complete a short paper version of the tool which was being trialled as part of a pilot project, and the focus of work was agreed to be on monitoring his mental health through relevant agencies and assisting him with accommodation. Although the short format assessment would have included questions on domestic abuse and substance misuse, there were no records of whether it was discussed. Nevertheless, the focus of the offender manager was on his mental health and addressing the perpetrator's original offence of domestic abuse did not feature in his sentence plan thereafter. Substance misuse appeared to have been missed despite alcohol use being inextricably linked to his offence. Unfortunately, the report of the assessment could not be located for this review. Shortly after this time, the pilot on short format assessments ended and they were not introduced into practice.

170. Since this time, the Community Rehabilitation Company has been given direction that, as part of their minimum case expectations, all domestic abuse cases should have a heightened level of assessment (level 3) of the Offender Assessment System (OASys) completed to ensure that risks are sufficiently assessed and risk management and sentence planning activities are completed.

171. As a result of his history in relation to suicide risk, domestic abuse, weapons and the assault of a police office, the perpetrator was assessed as being of medium risk of harm. However, he was considered to be low risk of re-offending.

172. After his initial sentence planning and assessment, the perpetrator missed the next six appointments as a result of the deterioration in his mental health. From January 2016 home visits continued on a monthly basis for the next six months. However, the perpetrator's lack of motivation to engage made the probation officer's supervision appear to be little more than a monitoring exercise within the context of a busy caseload.

173. During the year of his supervision period, one referral was made to in-house accommodation which was not taken up by the perpetrator. Further discussion around the motivation for needing to move was not recorded. Moreover, the perpetrator made many disclosures to his probation officer about mental health interventions such as medication reviews and assessments which the probation officer took on face value and did not verify. Neither were police callouts routinely checked for potential recidivism. Failed appointments were not enforced as the probation officer considered that enforcement action would exacerbate the perpetrator's mental health. At the time, enforcement was subject to officer discretion. National Standards have since been reintroduced requiring enforcement action to be taken.

174. Nonetheless, undertaking home visits following a period of non-contact was responsive to the perpetrator's agoraphobia and did allow for a view of the perpetrator's home environment and interaction with his mother. The probation officer reported seeing nothing of concern during these six visits and did not consider Angela to be a carer for her son. They did not consult with their manager as they believed all measures to monitor and manage risk were in place.

175. Angela's comments to the probation officer on the final visit, that mental health services had washed their hands of her son, does not appear to have been responded to, despite the fact that there was six weeks remaining of his supervision order.

176. At the time of their involvement with the perpetrator, SWMCRC as an organisation was in its infancy, having moved from being a Trust to a new private company under the umbrella of the Reducing Reoffending Partnership in February 2015. SWMCRC were able to detail to the review how operations have matured since this time but have made recommendations for themselves, relating mostly to actions which were already in motion, concerning:
    - Implementation of a senior leader led Public Protection Forum that directs organisational focus on public protection matters and overseas our response to emerging trends or issues. For example, this Forum has recently been responsible for the development of a safeguarding briefing pack that will be delivered by all managers, with domestic abuse themed for briefings to all teams during April 2019.
    - A Quality Management Framework measuring minimum expectations of individual performance and the quality of initial assessment and risk management practice. This includes each area conducting manager oversight and casework audits that contributes to individual performance and accountability where the extent of a practitioner linking index offences to sentence planning is considered.
    - The Quality Management Framework is also driving practice to ensure that risk flag registrations are up to date and reviewed regularly in line with public protection guidelines.
    - A good practice minimum expectation guide has been introduced called Every Case Essentials that details the minimum expectations of what would be expected in management of each case as well as a Service User Journey case management framework that detail how we manage our cases from start to finish

5.4 Coventry and Rugby Clinical Commissioning Group

177. The GP practice was aware in May 2013 that Angela's son was aggressive towards her and that this contributed to her depressed mood following the passing of her husband the year before. The majority of GP records related to her son's mental health, but the Practice was aware that Angela contributed to the management of her son's condition by providing a home, care, support and supervision. There is no mention of a formal carer's assessment being in place as the Practice did not recognise the relationship between mother and son as one of a formal carer's relationship. The IMR by the Clinical Commissioning Group (CCG) noted that this type of relationship in patients with mental health or social problems is commonplace in primary care, but that it is less common for a patient to have a formal carer.

178. Angela attended most of the healthcare appointments with her son, contributing to the consultations with information about her son's mental health and compliance with medication. The GP would see her son on his own before seeing them together, which is good practice. She rarely consulted with her GP Practice despite having a number of health issues for which she received care from secondary care services including the local hospital.

179. The perpetrator was known to be diagnosed with paranoid schizophrenia and it was identified that his mental health varied over the years, largely as a result of his varying compliance with medication. At one point the perpetrator stated that his original psychosis was drug induced and that he was left with no enduring mental illness. He was also concerned about the side effects of medication particularly reduced sexual ability and he compensated for this by using Viagra. By contrast, Angela gave opinions about his mental health and often suggested that he should have higher doses or remain on injectable forms of medication.

180. The GP Practice was aware from correspondence received from mental health services that there were increasing tensions between Angela and her son. These arguments were perceived to be a symptom of his mental health, rather than indicators of coercive control despite a letter detailing how Angela said that her son was becoming violent. Indeed, many of the GP and mental health interactions commented on the fact that the perpetrator was judged to be a risk to himself rather than to others indicating that the relationship between mother and son was seen as challenging rather than abusive.

181. In January 2017 Angela contacted the GP by phone directly reporting that her son had threatened to kill her. Although the GP considered that mental health continued to be the only factor contributing to risk, the police were already at the scene for the duration of the call and were considered the lead agency to manage Angela's safety at that time.

182. There was nothing in the medical notes to suggest that Angela lacked capacity to make decisions or that consideration had been given to the extent that she was being

coerced into making decisions to have her son return to stay. Despite several incidents being reported and Angela telling the GP about threats to kill, domestic abuse does not appear to have been recognised by primary care. The perpetrator's behaviour appears to have been considered to have occurred due to a deterioration in his mental health than recognising this as domestic abuse.

183. Neither did the GP Practice recognise Angela as a formal carer despite the level of care that she provided. At different points she was allocated, or assumed, the role of custodian of her son's medication and this is seen as normal and common practice within many family settings. Whilst it may not have been expected practice for GPs to undertake a formal risk assessment of the carer's role whether Angela should have been signposted or referred to Adult Social Care for a carer's assessment, by the GP or other agencies, is considered in the analysis section to follow.

184. The CCG also considered that it would not be expected practice to have followed up any of the five times that the perpetrator self-discharged himself from hospital in the twelve months before his mother's homicide. They referred to an onus on personal responsibility for a patient to seek healthcare in the manner they choose unless the patient lacks capacity to make the decision. It was noted that the GP national contract recently included a clause whereby the top two per cent of patients in that surgery who attended hospital most regularly were to be offered proactive follow-up by clinicians. This project has since been withdrawn as it failed to demonstrate any effect.

185. Over the period in question, it was recognised that there was some lack of continuity of care with a number of GPs seeing the perpetrator. Greater continuity may have helped identify indicators of domestic abuse. However, this was seen as an endemic issue in primary care who are faced with a need to balance patient choice, reducing waiting time for appointments and continuity of care.

186. As a result of their reflections, the CCG recognised that there was a need to improve clinicians understanding of domestic abuse in relationships and intergenerationally; to improve the identification of indicators of domestic abuse and coercive control; to recognise the risks associated with the "keeper of tablets" role and to improve their referral and signposting for carers.

187. Many of these needs would be met by the Identification and Referral to Improve Safety (IRIS)[8] Programme which was commissioned by Coventry and Rugby CCG during 2018 and is currently being rolled across GP practices in the city. IRIS is a model which provides clinical leadership, commissions a specialist domestic abuse service to work directly with a GP practice to increase competence and confidence in detecting domestic abuse across the patient population and direct referral to a domestic abuse advocate educator to support the patient in relation to their domestic abuse experience. This programme achieves this through training all staff within GP practices to recognise signs of domestic abuse, sensitively question to determine risk and

[8] Further information on the IRIS Programme can be found at http://www.irisdomesticviolence.org.uk/iris/

complete referral to domestic abuse service. In Coventry, the commissioned project will train GP practices covering a population of approximately 187000 patients over 2 years.

