Domestic Homicide Review
Ruth Fisher/September 2018
Overview Report
Cumberland Community Safety Partnership

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Commissioned by:
Cumberland Community Safety Partnership

Review completed: May 2023

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1. Introduction

1.1. This Domestic Homicide Review (DHR) examines agency responses and support given to Ruth Fisher, a resident of Town A, prior to her death in September 2018.

1.2. On that day Cumbria Police were called to the home which Ruth shared with her partner. Ruth was found dead at the property, and initially Police did not believe the death to be suspicious. The following day, a Coroner's Officer examined the photographs taken at the scene and raised a concern. Ruth's partner was then arrested for gross negligence manslaughter.

1.3. This DHR examines the involvement that organisations had with Ruth, a white British woman in her sixties, and Bill, a white British man also in his sixties, between 2013 and Ruth's death. The rationale for this scoping period appears to be the five-year period recommended in Home Office guidance – however, this is an assumption made by the re-write author in the absence of any other explanation.

1.4. This report has been re-written following feedback from the Home Office.

1.5. Cumberland Community Safety Partnership, and everyone involved in this review extend their deepest condolences to Ruth's family and friends.

1.6. The key reasons for conducting a Domestic Homicide Review (DHR) are to:

a) establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims.
b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change.
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working.
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

2. Confidentiality

2.1. The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published.

2.2. Dissemination is addressed in section 11 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms were agreed during the initial iteration of the review, it is not believed that the pseudonym was chosen by Ruth's family.

Details of the deceased and perpetrator:

Name (Pseudonym)	Gender	Age at time of death	Relationship to deceased	Ethnicity
Ruth Fisher	Female	In her 60's	*Deceased*	White British
Bill Price	Male	In his 60's	*Partner and perpetrator*	White British

3. Timescales

3.1 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review Core Panel meeting was held on 4th June 2019. It agreed that the criteria for a DHR had been met and this review was conducted using the DHR methodology. The Home Office were informed of the decision to undertake a DHR the following day.

3.2 In November 2019, a Chair and Author was commissioned to complete the DHR and on 7th February 2020 the panel met to set Terms of Reference.

3.3 The original report was delayed from its commission in November 2019, until completion January 2021. In 2020, Cumbria County Council underwent a restructure of their DHR processes. Prior to this, they were utilising inexperienced Independent Chairs/Authors, with little to no coordination of the process, which resulted in the process being extremely drawn out.

3.4 Following feedback from the Home Office, a new DHR Author was required to re-write the report. There was a delay in identifying an appropriate Author to re-write the review, and the new Author was commissioned in October 2022. The current report follows the required format, although it does include the original chronological overview with some minor amendments. An equality and diversity section has been included, which has informed a re-developed analysis, ensuring Ruth's experiences are central to the learning.

4. Methodology

4.1 The information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Ruth and/or Bill. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

4.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Ruth or Bill during the period covered by the review.

4.3 The author commissioned to re-write the review followed up further queries with some of the relevant agencies, this was in the form of interviews and written requests for information, to fill any gaps in learning.

5. Terms of Reference

5.1. The Review Panel first met on 7th February 2020 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined.

5.2. The Purpose of a DHR

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

5.3. The Focus of the DHR

5.3.1. This review will establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Ruth.

5.3.2. If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

5.3.3. If domestic abuse was identified, this DHR will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

5.3.4. The full subjects of this review will be the victim, Ruth Fisher and the perpetrator, Bill Price.

5.4. Specific Issues to be Addressed.

Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of the Ruth? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Ruth? 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 the victim subject to a MARAC or other multi-agency forums?
iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?
iv. 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?
v. 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?
vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?
viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?
ix. Was this information recorded and shared, where appropriate?
x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
xi. Were senior managers or other agencies and professionals involved at the appropriate points?
xii. 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?
xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?
xiv. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
xv. Did any staff make use of available training?
xvi. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?
xvii. How accessible were the services to Ruth?

6. Involvement of Family Members and Friends

6.1. it is unclear from the information provided to the re-write author how involved Ruth's family were with the original review process.

6.2. Upon commencement of the re-write process, the author contacted the Police Family Liaison Officer (FLO) linked to Ruth's case to discuss an introduction to Ruth's sister. The FLO explained that she was very elderly and had been quite confused and distressed by the review process previously. It was therefore decided that the re-write author would utilise the sister's victim impact statement and would offer an opportunity to view the updated report at the conclusion of the re-write process. This decision takes into account the age and possible vulnerabilities of the sister, and the time which has lapsed since Ruth's death.

7. Contributing Organisations

7.1. Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the DHR Panel. None of the IMR authors or the senior managers had any involvement with Ruth during the period covered by the review.

7.2. Each of the following organisations contributed to the review…

Agency/ Contributor	**Nature of Contribution**
North East and North Cumbria ICB	Summary report
Home Group	IMR and further information provided for the re-write
Cumbria County Council – Adult Social Care	IMR
Cumbria County Council – Housing Related Support	IMR
Cumbria Constabulary	Report

8. Review Panel Members

8.1. The original review panel was made up of the Independent Chair and senior representatives of organisations that had relevant contact with Ruth and/or Bill.

8.2. The members of the panel were:

Agency	**Name**	**Job Title**
	Jenny Farmer MBE JP	Independent Chair
West Cumbria Community Safety Partnership	Lisa Elder	DHR Co-ordinator
Cumbria County Council	Louise Kelly	Domestic Abuse Coordinator
Cumbria County Council	Julie Batsford	Public Health
Department for Work and Pensions	Amanda Buchanan	
CUMBRIA Constabulary	Martin Hodgson	Detective Inspector
Home Group (Landlords)	James Varah	

North Cumbria CCG	Louise Mason-Lodge	
Cumbria County Council	Sarah Joyce	Adult Safeguarding
GP Practice	Amanda Boardman	Named GP for North Cumbria CCG

8.3. Panel members hold senior positions in their organisations and did not have any contact or involvement with Ruth or Bill. The panel met on three occasions during the DHR process.

8.4. A core panel was assembled to agree the updated report, and the final recommendations. The panel had sight of the report on one occasion ahead of a panel meeting to discuss and finalise the report. This panel also included an independent domestic abuse specialist.

8.5. The panel consisted of:

Agency	**Name**	**Job Title**
	Dr Liza Thompson	Independent Chair
West Cumbria Community Safety Partnership	Alison Goodfellow	DHR Co-ordinator
Cumbria Constabulary	Sarah Edgar	Detective Constable
Cumbria Integrated Care Board	Molly Larkin	Safeguarding Designated Nurse
Home Group (landlord)	Robert Littler	Operations Manager
Cumbria County Council – Public Health	Julie Batsford	Service Manager

8.6. It is also of note that from 1st April 2023, Local Government in Cumbria changed. The current six district councils and Cumbria County Council have been replaced by two new unitary authorities - Westmorland and Furness Council and Cumberland Council. As a result of this, West Cumbria Community Safety Partnership became Cumberland Community Safety Partnership.

9. Independent Chair and Author

9.1. The independent Chair and author of the original report is Jenny Farmer MBE JP, who has 33 years' experience as a magistrate adjudicating on criminal, domestic violence and family panel cases. She has no connection with any of the parties involved. She had completed the Home Office initial and refresher training.

9.2. The Independent Author who completed the re-write process is Dr Liza Thompson.

9.3. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHR's, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs). She lectures at Christchurch University Canterbury, delivers

domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system.

9.4. Dr Thompson has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Homicide Reviews in Cumbria.

10. Other Reviews/Investigations

10.1. Ruth's death was referred to the coroner's office by Cumbria Constabulary, as a sudden death. Upon review of the referral and photographs taken at the scene, a Coroner's Officer raised a concern with Police, who opened an investigation of gross negligence manslaughter. Bill was arrested as a suspect.

