Executive Summary

of the Domestic Homicide Review

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

In respect of the death of Angela

In December 2017

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

Contents

1. Introduction

1.1 This review concerns the death of a sixty-eight-year-old woman, Angela[1], who was killed by her 36-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. He pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to sixteen years imprisonment, extended by a period of five years to be served on licence.

2. Summary of the review process

2.1 The decision to undertake a domestic homicide review was made by the Chair of Coventry Police and Crime Board following consultation with the city's Safeguarding Adults Review Sub-Group, which manages the domestic homicide review process locally. The Home Office was notified of the decision in March 2018, an independent chair and author was appointed, and the review was managed in accordance with the relevant statutory guidance. Beyond this review, the independent chair has never been employed by any of the agencies of Coventry Police and Crime Board.

2.2 The review panel members are listed in Appendix A and included Refuge who added a specialist perspective on gender and the broader 'victim perspective' to the review. The panel also included CGL who provided expertise on substance misuse. Panel members were all independent of the particular case.

2.3 The process began with an initial meeting of the review panel in May 2018 where the terms of reference were drawn up, incorporating key lines of enquiry and specific questions for individual agencies, where necessary, as featured in Appendix B. Agencies participating in this review are featured in Appendix C as well as those who had no contact. The review continued to run in parallel with criminal proceedings which concluded with the sentencing of the perpetrator in March 2019.

2.4 The review panel met on seven occasions and the chair met with family members who engaged with the review at different times. They contributed to the terms of reference and their views, together with the view of their advocates, have contributed to the final report, wherever possible.

2.5 The Overview Report was endorsed by Coventry Safeguarding Adult Board and thereafter by the Chair of Coventry Police and Crime Board in March 2020 before being submitted to the Home Office Quality Assurance Group for approval.

[1] Angela is a pseudonym for the victim that has been chosen by family members

3. Sequence of Events

3.1 Although the perpetrator had been prone to alcohol abuse since his teens, Angela's relationship with her son had been very positive until he started taking illicit drugs when in his late twenties. The drug taking had a profoundly adverse effect on his mental health and, as a result, he was diagnosed with schizophrenia, lost his marriage and his employment job and went to live with his parents.

3.2 After some years of staying with his parents thereafter, his mental health stabilised and he moved away, meeting a new partner in 2013. The couple began drinking heavily together and the police responded to ten reports of domestic abuse over the two years that they were together. Most incidents in this period were characterised by both parties being intoxicated and neither party disclosing any offence. Mostly his partner wanted the police to remove the perpetrator from her home and the police would generally take him back to his mother's home. On the tenth episode, he was charged and convicted for domestic abuse related criminal damage and received a community order, supervised by probation services.

3.3 During this period, the perpetrator missed several appointments with mental health services and was discharged back to his GP. This pattern of missing appointments, discharge from mental health services and discontinuity of care continued in the years to follow.

3.4 When the perpetrator's relationship ended in 2015, he returned more permanently to his mother's home. However, her impaired mobility meant that she had accepted a one bedroomed bungalow and for reasons of overcrowding, her son was not supposed to live there.

3.5 The perpetrator continued to miss health appointments as well as statutory appointments with probation services. He stopped engaging with substance misuse services, continued to drink heavily, stopped taking his medication and his psychotic symptoms returned.

3.6 Several agencies routinely visited the home and were aware that Angela had caring responsibilities for her son including managing his medication. They were also aware that the relationship between mother and son was deteriorating and Angela first called the police in 2016 because of her son's threatening, drunken behaviour towards her. The perpetrator was offered a social housing flat nearby in December 2016, and although resettlement activities were undertaken by various agencies, the perpetrator was reluctant to move.

3.7 In January 2017, the victim told the police and her GP that her son had made threats to kill her. He went on to disclose his violent thoughts to mental health services and the Emergency Department and he contacted the police himself to disclose his domestic violence towards his mother.

3.8 In August 2017, mental health services concluded that the perpetrator's problems were social rather than clinical and they started a process over the following months of discharging him from their service. However, during this period, there were indicators of a deterioration in his mental health: he attended the Emergency Department more regularly; he had had an increase in his medication; he told mental health services that he had raised a fist to his mother and was becoming increasingly paranoid himself. However, mental health services were confident that he would settle if he took his medication.

3.9 Four months before her death, Angela had made a decision that her son's behaviour was intolerable and that he had to leave. She contacted the police and they removed her son from the property, took him to the train station and downgraded their assessment of risk to standard as Angela had taken her house keys off him. 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.

3.10 The perpetrator killed his mother at the time that he was to be discharged from mental health services. Over fifty mental health staff had been involved with the perpetrator over the years but mental health services were not aware of some key episodes of his violence towards her which would have affected their assessment of the risks that she faced.

4. Key Issues and Learning

Indicators of Domestic Abuse

4.1 The review found that each of the perpetrator's relationships with women were characterised by domestic abuse and his history of domestic abuse should have informed practitioner's future understanding of risk.