188. In respect of carers, the CCG intends to review how the national strategy for supporting carers is being implemented locally by GP primary care providers and act to ensure that effective, joined-up services are being delivered to improve support for carers.

5.5 University Hospitals Coventry and Warwickshire NHS Trust

189. The perpetrator attended the Emergency Department on eight occasions between 2013 and his mother's homicide with all attendances relating to his mental health. In seven out of these eight attendances, he left the department of his own accord and did not wait for each review to be undertaken.

190. Various actions were taken as a result depending upon the significance of his presentation. These ranged from attempts to contact him by phone and leaving messages where no concerns had been raised with staff to contacting the police to undertake a 'safe and well check' for him and his mother when he had been assessed as higher risk.

191. On the occasion in February 2017 when he disclosed thoughts of violence towards others, he once again left the department prompting staff to discuss his case with AMHAT for further advice. AMHAT deemed him to be low risk and agreed to see him the next day.

192. The Hospital Trust reflected on their waiting times and whether these contributed to the perpetrator's dis-engagement. Whilst their policy requires that certain patients presenting with confusion should be seen by AMHAT within the hour. However, the perpetrator normally attended the Emergency Department during the evening or night when only one AMHAT practitioner was normally on duty and these timeframes could not be achieved. Additional resources were not available to increase AMHAT presence outside of daytime hours.

193. The perpetrator was allocated a cubicle, which would have helped to calm his agoraphobia each time, and there was an indication to keep him visible to staff, it was noted that he frequently went outside for cigarettes. On no occasion was he deemed to lack capacity to make his own decisions and so he could not be held against his will.

194. No recommendations were made for the Trust as they had been seen to be sufficiently responsive to the perpetrator's needs. They had made reasonable attempts to follow-up his departure each time; had joined-up working with mental health and had alerted the police when a risk was known as possible to himself and his mother. The Trust

were able to demonstrate that they had high compliance with adult and child safeguarding training which incorporated domestic abuse and had taken measures to lift the profile of domestic abuse across the health economy.

5.6 Whitefriars Housing Group

195. Whitefriars Housing had little contact with the mother and son. The perpetrator did not respond to the three attempts to contact him that their Tenancy Sustainment Team made when he moved in and intervened little when they had suspicions that he had not moved in three months later. Whilst there was evidence that the housing service knew that he received support for his mental health and that it was being managed, there did not appear to have been any awareness of the need to undertake a multi-agency approach to the difficulties that the perpetrator appeared to be experiencing in moving in. This appeared to the review to be a significantly missed opportunity to identify a person who needed a range of support to help move in and sustain his tenancy.

196. The review heard how their process for ensuring that tenancies commence satisfactorily has changed significantly since this time. As a registered provider of social housing, Whitefriars has the power to begin new tenants on introductory, or starter, tenancies for a period of time until the landlord is satisfied that the tenancy can be sustained. For Whitefriars this involves procedures with visits at various stages in the first year with visits at ten days, three months, six months and nine months.

197. Whitefriars now also undertake pre-tenancy needs assessment when someone applies for housing where they would speak to support workers and apply for grants to ensure that there is a joined-up system of care for the new tenant. Alongside this, the housing provider has recently undertaken a successful pilot issuing white goods and carpets to new tenants in need and this has shown to improve individual's ability to settle and sustain their new homes. There is no doubt that each of these developments would have been beneficial to the perpetrator. However, it is not known whether they would in themselves have been sufficient for him to move and the need for joined up multi-agency support at this time is considered in the analysis which follows.

198. In addition to these improvements in the support to new tenants, Whitefriars Housing has identified the need to promote the benefits of a carer's assessment with its staff and tenants. Recognising the privileged role that a housing provider has in being able to visit and see the living arrangements of its tenants and families first hand, Whitefriars Housing has also made a recommendation for itself to extend the existing domestic abuse training for staff and develop skills and knowledge amongst its workforce in identifying the potentially abusive behaviour of tenants and their families and responding safely to concerns, including taking robust action against perpetrators wherever possible. The manner in which these recommendations will be implemented features in their individual action plan below.

6. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS

199. In this section, we will consider the overarching themes arising within the review in respect of domestic abuse, the care and support of people with mental health and substance misuse issues and the support for their carers.

6.1 Indicators of Domestic Abuse

200. A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Section 7, Multi-Agency Statutory Guidance, 2016). The review has found that domestic abuse featured throughout the perpetrator's close relationships with women since the onset of his mental illness when he was in his late 20s. The degree to which mental health framed the abuse is difficult to tell. Whilst some research indicates that a history of a psychiatric disorder increases the likelihood of perpetration of domestic abuse against a partner (Oram et al, 2013) there is much research still needed to understand this phenomenon better in domestic abuse (Hester et al., 2015; Yapp et al, 2018) whether this be familial or interpersonal.

201. For the purpose of this review it is therefore only possible to recognise the co-existence of mental health and domestic abuse and seek to understand how agencies, as well as those personally involved, appeared to respond to the additional needs and risks that the co-existence of these factors created.

Domestic Abuse in [the Perpetrator]'s Previous Relationships

202. Domestic abuse was known to have been a feature in the perpetrator's previous relationships. The perpetrator had told the GP about domestic abuse in his marriage and, in his next relationship, told mental health services that his partner was being violent to him. The police knew about domestic abuse in this second relationship as a result of ten reports made by, or on behalf of, his ex-partner, Adult 3. Probation services knew of domestic abuse because he had been convicted of criminal damage that was committed in connection to domestic abuse and was subject to supervision with probation for one year.

203. How agencies respond to domestic abuse dictates the degree to which perpetrators are held accountable for their abuse. In turn, this frames the choices they make about their future behaviour. For the GPs involved, the disclosure was of historic domestic abuse but should have helped frame their understanding of future risk. The reports to the police would have been difficult to assess as both the perpetrator and his ex-partner were often inebriated and his ex-partner sometimes hostile to the police herself. Nonetheless, we have seen that the police missed opportunities to pursue victim statements at the time and after the event when the perpetrator's partner was more

sober. Neither the Mental Health Trust nor the Police undertook DASH assessments to inform the level of risk that was being faced. Indeed, for the Police, local procedures determined that undertaking DASH was a matter of professional discretion for officers at the time. Meanwhile, probation services did not link his sentence plan to the domestic abuse incident that had brought him into court in the first place. In this way, agencies would not have been seen to hold the perpetrator to account, irrespective of whether his behaviour was as a result of domestic abuse or his mental illness or both.

204. There were also aspects of the perpetrator's behaviour in these earlier times that did not appear to affect future indicators of risk. For example, the fact that on two occasions the police had recorded his withholding or moving to pick up hammers at times of conflict, needed to be flagged even if they would not feature later as crimes.

205. The reports of domestic abuse from his ex-partner often involved both parties being intoxicated and sometimes both were also abusive to the police. In this context, it was difficult for the police to obtain statements or discern that any crimes of domestic abuse had occurred. It would have also made it difficult for the police to understand the dynamics of the situation and effectively assess the risk even had the DASH had been used systematically.

206. Research has established that alcohol misuse by both parties increases the level of risk involved and the violence would be more likely to be seen as normal in a 'drinking couple' (Alcohol Concern and AVA, 2016). Hester (2006) found that in most domestic abuse cases involving alcohol, police officers rarely did more than remove the perpetrator for a short time and rarely referred to alcohol services. This was indeed the outcome of the majority of reports that the perpetrator's ex-partner made. Having researched the role of alcohol in domestic homicide, Alcohol Concern and AVA recommended that "addressing the normalisation of violence within drinking couples is critical in reducing the risk of harm to all involved and should be included in any training on alcohol-related domestic abuse" (2016, p14).

207. Whilst this period of domestic abuse occurred several years before the perpetrator went on to kill his mother, neither his abusive behaviour nor alcohol use was effectively addressed at the time. Neither was his ex-partner provided with a genuine opportunity to engage, provide evidence or be supported to access alcohol or domestic abuse services herself.

208. We have seen that since this time, West Midlands Police has made completion of the DASH mandatory in domestic abuse, which will have had the effects of securing a pathway to specialist police teams for follow-up in circumstances of medium and high risk and securing oversight and real-time accountability for decisions made regarding risk. We have seen that the police have also introduced electronic devices, not only enabling them to electronically complete a DASH at the scene but also streamlining the process thereafter for make ongoing referrals to specialist services and having the information readily available to investigators.

Learning points
Each of the perpetrator's relationships with women were characterised by domestic abuse and his history of domestic abuse should have informed future understanding of risk.

