safe & sound

Dudley's Community Safety Partnership

Executive Summary

Into

A Domestic Homicide Review
Overview Report
DHR 2

Report into the death of a 78 year old woman

'Annette'

in January 2016

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

April 2019 – Amended October 2019

Final Amendments September 2020

List of Abbreviations

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

An Executive Summary
Into the death of
'Annette'
aged 78 years
in January 2016

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

Annette's children request that their mother is referred to throughout this report by the pseudonym of 'Annette'. The children also request that they are known by the pseudonyms of Ann, Rosemary and Phillip respectively.

Introduction

This Domestic Homicide Review, commissioned by Safe & Sound Dudley's Community Safety Partnership, concerns the death of a woman known as Annette, who was 78 years of age at the time of her death in January 2016.

She lived with her son, Phillip who was 38 years of age at the time of Annette's death. The two older sisters of Phillip had lived away from Phillip and Annette for many years.

Annette had a significant medical history. She suffered from various ailments including Chronic Obstructive Pulmonary Disease (COPD) and she had been diagnosed with cancer shortly before she died.

From information gathered from the family, it appears that Annette had brought the children up under a very strict environment. They were all abused at an early age, mainly physically from their mother Annette, but the girls being sexually abused by family members during their early teenage years.

Both girls left the family home at relatively young ages and set up home by themselves. The youngest girl, (the middle of the children) is married and has a family of her own.

The emotional abuse of Phillip by his mother continued into his until he was in his 40's. He could do nothing right in the eyes of his Mother and he was constantly complained about, criticised and bullied by Annette, very often over the slightest, inconsequential occurrence.

On Christmas Eve 2015, Phillip was trying to plan the Christmas dinner the following day for Annette and himself. He describes how Annette picked an argument over the roast potatoes that resulted in Phillip taking hold of Annette to move her out of the way so her could leave the room and escape further argument. As he tried to move Annette, she slipped and fell fracturing her hip.

Annette was taken to hospital by ambulance where she was admitted. Her condition deteriorated in hospital and she died later in January 2016. A Forensic Pathologist determined that Annette had dies as a result of pneumonia caused by a combination of lung carcinoma, chronic obstructive airways disease and hospitalisation as a consequence of a fractured hip.

Phillip was arrested and interviewed about Annette's death. On the direction of Crown Prosecution Service (CPS) Phillip was charged with the offence of manslaughter. He subsequently appeared before the Crown Court where he was acquitted of all charges.

In compliance with the Home Office Guidance[1], the Community Safety Partnership was notified of Annette's death by the Police and a Domestic Homicide Review was authorised. The Home Office were duly made aware of the CPS's intention to hold a review and agreed that the circumstances met the criteria of the definition for a review.

The Terms of Reference for this DHR are set out in Appendix No 1 to this report.

Subjects of the Review

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

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

Summary of events and recommendations

The deceased in this DHR, Annette, was a 78 year old woman, who had three children, now all adults and referred to, at their request, by the names Ann, Rosemary and Phillip.

Annette married her husband in 1963 but they divorced in the early 1990's. From information gained from the children, it is clear that the marriage between Annette and her husband was troubled. The family moved from Birmingham to the Dudley area to be nearer her husband's family, but the children describe the relationship taking a turn for the worse when that happened.

The children describe an abusive lifestyle as they grew up as children, being physical and emotional abused by Annette. Both girls state there were sexually abused by family members. Ann left home at the age of about 14 years and asked to be taken into Care. Rosemary also left home and eventually married and had a family.

Phillip had a secure job in finance. He decided to stay at home and look after Annette as her medical conditions deteriorated over the years. He describes how over the years he was at home with Annette, she would constantly verbally abuse him, throw things at him such as ashtrays and resent any action he took to tidy rooms in the house.

Annette was, what would be described today, a hoarder. It has to be appreciated that at the time of Annette's illnesses becoming worse years ago, hoarding was not appreciated as a significant sign of self-harm and perhaps some degree of mental illness. Social Services visited the house with regard to Annette's situation and once described the house

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

as cluttered and Annette as a hoarder. Phillip was advised to pull the lounge carpet up as social workers considered it a trip hazard. He did as he was asked.

Phillip asked on numerous occasions for help with Annette. On one occasion he walked out of the house at night time with his jeans over his pyjamas thus avoiding an ongoing argument with his mother. He walked to Brierley Hill Social Services sobbing saying that he could not cope any more. Social Services said that Annette needed a Care Plan but Annette said that Phillip was being a 'drama queen' and refused a Care Plan.

This was to happen time and again. Agencies said that Annette needed assistance but Annette insisted that Phillip was exaggerating or that she was being well cared for by Phillip and refused agency support.

