BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP
WORKING TOGETHER FOR A SAFER CITY

Executive Summary

of a combined Domestic Homicide Review and Safeguarding Adult Review

under section 9 of the Domestic Violence Crime and Victims Act 2004
and section 42 of the Care Act 2014

In respect of the death of Rita

In August 2017

Summary produced for Birmingham Community Safety Partnership and
Birmingham Safeguarding Adult Board by
Paula Harding
Independent Chair and Author
August 2019

Contents

1 Introduction

1.1 This combined domestic homicide and safeguarding adult review concerns the circumstances leading to the death of Rita (pseudonym) who was aged 81 at the time of her death in 2017. Her youngest son, then aged 41, was convicted of her manslaughter. Rita was thought to have died in her bedroom several months before her body was found.

1.2 The review considered agency involvement with Rita and her youngest son between January 2012, when he returned to Birmingham, until the date that her death was discovered, in August 2017.

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

2 Summary of the review process

2.1 The decision to undertake a domestic homicide review was made by the Chair of Birmingham Community Safety Partnership on 15.02.2018, following consultation with the Partnership's multi-agency Domestic Homicide Review Steering Group. The Home Office was notified of the decision on 05.03.2018, an independent chair was appointed and the review was managed in accordance with the relevant statutory guidance.

2.2 The decision to combine this with a safeguarding adult review was taken later in the review process when it became clear that Rita had had care and support needs and that the circumstances also satisfied the criteria for this type of review. The review therefore proceeded in accordance with the requirements of The Care Act 2014.

2.3 The review panel members are listed in Appendix A and included Birmingham and Solihull Women's Aid 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.

2.4 The process began with an initial meeting of the review panel in April 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.

2.5 The review panel met on five occasions and the chair met with family members at the beginning, during and conclusion of the review in May 2019. Their views, and those of their advocate from Advocacy After Fatal Domestic Abuse, were incorporated into the terms of reference. Their contributions to the review, together with those of Rita's neighbours, have been woven into the narrative of this review.

2.6 The Overview Report was endorsed by Birmingham Community Safety Partnership and Birmingham Safeguarding Adult Board in June 2019. Further amendments were made following consultation with the family and the review was submitted to the Home Office for quality assurance thereafter.

3 Summary of the Chronology

3.1 Rita had experienced significant domestic abuse in her life from her second husband during and after their marriage. Thereafter, when her youngest son reached 16, he also went on to abuse his mother. In her later years she went on to care for this son, who experienced mental health and substance misuse issues, although she was frail and in poor health herself. Reports of her son's domestic abuse towards her had been made to agencies since 2014 and health, police and social care agencies had been involved at times of crisis.

3.2 In 2014, the perpetrator experienced a decline in his mental health although this, together with his chronic hallucinations, was considered by mental health services to be as a result of his alcohol dependency and withdrawal. He had made at least one serious suicide attempt during which Rita had witnessed her son attempting to hang himself. Within months of this attempt, with four kitchen knives about his person, he pushed his mother out of a ground floor window, saying that he was trying to protect her from him. The response of the main agencies thereafter is summarised below.

4 Key issues for individual agencies

4.1 **West Midlands Police** - The police actively responded to each domestic abuse incident; made clear attempts to engage and arrange safeguarding for Rita and had often been pro-active in managing the perpetrator's threat. However, completion of the DASH was inconsistent as it was not mandatory at the time and this led to a missed opportunity to refer Rita to a Multi-Agency Risk Assessment Conference where her high risk could have been managed. Likewise, given the difficulties engaging with Rita over the prosecution of her son, opportunities were missed to build an evidence-based prosecution, to consider the application of a Domestic Violence Protection Order and to refer Rita to support agencies. After Rita had disclosed domestic abuse to her bank and the police, there was no indication that this led to an investigation of economic abuse.

4.2 **Birmingham and Solihull Mental Health Trust** -The perpetrator made a number of disclosures to mental health practitioners regarding his potential to harm others. Disclosures included arguments and domestic abuse; hearing voices telling him to kill his

mother and that someone was accusing him of abusing children and his mother. Although practitioners were aware of his earlier conviction for his assault of his mother as well as a more recent incident where he had bent her fingers back, there was no indication that they attempted to gather information about his mother's well-being. Neither did they explore the validity of his paranoia or challenge him about his abusive behaviour. Moreover, there was no consideration given to the impact and risk to his mother when her son was discharged from hospital or home treatment, despite his history of violence towards her. In this way, practitioners lacked professional curiosity and an abuse informed approach. They appeared not to recognise domestic abuse and their responsibilities to those who may be at risk from it in a familial setting.