Domestic abuse should not be seen as a series of individual episodes of physical violence but as a pattern of coercive control and practitioners need to be professionally curious about exploring the victim's wider experiences of abuse below the surface of physical violence.

In order to reduce risk, practitioners need to address the normalisation of violence within 'drinking couples' and ensure that individuals are aware of services that can help them address problematic alcohol use and domestic abuse.

At times, the perpetrator indicated that he may be prepared to use a hammer to negotiate circumstances that he found difficult. Practitioners need to be aware of the increased risk that this presented to their own and multi-agency staff.

Manipulation of professionals

209. There were indications that the perpetrator manipulated professionals, although, again, the degree to which his mental ill-health contributed to these incidents is not known. For example, in February 2015 he spoke with his psychiatrist about having been split up with his partner for a year, despite there being evidence to the contrary. Whilst the psychiatrist would not have known about his partner's five calls to the police about domestic abuse during this period, records from his last visit to the psychiatrist did refer to his ongoing relationship. When confronted with his unwanted and inappropriate attention to a member of staff, he deflected concerns by saying that the staff member was intrusive. The perpetrator told mental health staff that his mother stole from him and abused him when in fact the opposite appeared true. He consistently minimised his alcohol intake when questioned by professionals preventing any opportunity to address a dual diagnosis of mental illness and substance misuse.

210. In assessments, the perpetrator referred to his caring role and his mother's ill health. Although mental health services rightly treated Angela as the carer throughout her son's episodes of care, they had also formed the view that there was a closeness and interdependency between mother and son. Angela's close family, on the other hand, did not see their relationship as having any degree of inter-dependence, but instead saw Angela providing care for her son and becoming frustrated when the treatment he received did not match what she thought he needed.

Learning point

Practitioners will already be aware from their professional experience that individuals with substance misuse or mental health issues will sometimes minimise their substance misuse, mask their condition or disguise their compliance with medication.

However, practitioners also need to be alert to manipulation by those who may be seeking to disguise their abuse of others

Mental illness disguising domestic abuse

211. Although agencies did not appear to understand her experiences as domestic abuse at the time, there is no doubt that Angela experienced domestic abuse from her son. She told one of her closest family members about this abuse when, at various times he called her vile names and told her that she had killed his father whom she had cared for until he died. She said that he had strangled her and had held a knife to her throat. The review found no evidence to suggest that practitioners had been told about these incidents.

212. However, Angela had told some professionals about her son's aggression towards her as early as May 2013 and in January 2017 other professionals were aware of his threats to kill her. Nonetheless, this abusive behaviour towards his mother was regarded as being due to a deterioration in his mental health and not due to domestic abuse, despite there being a recorded history of domestic abuse against his previous partner. For example, in 2013 the GP knew of the perpetrator's domestic abuse against his previous two partners but went on to minimise Angela's disclosure of her son's aggression towards her.

213. The role mental illness played in the degree of his domestic abuse is not known. For example, it is not known whether the perpetrator intended to isolate his mother, but his actions had the effect of doing so. As the perpetrator's condition got worse, he interfered with the companionship and support that she would get from close family. Her grandchildren no longer came to stay and if she went to visit family, the perpetrator would phone her every half an hour with spurious reasons for her to come home again. If he did not know where she was, he would phone his ex-wife repeatedly asking where she was. Having once been very gregarious and a beloved aunt, Angela feared going to family events in case he followed her and spoilt them for the rest of her family. She told close family that she wanted to protect other family members from the disruption that he caused.

214. Although practitioners were not aware, Angela had become increasingly isolated in her last twelve months and spoke to family members of her dread of leaving the home for fear of the disruption her son would cause at home in her absence. She stopped using the Ring and Ride service which she had previously used every week, and which had been a good source of social contact for her.

215. Professionals were aware that there was an issue over money and that this caused arguments but not that there was economic abuse involved. In order to help her son manage his money and avoid later arguments, Angela would lend him money, ask him to sign for the loan as a record and he would pay her back when he next received his welfare benefits. As she picked up his benefits, she would take out what he owed her and give him the remainder. As a result, the perpetrator always claimed that he had no money and would get into a nasty temper if his mother wouldn't give him any. Moreover, family members described how, in order "to keep the peace", Angela would get in a taxi to go to the local shops to buy him cigarettes. Professionals advised Angela not to lend him money, but it is hard to know what level of coercion or economic abuse was taking place underneath this seemingly benign yet flawed arrangement. Professionals were not aware that Angela had had to raise a considerable amount of money to pay off her son's loan to the loan shark.

216. The issue of familial domestic abuse is not well researched and therefore it is difficult to evidence that each of the well-documented risks of domestic abuse in inter-personal domestic abuse apply with equal resonance in familial domestic abuse. For example, it is not well-evidenced whether separation entails the same degree of risk as it would for domestic abuse in an intimate relationship.

217. In this case, the perpetrator had been under increasing pressure to leave his mother's flat and move into his own for a year. Had familial domestic abuse been recognised by professionals, the potential for increased risk at such times may have also been recognised.

Learning point: mental illness can disguise domestic abuse.
Professionals were unaware that the victim experienced physical, emotional and economic abuse and isolation from sources of support. The abusive behaviour that they were aware of was considered by practitioners only to be a result of the deterioration in his mental health.
Practitioners need to be professionally curious and recognise familial domestic abuse; engage with carers and family members; validate their concerns; assess and manage the risks that they face and ensure that support is available for them to deal with their experiences of domestic abuse.

Escalation of mental health concerns or increasing risk from domestic abuse?

"I told her more than once that he would kill her, but she always replied that he would never hurt me. I could see it getting worse and was frightened for her." (Angela's relative)

218. In the last year of her life there was a significant difference between how practitioners and how Angela and her family viewed the perpetrator's mental health. As practitioners were not aware of many of the circumstances, and there were indications

that he was masking his condition, they believed the perpetrator's mental health to be largely stabilising. However, relatives considered that the perpetrator's mental ill-health was deteriorating: he was becoming more delusional; was fascinated with knives and appeared to be spiralling out of control. He constantly shouted at his mother and had been warned not to harm her by his son. When his behaviour was becoming intolerable, Angela would ask his ex-wife to talk to him and that would calm him down, but he generally did not listen to advice or guidance from other people.

219. Angela told a member of her family that she thought that threats to others involving knives were all in his mind and that he was not going to carry them out. Nonetheless, she talked to family members about her frustrations at her not being able to get him the help that she felt he needed and could not understand why agencies could not see his paranoia escalating.

220. During this period, mental health services did observe a pattern of escalating discord between mother and son as well as an increase in his visits to the hospital Emergency Department and a deterioration in his mental health which resulted in an increase in his medication. The perpetrator had also contacted mental health services a number of times about his increasing paranoia. These presentations were not seen as unusual for someone with his condition and from a clinical perspective, the perpetrator's mental health was seen as stable on his medication and his problems were seen as social rather than clinical.

221. Clearly, there were a number of factors that mental health services were not aware of at the time they were planning to discharge him and it appears that the perpetrator was generally masking his condition. The issue of risk will be considered in subsequent sections of this report.

Learning point:
Practitioners have safeguarding responsibilities towards the family members of service users and in order to understand the risks that family members and carers face they need to encourage dialogue, listen and respond to their concerns, particularly when planning to discharge service users from services.

Experiencing domestic abuse as an older mother and carer

222. It is highly unlikely that Angela would have named her son's abuse of her as either domestic abuse or elder abuse. She clearly defined her role as carer and identified her son as being mentally ill, in keeping with his diagnosis. For this reason, it is even more unlikely that she would have engaged with domestic abuse services. Indeed, Bows (2018) found that older women were less likely than younger women to be engaging in domestic abuse services. Circumstances of inter-generational caring would appear to contribute to this position.

223. As an older mother of a son with chronic and enduring mental illness and alcohol misuse issues, Angela displayed overwhelming feelings of care and responsibility for her son. These feelings were consistent with societal expectations of the mothering role, which for older women may be even more entrenched, hence the intersection of sex, gendered violence and age is important to understand (Roberto et al, 2013).