10.2. Police received the Home Office Pathologist's report in January 2019, which revealed that Ruth had in fact suffered violent assaults, which had resulted in multiple rib fractures. Bill had died only days prior to Police receiving the Pathologists report.

11. Publication

11.1. This overview report will be published on the website of Cumbria Community Safety Partnership.

11.2. Family members will be provided with the website addresses and offered hard copies of the report.

11.3. Further dissemination will include:

- Independent Chair
- Members of Cumberland Community Safety Partnership
- Police and Crime Commissioner for Cumbria
- Chief constable Cumbria Constabulary
- Chief officer – North East & North Cumbria Integrated Care Board
- Chief officer – Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust, Mental Health and Disability Trusts
- Chief executive – North Cumbria Integrated Care NHS Foundation Trust
- Director – Adult Social Care, Cumberland Council
- Chief officer – North West Ambulance Service NHSTrust
- Chief officer – Cumberland Council

12. Equality and Diversity

12.1. The panel considered the nine protected characteristics under the Equality Act 2010, and discounted pregnancy and maternity, gender reassignment, race, religion and belief and sexual orientation.

12.2. However, the panel consider that Ruth's life experiences, including her access to and experiences of health, care and support services, were shaped by the protected characteristics of disability, sex and age.

12.3. Furthermore, these characteristics would have intersected at times, exacerbating one another in terms of how she may have been perceived by society and how she may have accessed services.

12.4. Ruth was living with reduced mobility. This is recorded in her Job Centre notes as Osteoarthritis, although her sister did not understand why her mobility was bad. There were "degenerative changes in the lumbar spinal area" noted in Ruth's GP records in 1998.

12.5. Until 2012, Ruth was prescribed regular medication, these were linked to alcohol dependency and depression symptoms. She last ordered these in September and December 2012, and had not seen her GP since 2014.

12.6. Despite the reason for Ruth's lack of mobility, both her sister and her HAWC describe her inability to walk unaided, which led her to lose confidence in leaving the house. Ruth was therefore isolated from the outside world, and presumably somewhat reliant on Bill.

12.7. Ruth was a woman in later life, living with a violent man. Police records indicate that Bill was charged with the following acts against Ruth; assault in 2008, threats to kill in 2005, Actual Bodily Harm in 2005, three counts of Actual Bodily Harm in 2004 and Actual Bodily Harm in 2003. These charges only resulted in the one conviction at court in 2005.

12.8. As a person's presence within the community reduces, they can become further isolated and invisible from society. Often people in later life describe feeling lonely, isolated and/or invisible[1] and this must be further compounded when access to the local community requires the assistance of a friend or family member, and further exacerbated when that friend or family member is abusive.

12.9. It has recently been recognised that domestic abuse amongst people in later life is prevalent,[2] yet underreported[3] and there is often a confusion between the terms "elder abuse"[4] and domestic abuse, when it concerns any victims over the age of sixty.

12.10. Ruth's enforced isolation and dependency upon Bill, due to her mobility issues and fear of leaving the house, placed her in a vulnerable position. As detailed below in the chronology, she appeared to achieve some level of routine while she had support from the HAWC service. However once this was closed, with nothing else to replace it, she relied upon her sister to take her to the Job Centre and to access her money to protect her from financial abuse from Bill.

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[1] Loneliness and isolation in older people: everyone's problem (gmjournal.co.uk)

[2] Meyer, S et al "Violence Against Older Women: A Systemic Review of Qualitative Literature *PLos ONE* (2020) https://doi.org/10.1371/journal.pone.0239560

[3] Domestic abuse of older people - House of Lords Library (parliament.uk)

[4] Bowes, H "Violence and Abuse of Older People: A review of current proposals for criminalisation" *Criminal Law Review* (10) (2020) pp.877-894

12.11. Bill was always present when professionals came to see Ruth. This is despite his insistence that he did not live at the property. He was always intoxicated and at times inappropriate or rude to those visiting Ruth. This may have been intended to deter them from coming to support Ruth and would also be an indication of his behaviours behind closed doors.

12.12 Despite Bills insistence that he did not live with Ruth, and he was a friend coming to visit. The flat served as a private "family unit" - which was situated away from society and professionals. Martha Fineman argues that:

"Society has devised special laws to apply to the family…these rules (are) justified by…the family's relational aspects and intimate nature."[5]

12.13 The privacy of the family setting has long been viewed as the primary source of women's oppression.[6] As Catharine Mackinnon argues "(the) ideology of privacy [is] a right of men to be left alone to oppress women one at a time."[7] The setting of the family home is private and therefore potentially untouchable by others; for example, Martha Fineman characterises the family as being "invisible" to those outside of it.[8] This privacy restricts state intrusion, "barring changes in control over….the existing distribution of power and resources within the private sphere."[9]

12.14 Ruth was invisible from society due to her lack of mobility, and her fear of walking outside alone. This was further exacerbated by her dependency on alcohol. This invisibility from society enabled Bill's abusive behaviour to go largely unchecked.

13 Background Information

13.1. Ruth's older sister provided a statement to Cumbria Constabulary as part of the criminal investigation. Much of the following background information has been taken from this statement.

13.2. Ruth had worked locally as a hairdresser, when she reached her forties, she developed bunions on her feet which required hospital treatment and led to her career ending. Around the same time, her mother was hospitalised, and Ruth planned to become her mother's carer, however her mother passed away in hospital, so this did not happen.

13.3. Ruth is reported to have had around £30,000 in savings at this time. She is described by her sister as being extremely house proud – her home and her appearance was immaculate – her sister described her flat as a "palace". This is the property she lived in throughout, and where her body was found.

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[5] Fineman, MA "What Place for Family Privacy" *Geo. Wash. L. Rev* (67) (1998-1999) p.1207
[6] Fineman, M *The Autonomy Myth* (2004) p.152
[7] Mackinnon, C "Roe v. Wade: A Study in Male Ideology" in Garfield, J L and Hennessey, P *Abortion: Moral and Legal Perspective* 45 (1984) p.53
[8] Fineman, above n 6 p.154
[9] Mackinnon, C *Toward a Feminist Theory of the State* (1989) p.193

13.4. Ruth's sister described how prior to Ruth's relationship with Bill, they would always socialise together. She said that Ruth liked to socialise and enjoyed a drink, and that Ruth was easily led. Ruth's partner prior to Bill had also drunk to excess and encouraged Ruth to do so too.

13.5. Ruth and Bill had been in a relationship for sixteen years. And Ruth's sister described him has "controlling from the start". She recounts an occasion when Bill had hid Ruth's makeup to stop her from going out, and after that occasion they rarely socialised again together.

13.6. Ruth's sister also recounted Bill's violence towards Ruth. In her statement she says that she'd tried many times to encourage Ruth to leave and had also "put him out" of Ruth's flat herself on occasions. She says that this became "pointless" as Ruth would wait until the "coast was clear" and call Bill to return, only to call her sister again when she needed help because of Bill.

13.7. Ruth's health is reported to have deteriorated during the sixteen years of the relationship. Her sister described her as an "alcoholic" and gives examples of pouring Ruth's alcohol down the sink, taking her to Alcoholics Anonymous meetings, and the GPs – but was told by professionals that Ruth had to want to help herself.

13.8. Ruth's sister describes Ruth's reduced mobility – which she said had no explanation. She would have to physically support her from the car to the house and back, and Ruth was unable to walk along the street without someone holding her up. She stated, "it was as though she lost the use of her legs".