4.3 **Birmingham City Council Adult Social Care** - Adult Social Care were alerted on three occasions to safeguarding concerns concerning Rita' experience of domestic abuse from her son, in 2014, 2016 and 2017. They responded promptly each time by visiting Rita who, on the first occasion, was open to receiving support and wanted support for her son, but this was not followed up sufficiently and an important opportunity was therefore missed.

4.4 On the later occasions, Rita minimised the social workers' concerns and declined their support. She was seen to have capacity to be making her own decisions and her case was closed each time. Consideration did not appear to have been given to whether she was experiencing coercion or control from her son and whether this may have undermined or compromised her ability to make decisions and this issue was recognised as a deficit in the training and support that social work staff received.

4.5 **The General Practice** - General Practice staff were aware on two occasions that Rita did not want her son to come back home and missed opportunities to speak with her on her own about her concerns. She repeatedly cancelled appointments or was said by her son to be out when staff called, despite her poor mobility. Her son told the GP that Rita was suffering from memory loss, confusion and hallucinations but her cognitive impairment test turned out to be normal. She had periods of not eating and not taking her diabetic medication which could account for some disorientation, but there was little evidence of practitioners considering Rita's history when attending her, particularly as her records documented incidents of domestic abuse. Individual presentations were looked at in isolation and taken at face value and, with one exception, consideration of coercion and control was missed.

4.6 **Staffordshire and West Midlands Community Rehabilitation Company** - Probation services were involved with the perpetrator after he had been convicted of the assault on his mother. The pre-sentence report included Spousal Risk Assessment identifying the risk to his mother but did not address the issue of where he would live on his release from

prison. After sentencing, the perpetrator consistently evaded appointments with probation and the probation officer's focus was on his attendance and enforcement activities to deal with his non-attendance. Following his breach of his community order, the perpetrator was curfewed and tagged to his mother's home and officers missed opportunities to explore his relationship with his mother, alcohol use, mental health and risk.

4.7 **University Hospitals Birmingham NHS Foundation Trust** - On both occasions that the perpetrator left the ward before he had been assessed, the Hospital ensured that internal and police emergency responses enabled him to be returned to the ward unharmed each time.

4.8 **Halifax Bank** - Rita visited her bank a number of times to discuss her son's access to her account during which she disclosed domestic abuse. Banking staff blocked her son's online access to her account which he had been using to pay for large amounts of alcohol and expensive electronic devices. Staff escalated concerns to the Bank Manager who spoke with Rita when she wanted to reinstate her son's access to her accounts, but she was adamant at that point that she was not being coerced by her son to do so.

4.9 Although the Bank was aware that the police were involved and have since signed up to the UK Financial Abuse Code of Conduct, the panel considered that an added safeguard would be to report their concerns to the local authority as Rita was a vulnerable person at risk, and that this should be written into their procedures.

5 Lessons to be learnt

5.1 **Indicators of domestic abuse, coercive control or neglect** - In addition to physical abuse, the perpetrator told his mother's GP that she was losing her memory and getting confused, although her cognitive test was normal. In order to conceal their abusive behaviour, perpetrators will often manipulate victims and professionals by questioning their victim's mental health in a manner known as 'gaslighting'

5.2 Akin to many victims of domestic abuse, Rita often minimised her experiences of abuse. Practitioners need to try to understand the range of complex reasons that will cause victims to do so and recognise the particular barriers that older parents and carers will often face.

5.3 Practitioners need to be curious when vulnerable individuals repeatedly miss or cancel appointments and consider the possibility that they are being abused or neglected

Practitioners need to be curious and open to the possibility of economic abuse. In this case agencies were aware that the perpetrator was not claiming benefits, abused alcohol and withdrew money from his mother's bank account but did not appear to identify this as economic abuse or contribute to understanding of coercive control. If we miss

economic abuse, we may potentially be missing the opportunity to uncover other possible forms of abuse.

5.4 Mental ill-health is a common consequence of experiencing domestic abuse and practitioners need to be routinely asking questions about an individual's experiences of violence and abuse.

5.5 Practitioners need to take seriously all of the indicators of abuse and neglect including those generated by the isolation of the victim and unexpected changes in their day to day lives.