224. All women experiencing domestic abuse will feel trapped at times, both physically and emotionally through conflicting emotions such as shame, guilt, care, responsibility, loyalty and fear (Stark, 2007). Carers will often feel trapped at times also. However, the responsibility of her mothering role in these circumstances may have felt overwhelming for the victim. This role, whilst lovingly adopted, trapped Angela who was dependent upon services to free her from abuse. This makes it all the more important for services to be able to identify domestic abuse specifically and not minimise or ignore it because of their abuser's mental illness. Indeed, the All-Party Parliamentary Group on Domestic Violence and Abuse recently agreed that "…abuse amongst older generations can often be minimised or ignored" and that there was a need to raise awareness about domestic abuse for older people amongst health staff in particular (5th December 2018)[9].

225. The review reflected upon the suitability of the Domestic Abuse, Stalking and Honour-based violence (DASH) Risk Identification Checklist in circumstances of domestic abuse for older women with caring responsibilities such as these. Had the full circumstances been known and informed the DASH, for example in September 2017, then it is probable that she would have been considered to be facing high risk, particularly if his attempts to strangle her had been known.

226. However, in the absence of knowing these critical risk indicators, the review panel considered that the DASH tool, had it been used, would not have given sufficient consideration to the issues that Angela faced and the risk she faced may have been missed. Bows (2018) considers that the DASH was designed around younger victims in the context of intimate violence and recognises that most of the questions contained in the DASH would fail to capture adult sons as perpetrators, despite current definitions of domestic violence and abuse capturing these dynamics. Indeed, the Older People's Commissioner for Wales (2015) introduced an amended Risk Identification Checklist that included questions aimed at older victims.

Learning points:
Practitioners need to be aware of the particular barriers that older mothers face when they are caring for grown-up children with multiple needs who may be abusing them.

The DASH Risk Indicator Checklist has not sufficiently prompted practitioners to consider domestic abuse in familial relationships. Practitioners will need to apply further professional judgement to assess risk for older victims effectively.

[9] https://www.womensaid.org.uk/wp-content/uploads/2019/01/Minutes-of-the-APPG-on-Domestic-Violence-and-Abuse-Meeting1.pdf

Recommendation 1: Indicators of Domestic Abuse
The agencies of Coventry Police and Crime Board should provide evidence-based assurance that their services are capable of

- identifying the breadth and range of domestic abuse, including tactics of coercive control and economic abuse
- identifying and responding to indicators of risk including recognising the history of domestic abuse and the potential to use weapons
- holding perpetrators of domestic abuse to account
- differentiating between domestic abuse and mental ill-health behaviours, intentions and effects

Recommendation 2: Domestic Abuse and Problematic Alcohol Use
The agencies of Coventry Police and Crime Board should consider how they can increase take-up of substance misuse services for individuals with multiple needs

Recommendation 3: Domestic Abuse and Older Women
Coventry Police and Crime Board should consider whether the barriers experienced by older women experiencing domestic abuse in accessing services, and the barriers experienced by agencies in providing services to older women, are sufficiently understood and being addressed.[10]

Recommendation 4: Tools for Assessing Indicators of Risk for Older Victims
The Home Office should consider commissioning a review of the domestic abuse risk assessment,[11] in its latest form, to ensure that it is capable of effectively assessing the risk indicators of domestic abuse for older victims.

Recommendation 5: Raising Professional Awareness of Familial Domestic Abuse
Coventry agencies to ensure that frontline staff have an understanding of, and are able to recognise, familial domestic abuse. This should include consideration of abuse to, and by, relatives who have a caring role.

Recommendation 6: Raising Public Awareness
Coventry Police and Crime Board should raise public awareness of familial domestic abuse including widely advertising sources of help and support; targeting families and friends

[10] For useful diagrams regarding barriers faced by victims and professionals see Kings College's resource: *Linking Abuse and Recovery through Advocacy for Victims and Perpetrators*, available at https://doi.org/10.1017/S2045796013000206

[11] DASH has since been replaced by the Domestic Abuse Risk Assessment (DARA) in West Midlands Police Force

6.2 Accommodation

227. The issues over accommodation were frequently mentioned as a source of conflict between the two, with the overcrowding in Angela's one bedroomed bungalow clearly exacerbated by other issues such as alcohol use, money, mental health and compliance with services and medication. There are strong indications that this became worse once the perpetrator had been offered his own flat.

228. Angela was increasingly frustrated that her son wasn't moving into the flat that had been provided to him nearby. She was also worried that his living with her would risk her losing her home. Meanwhile, her son appeared to lack regard for the pressure that this was putting onto his mother and complained about her stifling him, being intrusive and always telling him what to do.

229. Reference was made in several agencies' records to the opinion that Angela was allowing her son to continue living with her even where he had his own flat, without the reasons for this arrangement continuing being fully considered. Whilst agencies could not have predicted that the circumstances would result in Angela's homicide, they could certainly recognise that the tensions in the relationship were escalating and that for the perpetrator, as a vulnerable person with care and support needs, there was a risk of homelessness. Indeed, the Lankelly Chase Foundation (2015) recognised that individuals meeting the perpetrator's description of having multiple and complex needs were the most likely to find themselves destitute when family relationships had broken down.

230. Angela told relatives that professionals had told her to throw her son out and that they would find him temporary accommodation such as a hostel, but she said that she could never do that. She told her family that she felt that, as he was not on the streets, agencies did not care so much.

231. It is clear that several agencies were involved in trying to secure accommodation for him but having done so, there appeared to be a lack of enquiry into the complex reasons why he was not moving. Indeed, the perpetrator provided a series of different reasons for not moving including: the lack of furniture, which his mother and mental health support worker helped him with; access to his bank account, which was enabled; repairs being needed, which were undertaken and burglaries which were not evidenced. Although all practical matters were addressed, it appeared that the perpetrator was trying to communicate his worries about moving into his own flat but instead of exploring his fears, the focus remained on the practicalities.

232. It is likely that the perpetrator would have struggled to live on his own, as he had done before. The review found no evidence of agencies recognising the need for a co-ordinated, resettlement plan for him. As well as identifying his needs, this may have helped provide him with greater confidence to move in, and test whether he was

capable of living on his own, as his psychiatrist had earlier concluded. Agencies could also have considered whether supported living may have been a more acceptable option for him.

233. We have seen that Whitefriars Housing, who own and manage the properties which used to form the local authority housing stock, have significantly strengthened their pre-tenancy assessments and tenancy sustainment work. They are also piloting the provision of carpets and furniture (white goods) for new tenants with multiple needs. In the face of national concerns around homelessness, there is now a body of research which supports this type of approach as a means for individuals with multiple and complex needs to sustain their tenancies and homes (Cornes et al,2011; Robson, 2018). However, research also demonstrates that housing support agencies working alone will often feel isolated and out of their depth when trying to address the range of issues that individuals with multiple needs may have and the Joseph Rowntree Foundation recommends an integrated response to resettlement across health, housing and social care (McDonagh, 2011).

Learning Point: Individuals with care and support needs may need a wide range of practical and emotional support to resettle into a new home. Whilst many agencies and practitioners from different disciplines were involved with the perpetrator and taking practical measures to enable him to move into his new home, there was a need for a co-ordinated, multi-agency resettlement plan to ensure that all his practical and emotional needs could be understood and met.

Recommendation 7: Homeless Resettlement
Coventry Police and Crime Board to assess whether there is sufficient multi-agency support and co-ordination for the resettlement of homeless individuals with multiple and complex needs.

6.3 Carers and the Care Programme Approach

234. Mental health services and the GP Practice were aware that Angela had a caring role for her son. She assisted him with his mental health care, including: decanting his medication into 'medipacks'[12]; attending appointments with him: engaging with professionals regarding his care and looking after his medication in order to prevent him from taking an overdose. In respect of his personal care, she washed his clothes, prepared his meals, helped him manage his money and often supplemented his money with her own.

235. Under section 10 of the Care Act 2014, carers should be active partners in key care and support processes, including the assessment, support planning and review with the

[12] Medipacks distribute medication by day and time, reducing the risk of taking the wrong tablets at the wrong time

person they care for (Tri-X, online). There was good evidence provided that, through much of the time, professionals included Angela in the assessments of her son's treatment and needs and the perpetrator's care-coordinators were well known to Angela. However, the degree to which Angela's views were taken into account varied. For example, Angela's concerns about her son's alcohol abuse were not taken into account when her son contradicted her account and minimised his alcohol intake. Nonetheless, there were also times when her son's medication was changed as a result of her account of its negative effects. However, it was not routinely documented whether key questions that informed risk assessments were asked of Angela when she was on her own, although this would have been normal practice to do so.