With respect to Annette, she had a significant medical history with numerous serious conditions dating back to 2005 when she suffered a stroke. Her attendance at her GP was extensive, she was taking anti-depressants whilst grieving over the death of her brother but there are numerous records of Annette failing to attend her GP and other medical appointments.

It is well known from evidence given by Annette's son Phillip and her two daughters that she was very often argumentative and was reluctant to take advice. She was issued with a walking stick to assist her mobility but she would rather 'furniture walk' around the house than use a stick. She would sleep downstairs rather than negotiate the stairs and her main carer Phillip would have to assist her in and out the bath. He was also responsible for shopping, cooking, cleaning and kitchen tasks.

Annette refused a home visit assessment, blood pressure checks and continence assessments in November 2011 and she declined a referral to see a dietician and a dementia screening process in June/July 2014. She was known to be a heavy drinker and she was contacted by letter by FAST (Fast Alcohol Screening Test). She had completed a questionnaire about alcohol consumption where she had stated she consumed six or more drinks in one session less than once per month. All of the other questions were answered in the negative.[2] Dudley Council Social Care Falls Service conducted an assessment and made a referral for the provision of pendant alarm and a dossett box for Annette, but there was no response from Annette to letters or telephone calls.

In February 2016, the GP received a letter from Mental Health saying that Annette had disclosed that Phillip gets angry and has depression and that he is her main carer. Social Services attempted to support Annette but she declined their offer of help. She had by this time been diagnosed with cancer and Annette thought that Phillip was upset at her diagnosis. Annette disclosed that she had also declined the services of the Macmillan Nurses. GP records indicate that Philip was being treated for depression and Annette was declining all additional support being offered to her.

On Christmas Eve 2015 Phillip was preparing the food for the Christmas Day meal when an argument between him and Annette started over roast potatoes. Phillip's version of events is that Annette's criticism of him was relentless. In temper and frustration he pushed his mother of the way and she fell injuring her hip. (Initial information given by Phillip was that he had picked his mother up and she had slipped from his grip). He immediately called an ambulance and Annette was admitted to hospital. She refused surgery and her condition deteriorated and she died later in January 2016.

A Police investigation commenced and a forensic post mortem determined that the injury to her hip had led to her death together with her other medical complications. Crown

[2] The family are of the view that Annette did not consume alcohol after her stroke in2005.

Prosecution Service determined there was sufficient evidence to charge Phillip and he appeared before the Crown Court for the manslaughter of his mother. Following a trial Phillip was acquitted of all charges.

In the meantime Phillip's mental health was being affected by the constant emotional abuse from Annette. There were no concerns raised at all about Phillip's ability to look after Annette. Equally there was no consideration as the consequences on his mental and physical health living with his mother was having on him. He lost his job and a relationship he had with a woman.

In January 2015, Phillip was referred for an initial assessment with a Primary Care Mental Health Worker. Phillip had disclosed that he had been suffering for depression for 4 years and he told his GP that he had been having thoughts about harming himself or Annette. He was taking medication prescribed by his GP. He told the review that at that stage he considered jumping off a bridge he was so depressed and frustrated that he could not get any help. By that time had had been Annette's care for 10 years.

Phillip was referred to IAPT (Improving Access to Psychological Therapies) for Cognitive Behavioural Therapy (CBT) and it was decided that he should attend a Self-Management Carers Workshop which he agreed to do. However that course had been held and there was to be a few months delay before another course could be established.

In February 2015, Phillip told his GP that he could not cope as his mother's carer. He was told that he needed to contact Age Concern or Age UK to see if they could help. It was suggested by Primary Care Mental Health that he attend a Low Intensity Group Therapy but he had already contacted them and was told again, he would have to wait several months.

During the summer of 2015 Phillip's condition did not improve. He was still stressed caring for her mother who was refusing help from outside agencies. He was offered low intensity psychoeducation work through IAPT and his risk was determined as being low risk of harming himself.

In August 2015, he was supposed to complete five aspects of cognitive behavioural therapy. He attended one session, failed to attend the second and eventually he was discharged from the Well Being Group due to non-attendance at two group sessions.

In December 2015, his GP made a referral to social services saying that Phillip had said that he was going to leave his mother and he was her only carer.

Views of the family

The Overview Report Author has spent many hours with Phillip and his two older sisters, who have described in detail their life with their mother. They reiterated this account when they attended a panel meeting with the DHR Chair and panel. Full details of their account are contained in the Overview Report but in summary, as children, they were mistreated by their mother who had an alcohol problem. They described their father as a kind man who eventually left the family home. It seems that following this their mother treated all three children in a manner that put all of them at risk. Ann left home after asking to be taken into care by Social Services. Rosemary left home and got married and Phillip was left at home to look after his mother whose health was deteriorating. Phillip bought the family home off his mother so that she would have somewhere to live when her health. His caring role caused him stress, depression and anxiety. He gave up his job and developed suicidal ideations. He described how he begged Social Services for help but was told that as

Annette had capacity to make decisions, there was nothing more they could do if Annette decided that she did not want assistance.