13.9. Ruth's sister explained that as the couple's drinking spiralled out of control, so did the condition of Ruth's flat. She says that it got to the point where she would not go into the house, for several years, due to the neglect – she said it was unclean and unkempt, with no carpets.

13.10. As will be detailed in the following chronology, it is the neglected state of the property which raised the alarm to Ruth's circumstances in 2013, when a contractor sent by the social housing landlord refused to undertake works due to the state of the property.

13.11. Ruth's sister stated that Ruth had lost all her real friends, and only had a few people hanging on who wished to take advantage of her. By the time she died, her savings had all gone.

13.12. Ruth had made her sister a signatory for her building society, to prevent Bill from taking her money. Ruth's sister stated that the building society refused to allow Bill to withdraw money on Ruth's behalf, because they suspected financial abuse – however her statement does not indicate when this was, or how long Ruth had been safeguarded in this way.

13.13. Ruth lived in a housing association property since 1994. Bill was officially living there between 2016 and 2018, but since 2002 he had usually been present when professionals, and her sister, visited. The landlords had received two complaints from another resident of

the flats regarding Bill living at the property, and there had been anonymous reports of incidents of domestic abuse around 2013.

13.14. Ruth was found passed away in her flat, after her partner Bill raised the alarm. He described himself as a "friend" and didn't indicate that he lived in the property. Cumbria Constabulary had attended the property on numerous occasions spanning back to 2002, due to domestic abuse perpetrated by Bill – although they had last been alerted of his behaviour in 2014.

13.15. Initially Police dealt with the death as an unsuspicious sudden death. They took photographs of the neglected state of the property and of Ruth's body which had a large, ulcerated area on her back – a referral was made to the Coroner's Office, and the following day the Coroner's Officer raised the alarm with Cumbria Constabulary. Bill was arrested for Gross Negligence Manslaughter. The Home Office Pathologist found multiple broken ribs, and unusual marks which indicated either stamping or kicking of the body, or the use of a blunt instrument. Bill passed away days before the Pathologist report was sent to police.

14 Chronological Overview

14.1. This section will detail the events, contacts, and communications during the period 2013 to 11th September 2018. These events will be analysed in section 15.

14.2. From historic police records Ruth and Bill were in a relationship from 2003 – and from then until 2012 Cumbria Constabulary dealt with Bill for twelve offences against Ruth. These ranged from Actual Bodily Harm (ABH) to criminal damage. Prior to 2009, the DASH[10] was not in use, and instead a matrix was used to estimate frequency and potential risk faced, based upon the level of offences.

14.3. Cumbria's Independent Domestic Abuse Service (IDVA) first started in 2007. This was a pilot project, only in the North of the County and expanded to the West and South of the County in 2008. These services were merged and contracted pan-Cumbria in 2011.

14.4. In March 2013, a Housing Officer from Ruth's landlords, Home Group undertook a routine property inspection. It was evident from the condition of the property that Ruth was not coping well. She was also in breach of her tenancy agreement and was therefore at risk of eviction and homelessness and was in breach of her tenancy agreement, thus she was in danger of becoming homeless.

14.5. As a result of the visit, the Housing Officer raised a safeguarding concern to Adult Social Care (ASC). Home Group's case note state that this referral was "refused" – however there is no record of the referral on the ASC records from 2013.

14.6. A further safeguarding concern was raised with ASC on 16th May 2013, Home Group's notes state that "referral refused as criteria not met and advised to refer to Central Access Point."[11] Details of the local domestic abuse service were also provided.

[10] Dash Risk Checklist | Saving lives through early risk identification, intervention and prevention
[11] Central Access Point referral form (cumbria.gov.uk)

14.7. On 18th May 2013, Home Group made a referral to the Central Access Point (CAP), for housing related support, as suggested.

14.8. The CAP worker attempted to contact Ruth by telephone on 28th May 2013, but there was no answer. CAP and the Home Group Officer arranged to visit Ruth on the 4th June 2013 which Ruth cancelled; then on 7th June 2013, a letter was sent suggesting another appointment which Ruth did not response to. On 24th June 2013, the CAP referral was closed due to non-engagement.

14.9. On 14 August 2014, Home Group made an "application for housing support, via the Central Access Point for floating support". The referral recorded that Ruth had lived in the property for twenty years, and had been a victim of domestic abuse, although did not provide details of recent incidents. It was stated on the referral that there was asbestos in the property, but contractors could not progress with works due to the neglected nature of the property. There were cat faeces throughout the flat, and Ruth had rent arrears.

14.10. A joint visit, between the Home Group housing officer and Local Area Co-ordinator (LAC)[12] was arranged to try to engage with Ruth. Four more appointments were offered but were all unsuccessful. The CAP referral was closed on 22nd September 2014. Ruth was advised to get in touch should she need further support.

14.11. On 6th Feb 2015, Ruth attended an appointment at the Job Centre. Their case notes state that Ruth was prescribed anti-depressants and had Osteoarthritis meaning she was unable to stand for long periods of time or walk any distance. The Jobcentre made an appointment with the Croftlands Trust[13] on 11th Feb 2015, however, this was not followed up and it is not known whether Ruth attended.

14.12. On 6th May 2015, a contractor working for Home Group refused to enter Ruth's flat to service her boiler due to the neglected nature of the property – which was described as "squalor". A referral for Housing Related Support was again made by Home Group, and a joint visit between the Home Group Housing Officer and a LAC was booked for 11th May 2015. This was the first time the LAC had successfully gained entry to the flat.

14.13. The LAC then began support of Ruth – her primary role, as requested by Ruth, was to get her out into the community as she found it difficult to leave the flat.

14.14. It was noted at the initial visit that Bill was present, and he was intoxicated, and spoke inappropriately to the female LAC. He stated that he did not live there and was visiting. A question was raised in the notes about safety of lone working at the property. The contractor had not been able to complete the boiler service as there was no money available

[12]Working with individuals who due to the level of need or complexity of their vulnerability are challenging mainstream services. The service works with the individual and their families to ensure that their housing support needs are being met. In 2016 the role title changed to Health and Wellbeing Coaches (HAWC).

[13]Croftlands Trust | Counselling & Support - Mental Health Charities | Charity Directory - Charity Choice

on the meter. At this meeting Ruth agreed for Home Group to arrange a clean of the property, for which Ruth would repay the costs.

14.15. On 2nd June 2015, two LACs visited Ruth and provided her with a copy of Age UKs events calendar to encourage her to socialise. Bill was there and again intoxicated. He shouted at the two LACs and was very rude to Ruth. The following day, Home Group called the LAC to advise that the flat would be cleaned. A conversation was recorded between the LAC and the Home Group Officer regarding Bill's behaviour – it was agreed that despite concerns there was no "concrete evidence" around abuse.

14.16. The LAC was able to see Ruth alone on 10th June 2015. Ruth told her that she liked Bills company but would like him to have his own place to live. This was the first time the LAC was able to see Ruth alone – as often Bill was there, and a lot of contact with Ruth was telephone based. Ruth stated that he stayed a couple of nights a week. On 16th June 2015, Ruth told the LAC she did not feel confident going out alone, that she had been independent and outgoing, and wanted to be that way again. The LAC suggested coffee mornings, and she took her to the local library. The LAC noted that the property had a strong animal urine smell, but Ruth was trying to maintain the cleanliness in the kitchen.

14.17. On 19th June 2015, Ruth spoke to the LAC about her welfare benefits, which had stopped. The LAC took her to the DWP, where it was agreed that the sanctions against her would be lifted if she attended that day. The LAC organised some money for shopping to help until the benefit payment was received.