236. Family members thought that agencies were not asking Angela what she needed herself. However, mental health staff had spoken to Angela often about her needs and offered her a carer's assessment a number of times, but she turned them down on each occasion, which was her right. Relatives acknowledged that Angela would have been reluctant to take help for herself and she neglected her own health so as not to neglect her caring responsibilities. At one time she thought that she had pneumonia but would not go to the hospital as she was worried about leaving her son alone in the house.

237. From the GP Practice's perspective, Angela was not formally recognised as a carer. As a result, she was not offered a structured support package, formal risk assessments or respite options, despite the level of care that she provided to her son who was staying on her sofa for more than two years. The Clinical Commissioning Group observed that this level of care is a common role for family members to undertake and it is not routine or commonplace for GPs to undertake a formal assessment of this role, unless there is an identified risk in patients with a history of violence or particular addictions.

238. Nevertheless, there were missed opportunities for the GP Practice to make referrals to Adult Social Care for a carer's assessment for Angela. Whilst there is every indication that this referral would have been accepted by the local authority in these circumstances[13], it is not known whether Angela would have engaged with these opportunities, as she would likely have minimised her own needs. Indeed, carers often minimise their own needs (Onwumere, 2016). In response, it is important for professionals to develop skills in framing the carer's assessment as a means of improving the support for those they care for. In the absence of effective recording, it has not been possible to assess the degree to which mental health professionals framed their own offers to Angela in this manner.

239. One of the key strengths in the introduction of the Care Act 2014 was that carers were to be given the same degree of recognition, respect and parity of esteem as those they support (Department of Health and Social Care, 2016). Had a carer's assessment been undertaken, it would have enabled some reflection on the impact of Angela's caring role upon her own well-being and how the provision of support may impact upon her ability to continue caring for her son.

[13] As confirmed by the review panel member from Adult Social Care

240. Moreover, a formal approach to assessing the dynamics of risk could have been employed to analyse the growing tensions in the caring relationship. Agencies were aware that the perpetrator was, at times, resistant to the degree of his mother's care. Relatives were aware that he did not like his mother being involved in his business and he was increasingly shouting at her and calling her names.

241. The carer's assessment could have analysed the nature of Angela's isolation. Her son was resistant to leaving the household and mental health workers, seeing the strain that this was putting on the household, tried to encourage him out of the house with activities. However, without some focus on Angela, they may not have realised that she had become fearful of going out herself. From having had a thriving familial network she felt no longer able to visit them and attend family functions as she had become afraid of what disruption he may cause in her absence. She had dissuaded family from visiting and sometimes minimised her telephone conversations to avoid upsetting him. Kaschowitz and Brandt (2016) have shown that carers with strong social networks experience far less of the negative consequences of caregiving but, in this case, Angela's social networks had been depleted as a result of her fear of her son's behaviour.

242. Given the intensity of living in such overcrowded conditions, a carer's assessment could have considered the possibility of respite care. This may have provided further opportunities to understand the perpetrator's reluctance to live independently. Indeed, other than finding him somewhere else to live, there was no evidence to show that any action was taken to relieve the stress that Angela was experiencing from having her son staying with her in these overcrowded conditions after it had become evident that he was not going to move into his new accommodation.

243. Over fifty mental health staff were involved with the perpetrator and the review found much evidence of good engagement with Angela over her son's care needs. However, a gap appeared to have emerged between what Angela told her family and what professionals were made aware of. Indeed, Angela's voice was heard very differently by relatives in the year before her homicide compared to how professionals understood her. Relatives understood that she was becoming increasingly frustrated by services not responding to her son's escalating needs. By comparison, mental health services saw a deterioration in the relationship between mother and son but not necessarily a long-term escalation in his mental illness.

244. Angela told members of her family that she was asking for her son to be admitted to hospital for treatment. Mental health services, without knowing the full picture at the time and having no record of having been asked, were not alerted to a clinical need to do so in this last period of his care. Although Angela advised members of her family that she had alerted them to mounting difficulties, the review found no evidence that mental health practitioners had known that the perpetrator had developed an obsession with knives; was calling her vile names; was accusing her of killing his father; had strangled her and held a knife to her throat or was walking barefoot erratically

outside his mother's home. If they had known these details, their response would likely have been different.

245. The review also recognised that there is currently a driver towards strengths-based, whole family approaches in adult services. These approaches encourage, where appropriate and agreed by the individuals concerned, assessments under the Care Act being combined: that is, assessing the cared for and the carer at the same time. Although decisions would necessarily be taken on a case by case basis, the review recognised the need to offer a separate carer's assessment and to make sure that concerns around domestic abuse were clearly addressed before undertaking any type of combined assessment, strengthening the reasons to be talking with each person independently, on their own.

Learning Point:
The victim would have benefited from a carer's assessment, a structured support package and respite care. However, many carers are reluctant to accept help for themselves and just want the person that they care for to receive the help that they need. Practitioners need to be promoting the carers assessment as a means for the family unit to strengthen its resilience.

In the final months, a gap emerged between the victim's perceptions of her son's deteriorating health and what mental health practitioners were aware of and her son masked his condition to professionals. Agencies need to consider how carer's voices, and the concerns of their family and community, are empowered and heard.

Opportunities should be taken and documented, to talk to both carers and those being cared for, on their own.

Recommendation 8: Carers and the Community
Coventry Safeguarding Adult Board seeks assurance from its agencies that they are delivering their responsibilities to carers under the Care Act 2014.

6.4 Co-existence of substance misuse and mental health

246. Alcohol was clearly an issue for the perpetrator, but he regularly minimised his level of alcohol intake when questioned by mental health practitioners. Coventry and Warwickshire Partnership NHS Trust shared their policy on dual diagnosis[14] which covers their required practice on dealing with the co-existence of alcohol and mental health issues and included the need for systematic screening for alcohol in mental

[14] Dual diagnosis refers to the condition of suffering from a mental illness as well as a substance abuse problem

health assessments and care planning. Whilst the perpetrator was often asked about his alcohol intake by mental health practitioners, there was an over-reliance on his self-reported use rather than in the context of a long and well documented history of alcohol misuse.

247. In its study of domestic homicide reviews involving alcohol, Alcohol Concern and AVA (2016) recognised that minimisation of alcohol intake was not uncommon. They advised that screening alone was often insufficient, and practitioners needed to be professionally curious about the impact of alcohol in their service user's lives.

248. We have seen that there were a number of occasions when Angela challenged her son's account of his alcohol use, but her accounts were either not taken sufficiently seriously or his behaviour not questioned around domestic abuse. For the perpetrator, this had the effect of enabling him to avoid confrontation of his alcohol abuse as well as avoid consideration of how this affected his mental health treatment and his abusive behaviour towards his mother.

Learning Point:
The perpetrator minimised his accounts of the amount of alcohol that he was drinking.

Practitioners need to be professionally curious about the impact of alcohol in the lives and history of their service users to gain a more realistic perception and not rely on self-reported accounts.

Practitioners also need to be seeking advice from substance misuse services where individuals have problematic alcohol use and maintaining a dialogue with those service where the individual is reluctant to engage on the issue.

Recommendation 9: Dual Diagnosis
Coventry Safeguarding Adult Board should ensure that the multi-agency dual diagnosis policy (which is out of date) is refreshed between CGL, Coventry and Warwickshire Partnership NHS Trust and other mental health providers and overseen by commissioners of those services.

7. INDIVIDUAL AGENCY RECOMMENDATIONS

7.1 Coventry and Rugby Clinical Commissioning Group

- Implementation of the IRIS project in GP Primary Care
- Circulate the lessons from this case to all GPs in Coventry and Rugby CCG with a summary of the case history and discuss at the Face-to-Face GP training.

- The CCG will review how the national strategy for supporting carers is being implemented locally by local GP primary care providers. This piece of work will review the activities of the finance, contracting, communications and clinical groups to ensure a joined up approach is being delivered to improve support to carers.

7.2 Coventry and Warwickshire Partnership NHS Trust

- Frontline staff to have an increased understanding of, and be able to recognise, familial domestic abuse and how it may present in the client groups served by CWPT. This should include consideration of abuse to, and by, relatives who have a caring role.