5.6 Practitioners need to be aware that older mothers will face significant barriers to disclosure and help-seeking about domestic abuse that they experience from their grown-up children.

5.7 **Alcohol, Drugs and Mental Health** - Practitioners need to 'Think Family' and understand the impact of mental health and substance misuse upon others that they live with. They also need to be professionally curious and consider how someone's substance misuse is being funded.

5.8 Wherever possible, Alcohol Treatment Orders need to be considered where a perpetrator of domestic abuse is convicted of an offence.

5.9 **Safeguarding Adults, Mental Capacity and Coercive Control** - Practitioners need to consider how coercive control may be impacting upon a person's ability to make decisions and judgements freely, unfettered by fear, coercion, manipulation and undue influence. A judgement that a victim is free to make 'unwise decisions' should not be made until coercive control has been considered.

5.10 **Multi-Agency Management of Threat and Risk** - Domestic abuse is rarely a one-off incident and needs to be considered as a pattern of repeated and escalating abuse and coercive control. Agencies need to consider the known history of violence and abuse to assess threat and risk from domestic abuse effectively

5.11 BSAB Risk Enablement Guidance empowers practitioners to effectively and collectively assess and balance the safety and wellbeing of vulnerable adults experiencing domestic abuse but needs to be understood in the context of coercive control

5.12 Risk management requires practitioners to understand the resources and powers available to partner agencies and how these could be used to reduce the threat and risk from domestic abuse perpetrators.

6 Conclusion

6.1 This combined domestic homicide and safeguarding adult review has revealed that Rita was subject to a deliberate and repeated pattern of abuse from her son over the three years before her death at the age of 81. She incrementally revealed that she had been subjected to daily physical assaults and that she was "frightened to death" of her son who had experienced hallucinations and paranoia from his severe substance misuse.

6.2 Whilst responding to reports of physical assault, by and large, agencies did not appear to consider other indicators of potential domestic abuse and neglect such as: restricting Rita's access to medical appointments; her sudden weight loss; imprisonment in her room and the economic abuse that she was experiencing. Neither did practitioners appear to consider that the perpetrator may have been manipulating his mother and themselves around the issue of her memory and apparent confusion.

6.3 Whilst it was evident that agencies failed to identify the indicators of ongoing domestic abuse, the circumstances were not easy for agencies to deal with thereafter. Rita commonly withdrew her allegations and rationalised her son's behaviour making it difficult to assess the risks that she faced. Likewise, the perpetrator largely avoided contact with agencies, did not engage with treatment for substance misuse and repeatedly breached his supervision requirements with probation. In the absence of him being registered with a GP, he was often invisible to services in between the reports of his assaults on his mother.

6.4 Nonetheless, there were missed opportunities to question the possibility of coercive control when physical violence brought mother and son into contact with agencies. At these times, greater professional curiosity could have explored whether Rita was acting of her own volition when minimising her experiences of abuse, withdrawing allegations and resisting support and whether she had capacity to make free and unfettered decisions.

6.5 There were a number of times during these five years when it would have been advisable to refer Rita to MARAC or convene a practitioner's meeting to consider, from a multi-agency perspective, how the threat and risk could be managed. For example, there appears to have been missed opportunities to offer the perpetrator alternative accommodation or, if un-cooperative, take civil action against him and exclude him from the victim's home. The police could have considered a Domestic Violence Protection Notice or, as this was unlikely to be gained, they could have given greater consideration to building a case around coercive control. Ultimately, all other routes exhausted, the local authority could have considered assessing the undue influence, that her coercive and controlling son appeared to be exerting over Rita's decision making, as an issue of mental capacity.

6.6 Overall, practitioners needed to apply a greater understanding of domestic abuse and coercive control to the circumstances that they were faced with and thereafter employ

professional curiosity, pro-active engagement with the victim and multi-agency risk management to safeguard the victim effectively.

7 Overview Recommendations

Recommendation 1: Driving Consistency in Practice Response to Domestic Abuse

Birmingham Community Safety Partnership should seek assurance that local agencies are capable of identifying the breadth and range of domestic abuse; of using the tools and pathways to respond; have sufficient supervision and escalation procedures to be able to respond effectively to domestic abuse.