14.18. The LAC also took Ruth to Citizens Advice Bureau to discuss council tax arrears, provided her with food parcel when the benefit payment was further delayed, supported her to access her private pension fund.

14.19. On 15th July, and 2nd September 2015, joint visits were undertaken between the LAC and Home Group Officer, who found the property was cleaner, and Ruth seemed well in herself. Bill was present each time.

14.20. During September 2015, the LAC assisted with a large bill which Ruth received, helped to communicate with the DWP following another issue with welfare benefits, and worked with Ruth to identify goals which she could achieve.

14.21. During October 2015, the LAC supported Ruth with repayment plans for council tax, water rates and took her to the Citizen's Advice Bureau to assist with welfare benefit forms.

14.22. During November and December 2015, the LAC continued to undertake home visits, and continued to support Ruth with DWP communications. On 19th December 2015, Ruth's benefits stopped, and the LAC accompanied her to the Job Centre to recomplete forms which they had not received.

14.23. The LAC undertook a home visit on 13th, 20th and 26th January 2016. Ruth was due a back payment of benefits, and also received a back payment of private pension.

14.24. On 4th February 2016, the LAC accompanied Ruth to her Building Society. Ruth thought she had around £300 in her bank. However, the account was overdrawn, the benefit back payment had **not** yet been paid, and the private pension back pay had been withdrawn the same day. Ruth said she was unsure how the money had been withdrawn.

14.25. Bill rang his GP on 15 February 2016 stating that he was drinking heavily again and was sleeping in a bus shelter. He was given an appointment for a blood test but arrived at the appointment intoxicated so was asked to leave.

14.26. The LAC visited Ruth on 25th February 2016, the house was warm and due to be decorated. Ruth had not left the house for a week due to the icy weather.

14.27. During the LACs home visits in March 2016, Ruth was in good spirits, decorating had been completed in the house and the servicing of the gas boiler had been completed. Ruth said she would like more help to go out into the community.

14.28. During a home visit on 1st April 2016, Ruth said she had been going out with her sister. Ruth was happy and she had bought a new mobile phone of her own. Ruth agreed that LAC could call her on this phone in the future. Bill told Ruth that he was moving out to his own home, but Ruth told the LAC that she was concerned as she relied on him for help with meals etc. Bill confirmed he would continue to support her. On the 6th April 2016 a referral for Bill was opened by the LAC. The focus of this referral was to support Bill to find his own accommodation address issues in relation to finances, alcohol use and his decline in health.

14.29. Visits continued in April 2106, no concerns were disclosed, but Ruth stated she wanted to get out more. Also, during April 2016, Bill had secured a tenancy with Home Group, the property had been furnished and he had been supported to manage his household payments.

14.30. During a visit on 20th April 2016, the LAC asked Ruth if she wanted to go out, but she declined. Bill and his sister were also at the flat, and all were intoxicated.

14.31. On 4th and 10th May 2016 Ruth reported low mood, and stated she felt unwell. She did not disclose any specific issues.

14.32. On 18th May 2016, Bill's GP organised a session with the local alcohol service as he was drinking excessively. He was diagnosed with alcoholic hepatitis and was having discussions with the alcohol service about a community detox.

14.33. Also on 18th May 2016, the LAC supported Ruth to attend the Job Centre to fulfil her ESA requirements.

14.34. At the end of May 2016, the LAC has a discussion with Ruth about ongoing support and informed her that she needed to make some proactive changes to be able to keep the LAC support. Ruth disclosed that going out scared her, due to lack of mobility, but assured the LAC that things were ok at home. Ruth declined to go out with the LAC on the next two appointments. Bill was present at both of these visits.

14.35. On 5th July 2016, the LAC was due to accompany Ruth out of the house, however Ruth cancelled this as she had to look after Bill's dog.

14.36. On 22nd July 2016, the LAC visited Ruth and found her unwell. She was advised to contact her GP, but there is no evidence that she did this.

14.37. Bill was closed to the alcohol service due to lack of engagement.

14.38. On 27th July 2016, the LAC took Ruth shopping, she said she enjoyed being out. Another visit was arranged for 3rd August 2016, with a view to Ruth being encouraged to start going out independently. Ruth called and cancelled this, stating that she was unwell.

14.39. Ruth was feeling better by 9th August 2016, the LAC visited her, and on 17th August 2016, the LAC took Ruth out for a walk. Throughout this walk Ruth could not let go of the LACs arm and walk unaided.

14.40. A meeting on 22nd August 2016 was cancelled by Ruth as she was unwell. On 1st September 2016 the LAC walked Ruth into town, and again she could not let go of the LACs arm and walk unaided.

14.41. The LAC had a conversation with Ruth on 13th September 2016, as she was concerned that her support was not suitable for Ruth's needs. Ruth indicated that she was happy to continue with the level of support.

14.42. Bill is recorded as being present at all of the visits between the LAC and Ruth.

14.43. In 2016, the LACs became Health and Wellbeing Coaches (HAWCs) – which changed the criteria of the role and the support provision.

14.44. On 3rd October 2016, Bill told his GP that he had abstained from alcohol for three years and was currently drinking two pints per day.

14.45. Throughout October 2016, the HAWC visited Ruth, she stated she was fine on each occasion. Bill was always present.

14.46. Ruth cancelled her appointments with the HAWC on 1st and 7th November 2016 – due to being unwell – and on 9th November 2016 the HAWC accompanied Ruth to her Job Centre appointment. Ruth cancelled appointments on 22nd and 29th November 2016.

14.47. The HAWC accompanied Ruth to the Post Office on 1st December 2016, she was observed as being more confused than usual, but did not want to see a GP stating she was ok. Bill continued to be present at the appointments throughout.

14.48. The HAWC visited on 12th and 19th December 2016, bringing Ruth a food parcel on the latter date. Ruth complained of back pain and stated she had not left the flat - but declined support with contacting the GP. Bill was present at both meetings.

14.49. During visits in January and February 2017, Ruth stated that she had got in a mess with paperwork, that she wanted to go out more and, on each occasion, that things were OK. Bill was present in the property on three of six of these visits. The HAWC explained that support would be coming to an end as Ruth appeared a lot more settled and that she needed to go out more to prevent social isolation. Ruth stated she would wait until the weather improved before going out.

14.50. On 22nd March 2017, the HAWC offered to arrange a GP appointment because Ruth was feeling unwell. She declined the offer but did accept referral for smoking cessation. Again, on 10th April and 21st April 2017, Ruth said she was unwell and had spent a lot of time in bed but declined a GP appointment. Bill was present in the property on all occasion.

14.51. On 8th May 2017, the HAWC planned to meet with Ruth the following week to close support. Ruth stated that she was OK and didn't need any support. On 19th May 2017, Ruth agreed she no longer needed support and that she knew how to contact her key HAWC and the Adult Social Care department if required. Bill was present at the property on both visits.

14.52. The HAWC case was closed on 26th May 2017.

14.53. Between 19th May 2017 and 2nd November 2017, there is no chronology available – indicating that Ruth did not have any contact with the agencies involved in this review.

14.54. On 2nd November 2017, Ruth attended her DWP mandatory appointment; where she stated that she would continue to go to coffee mornings and the food bank – however there is no evidence that Ruth indeed visiting these places.

14.55. DWP saw Ruth for the last time on 31st December 2017. She attended her mandatory appointment and said she would continue much in the same way as she had said at the last appointment. However, the DWP contacted ASC, whilst Ruth was present, because Ruth had not managed to re-engage with them.

14.56. Ruth's sister stated that she would take her to the Job Centre, and although she could not remember the final time she saw her, she believed it would have been the last time she took her to the Job Centre – so possibly 31st December 2017.