- Team managers who provide supervision to staff to have the knowledge and skills necessary to identify domestic abuse, particularly in the context of familial abuse, even if the caseworker has not recognised the abuse and is not presenting the case in the context of domestic abuse

- Staff to recognise the importance of considering known risk factors, including information provided by relatives/carers, when assessing risk

7.3 Staffordshire and West Midlands Community Rehabilitation Company

- Comprehensive and ongoing review of all practitioner referrals to interventions

- Dip sampling of Responsible Office's case management/assessment records to ensure correct recording of factors linked to risk of harm

- Quality assurance of the Responsible Officer's enforcement action and decision making

7.4 West Midlands Police

- A feasibility study into the use of a referral portal app to be added to the mobile device thus enabling officers to make referrals directly from the scene. At present, front line officers have to return to a police station to do this which can be time consuming; completing a referral directly from the scene, affords vulnerable individuals greater service and is a better use time, relevant when policing faces increasing demands

7.5 Whitefriars Housing Group

- To promote the benefit of carers' assessments amongst housing practitioners

- To increase housing practitioner's awareness of indicators that a person may be a perpetrator of domestic abuse

8. CONCLUSIONS

249. It has been acknowledged that the circumstances of a mother caring for an adult son could be replicated across many thousands of families currently receiving mental health services and for whom, thankfully, lives have not ended with similar tragedy. Indeed, the vast majority of people with a diagnosis of paranoid schizophrenia do not present a risk to others and many family members undertake the care of loved ones through periods of crisis and help them to take their medication to keep them stable and well.

250. However, in this case, Angela's son had a history of domestic abuse against women for which he had not meaningfully been held accountable. The combination of mental ill-health and substance misuse in his last relationships meant that his abusive behaviour may have been disguised and this continued to be a feature of his subsequent behaviour. Having said that, it is not known how much the perpetrator's chronic and enduring mental illness contributed to his ongoing abusive behaviour.

251. Although agencies were not aware of the whole picture at the time, there is no doubt that Angela experienced physical, emotional and economic abuse from her son and became increasingly isolated.

252. Domestic abuse in the context of families is less understood than domestic abuse within intimate partner relationships. Factors such as substance misuse, financial issues and a known history of aggression were generally documented but not considered risk factors in the context of domestic abuse. The lack of recognition of indicators of domestic abuse meant that practitioners largely saw his abusive behaviour as a deterioration in his mental health and opportunities were therefore missed to safeguard Angela.

253. There was evidence that mental health services had, for the most part, engaged well with Angela as a carer, although there were times when her concerns over his alcohol intake were not responded to. Angela repeatedly turned down a carer's assessment which would have focussed on her own needs, preferring to pursue the services that she thought her son needed to make him well. The barriers which she faced as an older mother and carer were not widely known.

254. Several agencies were actively involved in trying to assist the perpetrator to move into his own accommodation and thereby reduce the stress for mother and son. However, as each obstacle was addressed, it became apparent that he was reluctant to move out of his mother's one-bedroomed home, revealing that it was more than practical issues that affected his motivation to move. The perpetrator would have benefited from a multi-agency resettlement plan which would have addressed his emotional as well as his practical needs. It is possible, that he would still not have moved, but this itself would have improved both the victim and agencies' understanding and contributed to future assessments of risk

255. Four months before her homicide, Angela had made a decision that her son's behaviour was intolerable and that he had to leave. She contacted the police who removed her son from the property and took him to the train station. They were aware that the perpetrator had another address and that Angela had taken her house keys off him. Because they thought the two individuals had been separated, the police supervisor downgraded the risk to standard. This had the effect of the circumstances not being shared with specialist teams and no referral was made to health services regarding his erratic behaviour.

256. Her son attended the Emergency Department more regularly during these last months. He had had an increase in his medication and told mental health services that he was becoming increasingly paranoid himself and was trying to stay awake for fear that the police would kill him in his sleep. He contacted mental health services to say that he had raised a fist to his mother but had not harmed her. It would appear that he was worried for his mother's safety. However, mental health services were confident that he would settle if he took his medication and, with the agreement of both Angela and her son, had been working with them for months to discharge the perpetrator from mental health services back to his GP. Neither mental health services nor the Emergency Department considered that his presentations at this time were a cause for concern.

257. The review has found no evidence to show that services were aware that the perpetrator had tried to strangle his mother; had held a knife to her throat or had held her responsible for her husband's passing. The absence of this knowledge, together with the perpetrator's masking of his condition and his substance misuse meant that agencies' risk assessments were rendered ineffective and clinical judgements impaired. There is therefore work for the area to do in strengthening its engagement with older victims of domestic abuse and carers; strengthening practitioner awareness about indicators of domestic abuse and how mental illness may mask domestic abuse and strengthening multi-agency approaches to the resettlement of vulnerable people.

POSTSCRIPT

Since completing this review, the Domestic Abuse Stalking and Harassment (DASH) Risk Model has been replaced by the Domestic Abuse Risk Assessment (DARA) within West Midlands Police and is being trialled in other areas. Recommendations concerning a review of domestic abuse risk assessment models in so far as they are able to capture the risks to older women apply equally to any endorsed risk assessment process.

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Appendix 1: Action Plans

Overview Report Recommendations

Recommendation 1: Indicators of Domestic Abuse

The agencies of Coventry Police and Crime Board should provide evidence-based assurance that their services are capable of

- identify the breadth and range of domestic abuse, including tactics of coercive control and economic abuse
- identify and responding to indicators of risk including recognising the history of domestic abuse and the potential to use weapons
- hold perpetrators of domestic abuse to account
- differentiating between domestic abuse and mental ill-health behaviours, intentions and effects

REF	Action (SMART)	Scope	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
PCB 1	**Data collection:** Ensure that all types of domestic abuse (crime and non-crime are collated) and made available to the Police and Crime Board (PCB) on a quarterly basis	Local	31st July 2020	A complete picture of incidents of domestic abuse in Coventry captured by the partnership, with accompanying trends.	Quarterly Police and Crime Board meetings. The Chairpersons of the Quarterly Harm and Abuse Reduction Partnership meetings.	Rising reports of domestic abuse (DA), but with reductions in rates of reoffending.
PCB 2	**Risk indicators.** Ensure that investigators are considering intervention and prevention opportunities across the entire risk spectrum (Low, Medium & High) including: - Appropriate	Local	31st July 2020	Risk factors are identified in each DA case and compliance with compulsory Domestic Abuse Risk Assessment (DARA) and Domestic Abuse Stalking and	The Chairpersons of the Quarterly Harm and Abuse Reduction Partnership (HARP) meetings. This is a sub-group of the PCB. Referral data from partners.	DA cases where these risk factors are identified, and measures put in place to reduce the risk

	referrals to partner agencies / 3rd sector, for both victim's and offenders, with appropriate consent. -Support pathways to be reviewed (accepting that high risk cases are captured well with current policy and practice). -A key indicator for support will include ensuring DIP tests are completed, where appropriate, for DA offenders in custody (non-mandatory as well as mandatory). -Police to raise awareness amongst supervisors, investigators and custody, particularly around non-mandatory offences. This will trigger support programmes and assist in managing risk.			Harassment (DASH) processes. Increased referrals to partners at an earlier stage, effectively addressing risk indicators and aiming to reduce future offending/behaviour. Imp roved support for suspect's who have a drug addiction. Three-month Pilot project to commence in January 2020 between Coventry Haven & West Midlands Police to provide earlier intervention with partners.	Re-offending data against those who have received intervention and support. DIP data from custody & subsequent referrals.	
PCB 3	**Justice.** Positive action taken to address the	Local	31st July 2020	Recording of DA convictions, legal sanctions and those	The Chairpersons of the Quarterly Harm and Abuse Reduction Partnership	An increase in the use of the various sanctions available.

	behaviour of DA perpetrators			entering DA perpetrator programmes. Confidence in Coventry that the partnership address, the behaviour of DA perpetrators civil intervention work and impacts on re-offending: Non-molestation orders, Domestic Violence Protection Order's, Criminal Behaviour Order's. Awareness of available perpetrator programmes and referral routes and appropriate signposting	(HARP) meetings. This is a sub-group of the PCB ODOC Reducing reoffending Group MAPPA	Sentencing for breach of non mols / sentencing for DVPO's (from CJ & Court).
PCB 4	**Mental ill-health behaviours.** Ensuring that DA is considered in all relationships where, one or both of the parties, are being treated for mental health issues	Local	31st July 2020	Scoping and reviewing the procedures of front-line mental health practitioners so that they are able to identify coercive control and inter-familial abuse. Training to be initially arranged for all front-line mental health practitioners and latterly all professionals who may	Lead to be confirmed and will be overseen by the Chairpersons of the Quarterly Harm and Abuse Reduction Partnership.	Completion of the scoping and a review of procedures for front line mental health practitioners. Number of people completing the training.