Phillip described how he was totally controlled by his mother who would criticise everything that he did, from cooking to trying to tidy the house. She would throw glass ash trays at him and berate him if he moved anything in the house. He would have to replace whatever it was where he found it. This happened when he attempted to tidy or declutter the living room.

Analysis and Recommendations.

As can be seen from the views of the family, Annette's medical and mental problems were recognised many years before her death. The children grew up in an abusive family atmosphere; often as a result of Annette's drinking habits. Ann and Rosemary left home and Phillip stayed at home to look after his mother but in doing so found himself in a situation where his daily life was disrupted by his mother's behaviour towards him.

Phillip described how he repeatedly asked Social Care for assistance for his mother, to which Social Care often responded but once Annette was asked if she needed assistance she refused and minimised Phillip's concerns. It was decided that Annette had capacity to make her decisions although there was no evidence of a capacity assessment being conducted.

Annette had significant dealings with the Dudley Disability Service (DDS) and their candid IMR identifies that more timely assessments could have been made which may have led to the family receiving support. It is also noted that allegations of harm to others should be taken seriously and checks should be made with other agencies to inform Safeguarding investigations.

The IMR from Dudley Group NHS Foundation Trust mentions the fact that the state of Annette's and Phillip's home was of concern in that it was obvious that Annette was a hoarder and there were areas of the house that were deemed to be 'trip hazards'. At that time in 2005 hoarding was not considered an indication of self-neglect as it is today. Had a holistic view been taken of the conditions of the house, Annette's health situations and more importantly the effect that Annette's behaviour and health were having on Phillip it may have resulted in positive action being taken to support both Annette and Phillip.

There were numerous occasions when Annette failed to attend medical appointments and she is described by the Community Nurse as being 'stubborn' in relation to her health care. It also appears that the Community Nurses were unaware that Phillip had had a nervous breakdown and did not appreciate that he was not coping with his mother's needs.

On another occasion after Annette's diagnoses of cancer both her and Phillip saw a MacMillan nurse consultant and at the end of the consultation Phillip specifically mentioned to the consultant that he was unable to cope with his mother any longer and he was unwell himself. He was advised to speak to his GP about his own health and contact Social Services about getting help at home. At this Annette said she did not want anyone in her house and refused help. This was a missed opportunity to explore with Phillip his concerns and more could have been done.

With regards to Annette's failing to attend appointments it appears that other than repeat letters no further investigation was made as to why the appointments were not kept.

There is no indication that domestic abuse was identified by any of the professionals involved with either Annette or Phillip. The lack of self-care and self-management of Annette's own health was obvious but there is no evidence of any discussion with Phillip about the effect of that was having on his own health.

Dudley Group NHS Foundation Trust (DGNHSFT) was also involved with Annette and their IMR identifies ten areas where learning could be improved, and makes three formal recommendations. Overall the IMR considers that whilst professionals may not have been able to predict the death of Annette, Phillip could have received more support as a carer and that the impact of self-neglect on other members of the family was not recognised. The DGNHSFT IMR states 'potentially if he had received the appropriate support as a carer, he may not have assaulted his mother'.

Dudley and Walsall Mental Health Partnership NHS Trust explained that during his initial face to face assessment with primary care mental health services, the Enhanced Primary Care Mental Health Nurse completed a patient health questionnaire and general anxiety depression score sheet. The results indicated his depression to be severe and that a referral to IAPT for Cognitive Behavioural Therapy would be beneficial. The referral was discussed at a multi-disciplinary meeting where it was decided that Philip's mental health would be better supported by attending the self-management Carers Workshop provided by Dudley Public Health with the onus on Philip to self-refer. In August 2015, Philip opted into the Mental Health and Well-Being Group but he only participated in two sessions and was discharged due to non-attendance

The Dudley and Walsall Mental Health Partnership concludes that there were no identified risk factors or disclosures made regarding domestic abuse and the main trigger for Phillip's depression was linked to the stress for caring for his mother. Consequently the emphasis was placed on providing co-ordinating support to reduce his stress level. The IMR identifies a lack of professional curiosity which may have led to opportunities for further enquiries into Annette's problems and a fuller understanding of Phillip's situation at home. The partnership makes six formal recommendations.