14.57. Home Group issued a legal letter on 27th Feb 2018 to Ruth stating that she had failed to allow access to Home Group to complete the gas servicing and that they may consider legal proceedings if access was not granted.

14.58. On 12th March 2018, gas engineers contacted Home Group saying they would not work in the property as it was in a poor condition. In line with Home Group policy, a breach of tenancy letter was issued on 14th March 2018 and an access appointment made for 22nd March 2018 when access was gained.

14.59. On 2nd May 2018, the Housing Officer sent an email to the Operations Manager stating that they had gained access but that the property was in a bad condition. The Visiting Officer did not have concerns regarding Ruth's health, other than how she was managing

the property which was in a poor condition. And on 30th May 2018, a deep clean was booked for the property.

14.60. On 18th June 2018, a Notice of Seeking Possession was served on Ruth as she had not allowed access to the property for the deep clean to be carried out.

14.61. Between 15th August and 22nd August 2018, the DWP received four cancellations from friends and family on behalf of Ruth. The reasons given were conflicting appointments, ill-health, and mobility issues. The DWP deferred Ruth's next appointment until 6th September 2018. Ruth did not attend this appointment, was uncontactable by phone, so the DWP sent her a letter.

14.62. On 22nd August 2018, Ruth's sister arrived at her flat to take her to the Job Centre. Bill answered the door and stated that Ruth was unwell. He told her that Ruth wanted some money out of the building society account – and as the signatory for this account her sister took the passbook and withdrew £500 as requested. When she returned, Bill was waiting outside for the money. Ruth's sister did not see or speak to her.

14.63. Home Group began court proceedings against Ruth on 30th August 2018, as she had still not allowed access to the contractors.

14.64. On 7th September 2018, Bill called Ruth's sister and asked her to withdraw some money from the building society on behalf of Ruth. She agreed to do this the following day.

14.65. On 8th September 2018, she arrived at the flat. Bill came outside and handed her the passbook – he told her to empty the account apart from £20 because Ruth had bills to pay. Her sister stated she would not hand him the money, and Ruth should come down to be handed the money upon her return. She took some money out, not as much as Bill had requested as she felt something was amiss. When she returned, it was Bill who answered the door – she handed over the money but told Bill that if Ruth did not contact her that afternoon, she would alert the police.

14.66. Later that afternoon Ruth called, and they had a conversation – her sister stated Ruth sounded fine and confirmed she had received the money, although she did not query the amount. Ruth agreed to contact her sister again in a fortnight when she would need more money from the building society.

14.67. On 11th September 2018, Northwest Ambulance Service (NWAS) received a call regarding Ruth in cardiac arrest which was witnessed by a 'friend' at the scene. The crew attempted advanced life-support, but the procedure was unsuccessful. And Ruth was declared deceased. Officers at the scene did not identify anything suspicious but took photos of the scene. Bill told officers he was a friend who did not reside there.

14.68. Ruth's sister went into the building society on 12th September 2018, to inform them of Ruth's death – they told her that Bill had been in that morning and had not mentioned it, despite the cashier asking after Ruth.

14.69. The following day, after reviewing the photos taken at the scene, the Coroner Officer raised a concern with the police, and an investigation began. Bill was arrested for gross negligence manslaughter. On 11th January 2019 the Home Office pathologist report found that Ruth had multiple rib fractures – six days before this Bill passed away from a liver related illness.

15 Overview

15.1. The chronology of events provides clear evidence of deterioration of Ruth's physical and mental health. The scoping dates for the review begin after Bill's apparent move into her home, however the information provided by her sister allows an understanding of how the serious effect of coercive control impacted on Ruth's life.

15.2. The offence of Coercive and Controlling Behaviour was not introduced in the England and Wales until 2015[14] and has taken a few years to embed into policing as new offences often do. However, it would be reasonable to expect professionals to be able to identify coercive control within Ruth's situation, if she became known to agencies in 2022 instead of during 2016.

15.3. Cumbria police had no reason to respond to Ruth during the scoping period. Despite Ruth's sister stating that the building society were concerned about financial abuse, this was not reported to police. And the last time Police were involved with Ruth and Bill was in 2014 – until they attended the scene of her death in September 2018.

15.4. The chronology also provides an insight into Ruth's self-neglect. Although she struggled with mobility, which would have made it difficult – or impossible – to go out unaided, she was offered support with accessing services which she declined. This may have been due to her alcohol intake, her mental health, or could have been linked to coercive control,[15] however, it does not seem to have been addressed by any of the professionals engaging with her.

15.5. Ruth was largely invisible to the statutory services for many years prior to her death. She did not attend her GP for any routine appointments, had stopped collecting her medication in 2012. She was not known to Adult Social care, Mental Health Services or any other healthcare providers. This placed a greater responsibility onto those who did have access to her and her living situation. The Home Group Officer who attended her home, the contractors who were reluctant to go into her property due to the neglected state, her Health and Wellbeing Coach, and staff in the building society, all had insights into her life – including spending time in the company of Bill.

15.6. It is quite common for non-statutory agencies to gain access into vulnerable people's lives, more often than police and statutory Health and Social Care providers do. It is therefore vital that all agencies have a sound knowledge of potential risks of harm, such as coercive control, or self-neglect. And vitally, the ability to refer into relevant services, and

[14] Serious Crime Act 2015

[15] The Care Act (2014) statutory guidance – self-neglect is included as a category under adult safeguarding.

the confidence to challenge decisions which don't seem correct. To ensure this is the case, agencies should have clear policies, and ongoing robust training around identifying *and* responding to issues.

16 Analysis

16.1. An analysis of the services and responses provided to Ruth which dating back to 2013 to 2018 would not provide a true reflection of current service provision.

16.2. This section will therefore comment upon opportunities for learning from that period, and will focus on current policies, procedures, and processes to establish whether the response Ruth would receive now would be more appropriate, and where gaps may remain. These will result in recommendations which are relevant to the current service provisions.

16.3. Home Group – Ruth's Landlords

16.3.1. The officers who were involved with Ruth are no longer employed by Home Group, so the information gathered for the review is based up on the case files. This posed a problem, as record keeping was an area of weakness, and the safeguarding referrals made by the housing officers were via telephone, so there are also no audit trails for these.

16.3.2. The case notes indicate that the housing officer had suspicions about domestic abuse, rather than specific disclosures from Ruth, family or neighbours. The policy would have required an Anti-Social Behaviour (ASB) officer's involvement if domestic had been disclosed or identified, and in the absence of this process being followed it is assumed that there were no direct disclosures. Poor record keeping has been identified as a learning point in many DHRs Nationally and will be raised as ongoing learning from this review.

16.3.3. There is no indication that DASH risk assessments were completed by any of the Home Group staff for Ruth, or with Ruth.

16.3.4. The Home Group housing officer returned to Ruth's flat a few days after her death, and was "extremely shocked", at the condition of the property, which was significantly worse than the last property inspection three months earlier. This suggests that Ruth's living conditions had rapidly deteriorated within the months prior to her death.

16.3.5. It was obvious from the poor conditions of the property throughout the period of the review, that Ruth was not coping with keeping to the terms of her tenancy agreement and that she was in danger of losing her tenancy. Home Group's focus was on the state of the property and Ruth's inability to cope with keeping to the terms of her tenancy agreement. However, aside from the initial safeguarding referrals made in 2013, there were no further safeguarding concerns raised – and no indication that the housing officer recognised this issue as one of self-neglect.

16.3.6. Housing Officers will often be the only professional to gain access into a vulnerable person's home. They may be the only professional who identifies issues of self-neglect. Learning from this review indicates a need to raise awareness around self-neglect with Housing Officers, and for Home Group to develop a stand-alone self-neglect policy. This

would include the expectation for Home Group to lead on multi-agency discussions required to respond effectively to issues of self-neglect.