4.2 During his previous relationship, reports of domestic abuse appeared to be seen as a series of individual episodes of physical violence rather than as a pattern of coercive control. The police missed several opportunities to pursue victim statements. The police and mental health services missed opportunities to undertake DASH assessments and probation services missed opportunities to address the domestic abuse behind his conviction for criminal damage. However, responding to domestic abuse was difficult for practitioners because of the couple's problematic alcohol use. 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.

4.3 The review heard from family members how Angela had experienced domestic abuse from her son. Some agencies were aware of the perpetrator's aggression towards his mother as early as May 2013 and in January 2017 other professionals were aware of

his threats to kill her. They were also aware of financial issues but did not identify this as economic abuse. Moreover, this abusive behaviour was regarded as being due to a deterioration in his mental health and not due to domestic abuse.

4.4 There were strong indications that the perpetrator manipulated professionals. He masked his condition, disguised his compliance with medication and minimised his alcohol misuse preventing opportunities to address a dual diagnosis of mental illness and substance misuse. However, he also disguised his abuse of others by making counter-allegations against both his ex-partner and his mother.

4.5 All women who are abused will experience barriers to gaining the help that they need. However, as an older mother with caring responsibilities for a grown-up child with multiple needs, Angela faced additional barriers, and these were largely unrecognised within the context of abuse.

Accommodation

4.6 The problems of overcrowding in Angela's one bedroomed bungalow were exacerbated by the perpetrator's alcohol use, mental health and poor compliance with services and medication. The perpetrator provided a series of different reasons for not moving into the flat which had been secured for him and several agencies addressed the practical matters without considering the complex reasons why he was not moving. Moreover, practitioners were aware that there were increasing tensions between mother and son but did not appear to consider that Angela was being coerced into him continuing to live there.

4.7 Individuals with multiple 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.

Carers and the Care Programme Approach

4.8 Through much of the time, mental health 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 her views were taken into account varied and it was not routinely documented whether Angela was spoken to alone when enquiring about risk.

4.9 Mental health services often spoke to Angela about her needs, offering her a carer's assessment a number of times but she turned them down on each occasion, reluctant to take help for herself. A carer's assessment could have revealed the risk she was facing; the impact of her caring role; her increasing isolation and the frustration that

she communicated more readily to her family and the opportunity to refer her for a carer's assessment was missed by the GP practice.

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

Co-existence of substance misuse and mental health

4.11 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. It was evident that he minimised his accounts and avoided confrontation of his alcohol use and Angela's more accurate accounts of her son's alcohol use did not appear to have been taken seriously.

4.12 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. They 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.

5. Individual Agency Recommendations

5.1 In addition to the overarching recommendations below, individual agencies have adopted the following recommendations to make improvements in their own services arising from the learning in this case:

5.2 **Coventry and Warwickshire Partnership Trust**

- 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
- All discussion relating to discharge, the rationale for discharge and the understanding of the patient, should be clearly and comprehensively recorded in the patient's mental health record. Carers to be seen alone and their thoughts on discharge sought and clearly recorded

- to provide assurance to the Board(s) of how the positive impact of the revised Policy for the Management of Non-Attendance can be evidenced.

5.3 **Staffordshire and West Midlands Community Rehabilitation Company**

- 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.
- 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**

- 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
- To improve their referral and signposting for carers.

5.5 **Whitefriars Housing Group**

- To 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
- 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.

5.6 **West Midlands Police** have already implemented changes in respect of:

- The mandatory completion of DASH assessments for all domestic abuse, including familial abuse, which is systematically audited for compliance
- The introduction of mobile electronic devices carried by all response officers enabling them to access information, complete in-depth checks and complete the DASH electronically at the scene

- the introduction of a Vulnerability Referral Form, available on the mobile electronic devices, enabling referral to other agencies, such as mental health, directly at the scene.

6. Overview 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:

- 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.

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, 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 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

Recommendation 6: 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.

Recommendation 7: 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.

Recommendation 8: 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 the commissioners of those services.

7. Conclusion

7.1 The review concluded that Angela's son had a history of domestic abuse against women for which he had not meaningfully been held accountable. 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. However, practitioners largely saw his abusive behaviour as only a deterioration in his mental health and opportunities were therefore missed to safeguard Angela. At the same time, the perpetrator masked his condition and minimised accounts of substance misuse which impaired clinical judgements and Angela's concerns were not fully heard in the final months of her life.

7.2 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.

Appendix A: Review Panel Members

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	CGL (Substance Misuse Services)
Lisa Pratley	Lead Professional for Safeguarding, University Hospital Coventry and Warwickshire
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)

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

Appendix B: Key Lines of Enquiry

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. 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, and **1st December 2017,** when Angela died. Any significant information which might come to light during the review outside the set timeframe, were to be agreed by the review panel for inclusion if determined to be of relevance.

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?*

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 a 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?*

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.*

The review will give 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.

Appendix C: Agency Involvement in the Review

Individual Management Reports and chronologies were provided by the following agencies:

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

Chronology and/or information reports were provided by the following agencies:

- The Recovery Partnership Coventry
- University Hospitals Coventry and Warwickshire NHS Trust
- West Midlands Ambulance Service
- Whitefriars Housing Group

The following agencies confirmed that they had had no contact with the victim or perpetrator:

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