Recommendation 2: Domestic Abuse and Older Women

Birmingham Community Safety Partnership should work with specialist domestic abuse services to develop the evidence base and share best practice in working with older women who may be subject to domestic abuse

Recommendation 3: Economic Abuse

Birmingham City Council promotes the adoption of the Financial Abuse Codes of Conduct through its business districts, through the West Midlands Combined Authority and through the Greater Birmingham and Solihull Local Economic Partnership and promotes opportunities for multi-agency training on domestic abuse and coercive control amongst financial institutions in the city.

Recommendation 4: Economic Abuse

Birmingham City Council to share this report with UK Finance with a view to them considering adding to the Financial Abuse Codes of Conduct that any safeguarding concerns are reported to the local authority where an individual with care and support needs may be subject to abuse or neglect. This report to be shared with Surviving Economic Abuse, WAFE, Safe Lives and UK Finance who have been working with UK Finance in the development of the Codes of Conduct.

Recommendation 5: Think Family in the context of substance misuse and mental health

Agencies should provide assurance to the Community Safety Partnership about how their services have improved in addressing the risks to family members living with or caring for those with problematic mental or behavioural disorders and substance misuse.

Recommendation 6: Assertive Engagement with Alcohol Treatment

Birmingham City Council should consider whether there is sufficient capacity within commissioned services to assertively engage with change resistant drinkers where there are serious risks or vulnerabilities involved.

Recommendation 7: Managing Perpetrators of Domestic Abuse

Birmingham Community Safety Partnership should further develop its 'Domestic Abuser Management Framework' and evidence how practitioners across agencies are familiar with the range of multi-agency powers to divert, manage, disrupt or prosecute domestic abuse perpetrators in MARAC and non-MARAC settings

Recommendation 8: Holding Perpetrators to Account

In light of concerns regarding the previous sentencing of the perpetrator, this report should be sent to the West Midlands Criminal Justice Board for their consideration.

Recommendation 9: Risk Enablement and Coercive Control

Birmingham's adult social work and commissioned domestic abuse agencies should provide assurance to Birmingham Community Safety Partnership of how Risk Enablement is being applied to effectively address the needs of adults experiencing domestic abuse.

8 Individual Agency Recommendations

8.1 Birmingham City Council Adult Social Care

Recommendation 1: Social Workers need greater insight into coercive control and how it operates in cases of domestic abuse
Recommendation 2: Social workers need greater insight into the need to consider more than one model of viewing citizen's decision making in cases of domestic abuse, so that in addition to considering the principles of the Mental Capacity Act and Making Safeguarding Personal, the possibility of the exertion of undue influence is also a consideration
Recommendation 3: Social Workers need greater insight into the need to consider multi agency decision making in complex cases of high risk
Recommendation 4: Social workers need greater insight into the function of DASH and MARAC and knowledge of when and how to follow this route
Recommendation 5: Social Workers need greater insight into considering a Think Family approach in domestic abuse cases where both victim and perpetrator have care and support needs
Recommendation 6: ACAP (the Adult Social Care contact point) needed to ensure staff considered past case history before making case decisions in relation to adult safeguarding cases

8.2 Birmingham and Solihull Mental Health Foundation Trust

Recommendation 1: To write, promote and implement a Domestic Abuse Good Practice Guide for staff embodying practical learning from DHRs generally and in relation to his

DHR that it will provide guidance on coercive control and mental capacity; cross-generational abuse; multi-agency working; assessing and managing risk where previous history of abuse and in context of discharge planning; talking with potential victims on their own

Recommendation 2: Staff should evidence their consideration of the increased risk posed to family members where domestic abuse, substance misuse and mental health are seen together particularly when discharge planning.

8.3 Birmingham and Solihull Clinical Commissioning Group

Recommendation 1: Primary Care Medical Service to become an IRIS Practice

Recommendation 2: Primary Care Medical Service to revise their domestic abuse policy, to include direct questioning.

8.4 Staffordshire and West Midlands Community Rehabilitation Company

Recommendation 1: To strengthen Case Managers' practice in responding to domestic abuse

Targeted local team activity to seek assurance and/or improvement of Local CRC risk management response for the following:-

- To ensure that all cases have correct alert flags (e.g. domestic abuse and safeguarding adults) applied to aid identification.
- Exchange of risk information with other agencies (in this case, Police and Electronic Monitoring Services) is evidenced.
- Assessments are completed in all cases, where information is available and respond explicitly to domestic abuse where known

Recommendation 2: To re-issue the Risk of Harm Go to Guide. Local Team Manager to discuss expectations around domestic abuse routinely in supervision with Case Managers

Recommendation 3: Adult Safeguarding. To review individual and team adult safeguarding practices and referral thresholds