16.3.7. The referrals to ASC during 2013 raised the concern of domestic abuse, and in response to this, ASC signposted to the local domestic abuse service. This did not appear to come to anything, and no further actions were taken by Home Group. Had the Officer disagreed with the decision not to proceed with the ASC referral, due to Ruth's apparent lack of care and support needs – they could have utilised Cumbria Safeguarding Adult Board (CSAB) Escalation Policy.[16]

16.3.8. In May 2015 there is indication that the safety of Home Group staff lone working at Ruth's property – due to Bill's behaviour - however this did not appear to extend to a concern for Ruth being alone at the home with Bill.

16.3.9. Throughout her tenancy, Home Group supported Ruth by arranging for the property to be professionally cleaned on two occasions and for the gas boiler to be repaired. However, this could be viewed as provided a "sticking plaster" to cover Ruth's issues in the short term – as she was unable to maintain the upkeep of her property because of all the reasons contained in this review.

16.4. Cumbria County Council – Health and Wellbeing Coaches

16.4.1. In August 2014, a referral was made by Home Group to the CAP, and this resulted in a long period of support.

16.4.2. The HAWC[17] worked with Ruth for over two years and made regular visits, often weekly, backed up with phone calls to Ruth. By working with her, the HAWC managed to improve Ruth's confidence, living conditions, her financial state and her general wellbeing. Ruth became more independent and more confident.

16.4.3. In 2017 the HAWC support came to an end. This is because the outcomes which had been achieved, and Ruth no longer fit the criteria of need for the service. Ruth agreed with the service ending. The HAWC support would usually be provided to a tenant for around six months, however, due to Ruth's complexities, the HAWC worked with her for a longer period. The current provision does not have a timescale for support, and the service has been expanded to provide more support around health and wellbeing, in addition to housing support.

16.4.4. Ruth clearly had care and support needs; however, these needs did not appear to reach the criteria for Adult Social Care, although there were no Care Needs Assessments for Ruth on file. It is not clear whether these needs would reach the current criteria for Adult Social Care intervention, and there remains a gap in services available for those who have similar needs to Ruth's.

[16] https://cumbria.gov.uk/elibrary/Content/Internet/327/949/41941154955.PDF
[17] Health and Wellbeing Coaches - HAWC | Cumbria's Family Information Director

16.5. Cumbria County Council - Adult Social Care

16.5.1. It would appear from the information gathered for this review, that ASC didn't receive the referral which was submitted by Home Group in March 2013. There was a further referral submitted by Home Group in May 2013, which was declined although there is no rationale available to indicate the reason for this. It can only be assumed that the information provided did not indicate that Ruth reached the criteria for a care and needs assessment.

16.5.2. Information was passed to Ruth regarding support available, from a local domestic service. This is problematic, as Bill was constantly present at the home and would have easily been able to intercept this information. This would both reduce Ruth's likelihood of reaching out for help and could also have increased her risks as Bill may have escalated his abusive behaviours to reinforce his control over Ruth.

16.5.3. The CAP worker attempted to contact Ruth by telephone on 28th May 2013, but there was no answer. CAP and the Home Group Officer arranged to visit Ruth on the 4th June 2013 which Ruth cancelled; then on 7th June 2013, a letter was sent suggesting another appointment which Ruth did not response to. On 24th June 2013, the CAP referral was closed due to non-engagement.

16.5.4. There was an eighteen-day delay between the CAP referral and the initial contact on 28th May 2013. During this time the intake policy for CAP was very broad, and there was no response time requirement. The intake process and system has completed changed since this time. Referrals are now turned around within five days, an initial assessment will be completed during which questions are asked about domestic abuse. The HAWC's are now trained to completed DASH risk assessments, and if domestic abuse is indicated a DASH will be completed, and the HAWC would make a MARAC referral where appropriate.

16.6. North East and North Cumbria Integrated Care Board

16.6.1. Ruth had contact with her GP surgery and in 2012 she was prescribed repeat medications such as anti-depressants, vitamins, and iron tablets to deal with her dependency on alcohol.

16.6.2. In 2013 she was discharged from hospital after a urinary tract infection, the GP was informed, however Ruth did not follow up with a GP appointment.

16.6.3. In 2014 Ruth requested a medical certificate, as advised by the Citizen's Advice Bureau.

16.6.4. Although Ruth repeatedly complained to the HAWC that she was experiencing periods of ill health, there were no more visits to the surgery between 2014 and her death in 2018. This was despite being encouraged to attend. Therefore, the practice was unaware of her circumstances. Current systems in place include better communication between the HAWCs and other services – this includes information sharing with GPs.

16.6.5. Ruth's GP practice had a Did Not Attend (DNA) policy during this period, which was to write to the patient if they DNA'd three appointments. The policy has now been updated, which requires DNAs to be reviewed monthly, these are referenced against a practice held

list of vulnerable patients and actioned appropriately on an individual case basis. Although Ruth did not have any routine appointments to DNA – this policy development is good practice and worth mentioning within the context of this review.

16.6.6. Ruth failed to attend her medication reviews in 2012, and therefore her medications were not reordered – this was in line with the Practice policy at the time – this has remained broadly the same since the period of this review.

16.6.7. Bill's GP Practice prescribed him medication and arranged meetings with local alcohol support service UNITY. However, due to Bill's non-compliance, UNITY withdrew their support.

16.7. Cumbria Constabulary

16.7.1. Prior to 2012 the police were called to Ruth's property on numerous occasions regarding reports of domestic abuse which involved Bill. Between 2006 and 2009 there were fourteen calls to the home. Ruth was not referred to MARAC following any of these incidents.

16.7.2. During this period, the criteria for a referral to MARAC was three police callouts within twelve months, a high score on the DASH risk assessment, or professional judgement.

16.7.3. During the latter years of her life Ruth no longer raised the alarm with police, even though it now known that she was still living with abuse. This is likely to be because she had both "normalised" the day-to-day abuse, and lost faith in "the system" due to her poor experiences.

16.7.4. The first time the police were called to Ruth's property after 2012, was on the day of her death in September 2018. Bill was known to the police, had a police record for violence and was known to be abusing alcohol.

16.7.5. During the period between 2002 and 2012, calls to the police from Ruth because of domestic violence had resulted in Bill being arrested. However, only one case ever proceeded to court which resulted in a conviction. Though victimless or evidence-based prosecutions were sought at that time, the process was less developed than it is now. Prosecutions for domestic abuse are always difficult without the main witness attending court and giving evidence. Clearly this was not what Ruth was prepared to do against the man she was living with.

16.7.6. Prior to 2012, the police gave Ruth appropriate support and advice by attending each time she phoned for help with DA perpetrated by Bill. They gave her advice and prosecuted Bill when possible. However, as their last call to the property was in 2014, they had no contact with Ruth or Bill from then until Ruth's death in September 2018.

16.7.7. On the day of Ruth's death, the police who attended the scene concluded that there were no suspicious circumstances to the death and the body was released to the morgue. Subsequent information revealed that this may not have been the case and a post-mortem

was requested. When the post-mortem report was finally received some months later, it concluded that Ruth had died of a violent assault. Bill was the only suspect but had died just prior to the police receiving the pathologist's report.

16.7.8. The police have accepted that their initial handling of the case at this juncture was not what is should have been. Since Ruth's death, Sudden Death Supporting Procedures have been revised – these procedures require the duty Detective Inspector to make an informed, common-sense decision with regard the need to attend a sudden and unexplained death. When considered appropriate to do so, the senior officer will always attend the scene.