				encounter similar situations; this should include GPs		

Recommendation 2: Domestic Abuse and Problematic Alcohol Use The agencies of Coventry Police and Crime Board should consider how they can increase take-up of substance misuse services for individuals with multiple needs						
REF	Action (SMART)	Scope	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
PCB 5	**Substance Misuse.** Raise awareness amongst our partners and commissioned services as to how persons can be referred to substance misuse services (See also PCB2)	Local	31st July 2020	Raised awareness of current and future service options Active collaboration between DA services, Mental health and substance abuse service. See recommendation 8.	The Chairpersons of the Quarterly Harm and Abuse Reduction Partnership (HARP) meetings.	An increase in the number of adults referred from DA services (Council, CSF and partner provided) into commissioned substance misuse services and successful outcomes

Recommendation 3: Domestic Abuse and Older Women Coventry Police and Crime Board should consider whether the barriers experienced by older women experiencing domestic abuse in accessing services, and the barriers experienced by agencies in providing services to older women, are sufficiently understood and being addressed.[15]						
REF	Action (SMART)	Scope	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
PCB 6	**Barriers faced by older woman.** Continued and wider access to IRIS services in Coventry	Local	31st July 2020	Securing a widening of IRIS provision in Coventry for all GP practices A focussed campaign to raise awareness across the partnership of the types of abuse suffered by older persons; particularly coercive control and familial abuse.	Quarterly Police and Crime Board meetings.	City wide provision has now been procured and is being rolled out in 2020 to all remaining GP practices in Coventry. Appropriate campaign completed to raise awareness of domestic abuse suffered by older persons

[15] For useful diagrams regarding barriers faced by victims and professionals see Kings College's resource: *Linking Abuse and Recovery through Advocacy for Victims and Perpetrators*, available at https://www.kcl.ac.uk/ioppn/depts/hspr/research/ceph/wmh/assets/lara-vp-online-resource.pdf

Recommendation 4: Tools for Assessing Indicators of Risk for Older Victims
The Home Office should consider commissioning a review of the endorsed domestic abuse risk assessments to ensure that they are capable of effectively assessing the risk indicators of domestic abuse for older victims

REF	Action (SMART)	Scope	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
PCB 7	**DASH/DARA and older woman.** Write to the Home Office to request that they consider a review of domestic abuse risk assessments	Local	31st July 2020	A letter is sent to the Home Office from the Chair of the PCB requesting a review of DASH	Quarterly Police and Crime Board meetings.	Letter sent and acknowledged

Recommendation 6: Raising Public Awareness
Coventry Police and Crime Board should raise public awareness of intra- familial domestic abuse including widely advertising sources of help and support; targeting families and friends

REF	Action (SMART)	Scope	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
PCB 8	**Awareness Raising.** Ensure that we continue to keep DA in the public eye.	Local	Ongoing	There are already directly commissioned services in Coventry to perform the role of raising and maintaining public awareness in this area. Use the 'Safe to Talk' website to raise the profile of familial abuse and create a 'one minute' guide.	Contract management in Coventry City Council's Public Health Service	Continued high demand for our DA services. Hits on our safe to talk website. Production of one-minute guide for professionals

				Maximise publicity of a number of cases, which have had positive outcomes		

Recommendation 7:
Coventry Police and Crime Board to assess whether there is sufficient multi-agency support and co-ordination for the resettlement of homeless individuals with multiple and complex needs (MCNs).

REF	Action (SMART)	Scope	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
PCB 9	**Homeless Individuals with MCNs.** Examination of service provision and pathways to facilitate the creation of suitable accommodation and sustainable tenancies.	Local	31st July 2020	Suitable processes embedded in the service provision of our Registered Providers designed to: ensure the provision of suitable accommodation, with suitable support to ensure vulnerable tenants are able to maintain their tenancies. To ensure appropriate representation of housing providers on relevant partnership boards	The Chairpersons of the HARP, Multi-agency Risk Assessment Conference (MARAC), Housing First	Identification and suitable placement of individuals with MCNs in accommodation. Key housing providers are represented on our partnership boards

Recommendation 8: Carers and the Community

Coventry Safeguarding Adult Board seeks assurance from its agencies that they are delivering their responsibilities to carers under the Care Act 2014.						
REF	Action (SMART)	Scope	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
7.1	Health, social care, housing and criminal justice agencies provide evidence of increased numbers of carer assessments being offered and delivered	Local	December 2020	Carers are identified, supported and their needs met	Reporting to Safeguarding Adult Board	Increased carers assessments

Recommendation 9: Dual Diagnosis

Coventry Safeguarding Adult Board should ensure that the multi-agency dual diagnosis policy (which is out of date) is refreshed between CGL, Coventry and Warwickshire Partnership NHS Trust and other mental health providers and overseen by commissioners of those services.

REF	Action (SMART)	Scope	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
8.1	Refresh of multi-agency dual diagnosis policy Framework for monitoring evidence of adherence	Local	July 2020 December 2020	Multi-agency practitioners are able to meet the needs of individuals with both substance misuse and mental health issues through robust, co-ordinated and seamless services	Reporting to Safeguarding Adult Board	Report available to Safeguarding Adult Board Evidence of adherence

Individual Agency Recommendations: Coventry and Rugby Clinical Commissioning Group

Recommendation 1:
The IRIS programme is perhaps the biggest evidence-based opportunity for Coventry and Rugby CCG to implement the three lessons from above. It is hard to guarantee that IRIS will continue indefinitely as it is currently from an income stream that is non-recurrent. At present though it is being implemented and it is hoped this will deliver a step change in the recognition and management of domestic abuse in our region.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
1.1	Implementation of the IRIS project in GP Primary Care	Safeguarding Lead	During 2018/19	Increased detection of Domestic Violence in GP Primary Care	GP practices are trained and then have a IDVA worker allocated with referrals rates audited	Whether the number of Domestic Abuse cases detected increases.

Recommendation 2:
The lessons from this case will be circulated by email to all GPs in Coventry and Rugby CCG with a summary of the case history and discussed at the Face-to-Face GP training.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
1.1	Email a summary of the case with all the lessons to all GPs in CRCCG and discuss the case at the GP training event	Named GP for Safeguarding	End March 2019	Increased awareness of inter-generational domestic violence	Circulation of the email to GPs and inclusion of the case on the agenda for the 2019 safeguarding training	Linked to the IRIS project, aims to increase detection rates of domestic abuse.

Recommendation 3:
The CCG will review how the national strategy for supporting carers is being implemented locally by local GP primary care providers. This piece of work will review the activities of the finance, contracting, communications and clinical groups to ensure a joined-up approach is being delivered to improve support to carers. Dr James Burden suggests that the outcome of any review ensures that the actions result in a system that are created in conjunction with GP representatives and will therefore have an increased chance of being an acceptable service change that all can implement.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
1.1	The CCG will review how the national strategy for supporting carers is being implemented locally by local GP primary care providers and use the CCG to help improve this element of care.	Safeguarding Lead	During 2018/19	GP practices support carers in their role to ensure they remain safe, happy and healthy.	The CCG will report the outcome of the work back to the LSAB	Parameters for this success will be agreed as part of the work group

Individual Agency Recommendations: Coventry and Warwickshire Partnership NHS Trust

Recommendation 1:
Coventry agencies to ensure that frontline staff have an increased understanding of, and be able to recognise, familial domestic abuse and how it may present in the client groups served by CWPT. This should include consideration of abuse to, and by, relatives who have a caring role.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
1.1	CWPT Level 3 Domestic Abuse Training to be revised to ensure increased emphasis on familial abuse.	Lead Nurse for Adult Safeguarding	January 2019 (Training amended) January 2020 (Survey monkey review)	Staff will be able to recognise and differentiate between intimate partner abuse and familial abuse	Level 3 Domestic Abuse training lesson plan to reflect changes in learning outcomes. Survey monkey evaluation forms to be amended to include a question regarding candidates' knowledge of familial abuse.	Review of survey monkey responses to be completed 12 months after review of training

1.2	'Standalone' DASH Risk Indicator Checklist module, to include an exercise which requires staff to consider familial domestic abuse in families with complex needs, to be developed and delivered to teams in accordance with CWPT training needs analysis	Lead Nurse for Adult Safeguarding	September 2019 (Training) March 2020 (Survey monkey review)	Staff will be able to use the DASH to identify risk and be aware of the risk factors relating to families with complex needs, particularly where there is a caring role.	Survey monkey evaluation forms to be amended to include a question to determine candidates learning relating to recognising and assessing risk in complex family relationships	Review of survey monkey responses to be completed six months after review of training

Recommendation 2:

Team managers who provide supervision to staff to have the knowledge and skills necessary to identify domestic abuse, particularly in the context of familial abuse, even if the caseworker has not recognised the abuse and is not presenting the case in the context of domestic abuse.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/ Outcome
1.1	CWPT Safeguarding Team to contact team managers to offer targeted training/support, specifically related to supporting staff in supervision.	Lead Nurse for Adult Safeguarding	April 2019	Team managers will have the knowledge and skills necessary to identify domestic abuse and will be familiar with CWPT domestic abuse policies and procedures.	Information relating to which managers have been offered, and have taken up, supervision to be recorded on Safeguarding Supervision database (already established).	Report regarding team manager compliance with supervision extracted from supervision database and reported to the bi-monthly Safeguarding Operational Group. First report due November 2019 to allow time for embedding of targeted training and support.