All three Health IMR's suggest Multi-Agency recommendations which are for the Overview Report to make:

Recommendation 1

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

Recommendation No 2

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

One of the main issues identified in this review was the difficult position professionals were placed in was Annette declining treatment and care. It was deemed she had capacity to make those decisions without challenge or any curiosity being demonstrated. Whilst it is appreciated it is difficult for professionals who are unable to compel anyone to receive treatment and support if they have made a decision not to do so, it is clear in this case that Phillip's view and concerns were not considered. The following recommendation is made:

Recommendation No 3

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

Conclusions

It is beyond doubt that Annette's children had a dreadful childhood at the hands of their mother and are still suffering the effects. Phillip stayed with his mother because he recognised she was ill and needed significant care. He bought the house from her so that she would have somewhere to live when she would eventually become unable to manage on her own. Doing so cost him in terms of his employment, his own social and family life. His mother was his main focus of attention 24 hours a day. He cared for her as best as he could whilst suffering from his own mental and physical health problems.

On numerous occasions he attempted to raise the alarm about his mother's situation and deteriorating mental health but when health agencies responded his mother rejected the offer of help and assistance.

It is clear that there were opportunities missed to help and support Phillip with his care for Annette. He made the fact that he was unable to cope and needed help clear to several professionals, but as Annette was deemed to have capacity to make decisions for herself, when she was offered help and assistance, she refused. The effects Annette's illnesses were having on Philip' health and wellbeing was not recognised and it appears that he was not being listened to. The difficulty professionals had with Annette refusing treatment and assistance is appreciated, and without a Mental Capacity assessment there is little they could do about her. However, Phillip was ill due to the stress of looking after Annette and that was not recognised or addressed.

Phillip was discussed at a Multi-Disciplinary Team Meeting on 12th January 2015. It was decided he would be better supported by a self-referral to a self-management Carer's Workshop provided by Dudley Public Health. On 9th February 2015, the clinician received an email from Philip who advised that he had contacted the Self-Management Group (Carer's Workshop) but had been advised that the current course had concluded.

List of Overview Report Recommendations

Recommendation 1

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

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

List of IMR Recommendations

Dudley Disability Service

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

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

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

Dudley Group NHS Foundation Trust

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

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

Complete the Domestic Abuse Guideline that is being developed.

Dudley and Walsall Mental Health Partnership

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

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

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

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

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

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

Appendix No 1

Terms of Reference

Purpose of the Review

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[3] on 13th April 2011 and reviewed in December 2016[4]. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

> *(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death"*

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

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

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

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

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

[3] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016
[5] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.
[6] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 18 page 8

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

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

> 'Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
>
> Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

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

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

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

Process of the Review

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

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

The Community Safety Partnership was asked to consider and discuss the circumstances of Annette's death in line with Home Office Guidance.

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

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

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

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

Independent Chair and Author

Home Office Guidance[8] requires that;

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

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

Review Panel

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

[8] Home Office Guidance 2016 page 12

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

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

The Panel met on 5 occasions on the following dates: 24th April 2018, 14th June 2018, 16th July 2018, 5th October 2018, and the family members attended a panel meeting on 21st December 2018. The Board approved the report on 29th April 2019.

Parallel proceedings

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

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

Time Period

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

Scoping the Review

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

Individual Management Reports

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

IMRs to be produced by:

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

Statements of information were received from:

- West Midlands Police
- West Midlands Ambulance Service

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

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

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

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

Terms of Reference

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

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

Generic Questions are:

- Were practitioners sensitive to the needs of Annette and Phillip, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about Annette or Phillip? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse of Annette or Phillip and were those assessments

[9] Home Office Guidance 2016 Page 20

correctly used in this case? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Annette subject to a MARAC or other multi-agency fora?

- Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were Annette's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of Annette should have been known? Was Annette informed of options/choices to make informed decisions? Were they signposted to other agencies?
- Was anything known about Phillip? For example, were there any injunctions or protection orders that were, or previously had been, in place?
- Had Annette disclosed to any practitioners or professionals and, if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of Annette, Phillip, Ann, Rosemary and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard Annette and promote her welfare, or the way it identifies, assesses and manages the risks? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- Did any staff make use of available training?
- Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?
- How accessible were the services for Annette?
- Were agencies cognisant of any care or support requirements for the son as a carer?
- Were agencies aware of any care or support needs for Annette?

Individual Needs

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

[10] Home Office Guidance 2016 page 36

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

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

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

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

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

There was nothing to indicate that there was any discrimination in this case that was contrary to the Act.

Family Involvement

Home Office Guidance[11] requires that:

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

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

> a) assisting Annette's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide;
>
> b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises Annette helping the process to focus on Victims and perpetrator's perspectives rather than just agency views.
>
> c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.
>
> d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of Annette and/or the soon in order to see the homicide through the eyes of Annette and/or Phillip. This

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

approach can help the panel understand the decisions and choices Annette and/or Phillip made.

e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

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

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

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

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