17 Conclusions

17.1. Coercive Control

17.1.1. At the time of Ruth's death, the offence of Coercive and Controlling Behaviour had been introduced through The Serious Crime Act 2015. This chronology of Ruth's experiences highlights the need for professionals to be able to identify the presence of this behaviour.

17.1.2. The elements of the offence are:

a) A person (A) commits an offence if they repeatedly, or continuously, engage in behaviour towards another person (B)
b) At the time A and B are personally connected
c) The behaviour has a serious effect on B
d) A knows, or ought to know, that the behaviour will have a serious effect on B.[18]

17.1.3. For the purposes of this offence, until 4th April 2023, personal connection meant:

a) A and B are in an intimate relationship
b) A and B live together, and are members of the same family
c) Or have previously been in an intimate relationship.

17.1.4. From 5th April 2023, the definition of 'personally connected' in section 76 of the Serious Crime Act will be replaced with the definition in Part 1 of the Act, so that the offence may apply to former partners and family members.[19]

17.1.5. For the purposes of this offence, serious effect means:

a) The behaviour caused the fear - on at least two occasions - that violence would be used.
b) The behaviour caused alarm or distress, which had a substantial adverse effect on B's Day to day activities.

17.1.6. Ruth told the LAC on one occasion that she wished Bill would move to his own property. In April 2016 LAC did support Bill to secure his own independent tenancy which

[18] S.76 (1)

[19] https://www.gov.uk/government/publications/controlling-or-coercive-behaviour-statutory-guidance-framework

was set up ready for him to live in. However, information suggests that he did not spend much time at the property despite efforts from the LAC to look at the reasons for this.

17.1.7. Between 25 October 2016 and 8 May 2017, the LAC/HAWC recorded Bill being present at the property on thirteen occasions. Neighbours had complained as far back as 2013 regarding Bill living at the property.

17.1.8. Bill was clearly living at the property and not, as he said after her death, that he was just a friend visiting. He had issues with alcohol abuse, and had a record for violence, including a prosecution for threats to kill Ruth. Bill spoke of a large extended family, but there was no evidence that they were in contact with Bill.

17.1.9. Ruth died because of a violent assault having been struck multiple of times to her back causing multiple posterior rib fractures on both sides of her body. Unusual marks to the skin on her back led the Pathologist to conclude it was the result of footwear – stamping or kicking with considerable force. Ruth's body condition was very poor at the time of her death, and she wore urine-soaked clothing.

17.1.10. Ruth went from being a confident person, who held a job, to a highly dependent person with little or no self-confidence, almost housebound, hardly any social life and unable to cope adequately with personal hygiene, the upkeep of the property or the paperwork necessary for day to day living.

17.1.11. Ruth had become increasingly dependent on alcohol, and dependent upon Bill, to provide her meals, and possibly to provide the alcohol as she did not leave the house. Alcohol may have been her way of coping with the abuse, and this impacted her mental health in the long term. It may have been that Ruth's alcohol use may have had some impact on how agencies perceived her needs, and her ability to keep herself safe, including making safe decisions for herself, and her ability to access services.

17.1.12. Ruth complained on fourteen occasions to the LAC that she was unwell and had become more confused but did not want to attend the GP for help. The LAC could have considered self-neglect as an issue at this point and followed the CSAB self-neglect protocol – this would have involved pulling together a multi-agency meeting to discuss Ruth's circumstances.

17.1.13. Ruth's sister tried to encourage her to get Bill out of the house but in the 18 months before her death, Ruth had become highly dependent on him and always allowed him back in. At one point her sister told her, "He will kill you", Ruth replied "I know".

17.1.14. Ruth used to phone her sister regularly to chat but, in the latter months of her life, this had ceased.

17.1.15. On the 7 September 2018, Ruth's sister threatened Bill with calling the police if she could not speak to Ruth. Later that afternoon, Ruth made a brief call to her sister, stating she was fine – this was the last call they had.

17.1.16. During the time the LAC was involved, Ruth was able to make progress but, when the case was closed on 24 May 2017, she became more vulnerable. No access was granted to the gas servicing engineer between October 2017 and February 2018. At the point where Home Group identified that the house was again in a neglected state, and that Ruth was not allowing access to the property, an ASC referral could have been made citing self-neglect.

17.1.17. The Home Group cleaning contractors tried to gain access following the engineer raising the concern about the state of the property. They were unable to gain access, and their role was to clean the property, not attend to Ruth's wellbeing.

17.1.18. With no police involvement since 2014, no Social Services involvement since May 2017 and focus being on the state of the property, there was no official monitoring of Ruth's serious decline. During this period, Ruth did not ask anyone including her brother or sister, for help. Ruth never complained to anyone regarding her abusive treatment by Bill. His increasing control over Ruth meant that she was isolated from her sister's involvement and from any outside support.

17.1.19. Ruth had been living with a violent and abusive partner for many years. During that time none of the agencies had sufficient involvement with Ruth and her life to effect a meaningful change in her circumstances and prevent the outcome.

17.1.20. When HAWCs were introduced in September 2016, replacing the LACs, the approach to Ruth's support also changed. This fundamental change meant the emphasis changed from one of supporting (doing for) to coaching (guiding, encouraging, finding a person's potential). In Ruth's case it moved from supporting her housing and budgeting requirements to coaching her to improve her overall health and wellbeing. At this point, Ruth's circumstances could have re-reviewed in terms of her care and support needs. When it became clear that she was not going to respond well to the coaching and encouraging, possibly because she was simply unable to "do it for herself" – a further ASC referral could have been submitted for her care and support needs to be assessed.

17.1.21. The changes in Ruth, from a sociable working woman, to a physically and mentally ill reclusive person with alcohol addiction, can clearly be seen as the "serious effect" of coercive control. The Coercive and Controlling Behaviour offence had been in place for three years when Ruth died, however at that point she had not been seen for over a year. The law was in its infancy so it is reasonable that Housing officers, and Health and Wellbeing Coaches may not have been trained to spot coercive control at this point. However, this case should be used as a case study to raise awareness with all professionals who encounter potential victims of coercive control – especially those who gain an insight into their homes when undertaking their roles.

17.2. Homicide Timeline

17.2.1. Professor Monckton-Smith is a forensic Criminologist who specialises in homicide, stalking and coercive control. Her teaching at The University of Gloucester focuses on forensic and criminal investigation, and addresses issues in public protection.

17.2.2. The Eight Stages of Homicide[20] framework has been developed from Professor Monckton-Smith's ground-breaking research which has spanned many years. The homicide timeline lays out identifiable stages in which intimate relationships where one partner is coercive, can escalate to murder. The timeline aims to support a better understanding of coercive control and domestic homicide amongst professionals responding to domestic abuse.

17.2.3. Professor Jane Monckton-Smith clarifies further that, although people outside of a relationship may find it difficult to identify coercive control, there is always a trail left by victims and abusers, often in the form of "repeating patterns".[21] To facilitate the identification of this trail, she has created the "eight stages of homicide". This theoretical tool can be applied practically by practitioners who want to identify the risk of homicide in a relationship.

17.2.4. Stage one occurs before the relationship even begins; this stage refers to a "type" of person who may be predisposed to domestic homicide rather than the dynamics between two people. Monckton-Smith talks about the "predictive strength of someone's past behaviour."[22] The most significant red flag being that they are controlling and have been controlling before.[23] They will often tell their friends, or new partners, about their "crazy-ex" who knew how to "push their buttons".[24] We do not have any information about Bill's past relationships, as he had been with Ruth for many years.