Recommendation 3
Staff to recognise the importance of considering known risk factors, including information provided by relatives/carers, when assessing risk

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will success be Measured/ Outcome

1.1	'Signs of safety' model of supervision to be rolled out across the Trust to enable staff to consider the importance of not relying on self-reported risk and on considering all risk factors, including historical factors, when assessing risk	Lead Nurse for Adult Safeguarding	January 2020	When assessing the risk posed by the patient to self and other staff will take into account wider factors, including historical factors, and not be reliant on the patients reporting of risk.	Team managers to monitor through supervision, Multi-Disciplinary Team meetings, and safeguarding concerns raised and other documentation.	Dip sample of case notes to be conducted to establish whether staff are including wider risk factors, including historical factors, in risk assessments.
1.2	CWPT Level 3 Domestic Abuse Training to be revised to emphasise the importance of considering known risk factors, including information provided by relatives/carers, when assessing risk.	Lead Nurse for Adult Safeguarding	January 2019 (Training amended)	When assessing the risk posed by the patient to self and other staff will take into account wider factors, including historical factors, and not be reliant on the patients reporting of risk.	Level 3 Domestic Abuse training lesson plan to reflect changes in learning outcomes. Survey monkey evaluation forms to be amended to include a question regarding candidates' knowledge of the importance of considering known risk factors, including information provided by relatives/carers, when	Review of survey monkey responses to be completed 12 months after review of training

Individual Agency Recommendations: Staffordshire and West Midlands Community Rehabilitation Company

Recommendation 1: *Comprehensive and ongoing review of all practitioner referrals to interventions*						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured/Outcome**
1.1	Team Manager use of the PMF (Performance Management Framework) on a monthly basis to target low referring practitioners.	Overseen by Deputy Head of Resettlement and Pathway Interventions for SWM.	Ongoing	Increased referral rates per practitioner leading to an increase in needs-based intervention for service users.	Deputy to monitor with local PDM's and reports issues to relevant Regional Manager via the Senior Leaders Team monthly meeting.	Increase in referral rates, quality assurance of practitioner's assessments, scrutiny of MI (Management Information) dashboards.

Recommendation 2: *Dip sampling of Responsible Office's case management/assessment records to ensure correct recording of factors linked to risk of harm*						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured/Outcome**
1.1	To review 3 cases per month during supervision with specific focus on changes in risk and recording of changes.	Team Manager	December 2018	Improved recording of risk via the use of Delius risk flags. Rich, timely and concise information that demonstrates an assessment of change in circumstances linked to risk of harm.	To be monitored by PDM as part of Quality Assurance arrangements. PDM to report back to Regional Manager	Increased recording and reviewing of risk flags in identified cases.
1.2	Team Manager to review 1 OASys per	Team Manager	December 2018	Recorded evidence of defensible decision making,	To be monitored by PDM as part of Quality Assurance	Minimum of three OASys assessments quality

	month during supervision with specific focus on Responsible Officer's analysis and defensible decision making in respect of sentence plan objective setting.			appropriate risk assessing and the formulation of targeted sentence plan objectives.	arrangements and reported back to Regional Manager	assured with formal recorded feedback to the Responsible Officer as part of ongoing individual and team development if required.

Recommendation 3: *Quality assurance of the Responsible Officer's enforcement action and decision making*						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured/Outcome**
1.1	Team Manager to quality assure 3 cases with specific focus on enforcement action/management oversight.	Team Manager	December 2018	Evidence of prompt and appropriate enforcement action for non–compliance and management oversight to demonstrate discussion and reflection with Manager.	To be monitored by PDM as part of Quality Assurance arrangements and reported back to Regional Manager	Minimum of three cases scrutinised, with associated feedback. Improved enforcement recorded on Delius in when service user absence occurs, increased Management Oversight recorded on Delius.

Individual Agency Recommendations: West Midlands Police

Recommendation 1: WMP makes recommendation for a feasibility study into the use of a referral portal app to be added to the mobile device thus enabling officers to make referrals directly from the scene. At present, front line officers have to return to a police station to do this which can be time consuming; completing a referral directly from the scene, affords vulnerable individuals greater service and is a better use time, relevant when policing faces increasing demands.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured/Outcome
1.1	Develop a referral app for inclusion on the mobility device used by frontline officers	To be nominated but to include WMP IT support department	April 2019	App to be included on the mobility device	Recommendations from statutory reviews are monitored through WMP Crime and Governance oversight	Completion of the feasibility study with detailed results. As of 07th December 2018, a Vulnerability Referral Form has been made available to officers' mobility devices, enabling them to refer a given person for a variety of themes such as mental health, housing etc. Consent needs to be obtained from the person there and then before the referral can be made.

Individual Agency Recommendations: Citizen Housing (Previously Whitefriars Housing Group)

Recommendation 1: To promote the benefit of carers' assessments amongst housing practitioners						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured/Outcome**
1.1	Brief all front-line Managers of the principles of the Carers' Assessments so that this can then be cascaded to their operational teams. It should be recognised that whilst this action is specific to Whitefriars it is relevant in other operating areas as the manager and teams involved cover all the West Midlands giving added value and spread of information.	Director of Care and Support	Completed	Greater awareness and understanding of the carers' assessment That housing practitioners identify the need for carers assessments and promote their take-up amongst their tenants	A summary of the event(s) will be provided to Coventry City Council and be made available to other authorities upon request	Increased number of referrals made to Adult Safeguarding for carers assessments
1.2	Ensure the principles of the carers' assessment are shared as part of	Director of Care and Support	Completed	Greater awareness and understanding of the carers' assessment	Feedback will be obtained from inductees and then shared more widely with Coventry City Council and	Increased number of referrals made to Adult Safeguarding for carers assessments

	new staff induction programmes				other authorities upon request	

Recommendation 2: To increase housing practitioner's awareness of indicators that a person may be a perpetrator of domestic abuse						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured/Outcome**
1.1	Safeguarding awareness training has been delivered to over 600 front line staff and this focused on key areas like domestic violence	Director of Care and Support	Completed	That housing practitioners have the skills and knowledge to identify and interpret domestic abuse perpetrating behaviours amongst their tenants, partners and families and know how to respond, including taking action against perpetrators and supporting victims	Outcomes and learning events will monitor how the skills gained are being used practically across the operational teams	Increased action taken against perpetrators of domestic abuse, including evictions and civil orders. Increased number of domestic abuse victims are supported to access domestic abuse services and supported to understand the choices that are available to them. Increased referral to MARAC where high risk identified.
1.2	Review underway to determine if we need to designate a Group wide domestic violence support role	Director of Care and Support	1st June 2019	Analyse the involvement teams have across the Group in domestic violence, engagement with key partners like Women's Aid and The Haven and	Updates on progress will be provided to Coventry City Council	Potential single point of contact with consistent approach to managing and supporting domestic violence

				determine if a single Group wide point of contact as part of a wider tenancy sustainment team is required		
1.3	Emphasise to operational teams of the need to be aware of the number of persons in a property when visiting and are there signs of more persons living there than indicated	Director of Care and Support	Completed	Operational teams are aware of the number of persons in a property where domestic violence potentially occurring, and this is different to the prescribed numbers in the tenancy agreement	Will be managed at operational team meetings	Greater awareness and understanding of the triggers relating to domestic violence and coercive behaviour