Recommendation 4: Risk. To ensure that all community cases are enforced in accordance with timescales and include:

- the timely completion of good quality breach reports that make recommendations that reflect accurately issues of domestic abuse and safeguarding
- include the nature of that threat and actions required through breach action to manage those risks

Appendix A: The review panel members were:

- Paula Harding, Independent Chair and Overview Author
- Cath Evans, Head of Safeguarding, Birmingham and Solihull Mental Health Trust
- David Gray, Head of Adult Safeguarding, Birmingham City Council Adult Social Care
- Emma Hickl, Detective Inspector, West Midlands Police
- Kerry Clifford, Safeguarding Lead, Change Grow Live (addiction, health and behavioural services)
- Luisa Blackwell, Deputy Designated Nurse for Safeguarding, Birmingham and Solihull Clinical Commissioning Group
- Maria Kilcoyne, Head of Safeguarding, University Hospitals Birmingham NHS Foundation Trust
- Parminder Dhaliwal, Outreach and Helpline Manager, Birmingham and Solihull Women's Aid (specialist domestic abuse service)

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 the following specific issues identified in this particular case:

- What decisions could have been made and action taken by agencies to prevent the homicide?
- How effective were agencies in identifying and responding to both need and risk for the victim?
- How effective were agencies in working together to prevent harm through domestic abuse?
- What lessons can be learnt to prevent harm in the future?

Individual Management Review Authors were therefore asked to provide a comprehensive chronology and respond to the following questions in respect of their involvement with the victim and perpetrator for the period January 2012 until the victim's death was known about in August 2017:

- Can you provide a comprehensive chronology of your agency's involvement within this timeframe?
- Can you provide a brief summary of the role of your organisation in responding to domestic abuse, including coercive control?
- Can your agency provide a brief pen picture of the victim and the perpetrator?
- What needs and risk did your agency identify for the victim and the perpetrator and how did your agency respond? In particular:
- Was domestic abuse, including coercive control, identified and how did your organisation respond?
- If your help and assistance was denied by the victim, how satisfied are you with your organisation's response?

- If domestic abuse, including coercive control, was not known, how might your organisation have identified the existence of domestic abuse from other issues presented to you?
- How well equipped were staff in responding to coercive control in this case?
- How effectively was risk was assessed and acted upon in this case? How did the victim's attitude to that risk affect decisions made or actions taken?
- How did previous history affect decisions made?
- On closure of cases, what was the analysis of risk and could anything have been done differently to act upon that risk?
- Is it expected for your organisation to adopt a Think Family approach and how was that type of approach followed in this case?
- 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 lessons 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?

University Hospitals Birmingham were asked to provide an information report in respect of their briefer involvement

- Describing how their policies and processes have changed since 2014 in respect of absconding patients. What difference would these have made to their organisation's response to the victim's son had they been in effect earlier?
- Whether it was expected for their organisation to adopt 'think family/whole family' type approach and how this type of approach was followed in this case.

The victim disclosed domestic abuse to her bank, the Halifax. The bank was therefore asked How staff responded to the victim when it was discovered her son was mis-using her account

- Whether financial abuse or coercive control was identified
- Whether any support was offered, or referrals were made regarding her safeguarding?

Whether the Lloyds Banking Group plc, to which the Halifax belongs, provides guidance or training to staff concerning domestic abuse, financial abuse, coercive control and safeguarding

Appendix C: Agency Involvement in the Review

Individual Management Reports and chronologies were provided by the following agencies

- Birmingham City Council Adult Social Care
- Birmingham and Solihull Clinical Commissioning Group
- Birmingham and Solihull Mental Health Foundation Trust
- Staffordshire and West Midlands Community Rehabilitation Company
- West Midlands Police

Chronology and/or information reports were provided by:

- Aquarius
- Birmingham City Council Landlord Services
- Birmingham Community Healthcare NHS Foundation Trust
- Lloyds Bank regarding their subsidiary bank the Halifax
- National Probation Service
- University Hospitals Birmingham (Heartlands Hospital)
- West Midlands Ambulance Service

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

- Age Concern
- Birmingham City Council Advice and Information and Housing Options Services
- Change Grow Live (CGL)
- Specialist domestic abuse and sexual violence services: Anawim, Birmingham and Solihull Women's Aid, Rape and Sexual Violence Project, Gilgal, WAITS
- MIND
- Shelter
- Salvation Army