17.2.5. Stage two is the "commitment whirlwind". Monckton-Smith explains that when a controlling person finds someone they want to be in a relationship with, they move things on very quickly. They demand commitment, which in their minds can never be withdrawn. They display jealousy and possessiveness.[25] We know from Ruth's sister that Bill moved into Ruth's flat very quickly after they met.

17.2.6. Stage three is where the victim is "living with control", and Monckton-Smith describes two pillars of this control. One being "patterns of jealousy", which leads to the victim behaving in a way which aims to stop the jealousy, which in turn "manoeuvres them into living isolated lives to stop the jealousy."[26] The abuser will use emotional blackmail during this time. The second pillar of control is "the loyal code", which is a series of hidden tests designed to make the non-abusive partner prove their devotion, and at the same time removes or controls any influence that others may have over them. We know from the chronology, agency analysis and also from Ruth's sister that her life was confined mostly to the flat. Bill was always present, and we do not get a sense of Ruth having very much of a life outside of the relationship with Bill. We also know that Ruth alcohol intake became problematic. This could have been a coping mechanism for her, or it could have been encouraged by Bill to increase his control of her.

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[20] Monckton-Smith J *In Control: Dangerous Relationships and How They End in Murder* (2021)
[21] Monckton-Smith, J *In Control: Dangerous Relationships and How they End in Murder* (2021) p.45
[22] *Ibid p.49*
[23] *Ibid* p.23
[24] *Ibid p.35*
[25] *Ibid pp.63-69*
[26] *Ibid p.77*

17.2.7. During stage three the abuser maintains routine and ritual, and the victim complies with this as to change anything that will cause trouble for them.[27]

17.2.8. It is important at this stage that those responding to domestic abuse are aware that when a victim is managing their safety, this may look to the outside world as choosing to maintain their relationship. The victim knows by now that the only way to stop the abuse is to comply with the demands, as once the victim stops complying, the perpetrator will become dangerous.[28] To the untrained eye, "compliance doesn't look like fear, it looks like consent."[29]

17.2.9. Monkton-Smith tells us that stage three is all about making sure the non-abusive partner is compliant and trapped within the relationship. If there is no challenge to the control, or any challenges are effectively overcome, this stage can last a lifetime.[30]

17.2.10. Stage four introduces the "trigger"; this could be something within the relationship or external to the relationship, which indicates to the abuser that they are losing control of the victim. For example, actual or perceived separation from the victim.[31] In Bill's case, this trigger could have been Ruth's engagement with support services, but it also could have been his own deteriorating physical health which triggered an increase in violence which led to Ruth's death.

17.2.11. Stage five moves into "escalation", where the abuser "ramps up the control to frighten or coerce the victim back into line."[32] At this point, the escalation tactic may work, the relationship may resume, and the timeline will circle back to stage three. Monckton-Smith tells us that this is very common, and relationships may constantly circle between stage three and five, with the victim never being able to leave. On rare occasions, the relationship may stay broken, the abuser accepts the breakup and circles back to stage one with a new partner – telling the new partner about the crazy-ex and messy breakup from before. However, on some occasions the abuser moves onto stage six.

17.2.12. Stage six is "a change in thinking", which Monckton-Smith describes as "a move on from attempting to keep the partner in the relationship to destroying them for leaving it."[33] Often victims and family members describe this stage as the calm before the storm.

17.2.13. Stage seven is the "planning" stage, which is self-explanatory, and stage eight is the act of homicide.

17.2.14. Stages five through to eight can happen very quickly, sometimes within a matter of hours. In Ruth's case, this escalation could have happened after the time she was last seen by practitioners, and therefore not recognised or identified as a time of risk for her.

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[27] *Ibid p.111-114*
[28] *Ibid* p.99
[29] *ibid*
[30] *Ibid* p.127
[31] *Ibid* p130
[32] *Ibid* p.158
[33] *Ibid* p.164

17.2.15. By applying the circumstances of Ruth's relationship with Bill to this framework, in the context of hindsight, we are able to better identify the risks to Ruth from Bill's behaviours. However, this is a valuable tool for learning to make the future safer.

17.3. Financial and Economic Abuse

17.3.1. Economic involves financial abuse, but it also incorporates other abusive behaviours on might use to control someone else's economic situation, such as access to housing, food, and employment.

17.3.2. Financial abuse is the mistreatment of someone in terms of their money or assets, such as their property. Financial abuse often occurs alongside other forms of abuse.

17.3.3. Financial abuse can include money being stolen or misused, fraud or putting someone under pressure in regards their money or property. As a form of abuse, it can often be missed due to gendered dynamics of money management within relationships.[34]

17.3.4. It was clear from the information presented in the IMRs that Bill was financially abusing Ruth. When the LAC took Ruth to the bank to withdraw a back payment of private pension, the money was already gone from the account, and Ruth stated to not know where it had gone. It is recorded that the building society staff were aware that Bill was financially abusing Ruth. And Ruth was aware of the financial abuse, because she made her sister a signatory of the account.

17.3.5. Some of Bill's actions also pointed towards economic abuse, for example removing her makeup to stop her going out (paragraph 13.5) is a clear example of Bill taking Ruth's property; and the lack of money on the gas meter leading to the meter not being serviced (paragraph 14.14) moves beyond financial abuse and into the wider remit of economic abuse.

17.3.6. However, there is a distinct lack of language around either economic or financial abuse in the IMRs. It may be that the abuse was not named as such, and it is clear that it was not responded to as such.

17.3.7. When interviewed for the review, the HAWC reflected that "when I picked up the referral money was a mess. Ruth was not on the correct benefits and so money was tight for day to day living." There were rent arrears, debts with Council Tax, gas and water. The HAWC arranged an appointment with the Citizens Advice Bureau (CAB) and welfare benefits were organised. She was also able to access some of her pension via support from the CAB. The HAWC stated that "once all benefits were in payment, Ruth kept on top of them – using a diary to make sure." However, the financial abuse may have occurred after the HAWC stepped back, as she did not recall this being an issue.

[34]Anderson, K "Who gets Out: Gender as Structure and the Dissociation of Violent Heterosexual relationships" *Gender and Society* (21) (2007) pp.173-201, also Bell, K and Kober, C *The Financial Impact of Domestic Violence"* Family Welfare Association and Gingerbread (2008)

17.3.8. Research shows that economic and/or financial abuse are rarely employed in isolation and is often linked with other forms of abuse.[35] It would appear that professionals did not identify financial abuse as a current issue for Ruth and did not link this to other forms of abuse she may have disclosed, or that police had records of.

17.3.9. The financial abuse led to Ruth having a lack of funds to spend on the upkeep of the flat, and social activities which would have allowed a more independent lifestyle for Ruth. The economic abuse further reduced Ruth's options outside of the home. In these ways,, Bill was able to further control Ruth.

17.3.10. The HAWC also reflected on the issue of Ruth being overdrawn when she took her to the bank. From memory she said that Ruth had an explanation for this, that she had withdrawn the money to pay bills and had forgotten about this. The HAWC stated that she believed what Ruth had said about forgetting she had spent it.

17.3.11. As with coercive control, financial abuse – and certainly economic abuse[36] - were less understood during the scoping period for this review. However, the building society were concerned for Ruth's welfare and identified the issues with Bill withdrawing money from Ruth's account. Their response was limited; however, banks and financial institutions are becoming more able to spot and respond to issues of financial abuse[37] and in October 2018 the UK Finance *Financial Abuse Code* was launched.[38]

17.3.12. This case should be used as a case study for financial abuse, to raise awareness for all agencies, including banks and building societies.

17.3. Self-Neglect

17.3.1. There are many presenting factors and behaviours which may be indicative of self-neglect in adults. One factor would be the failure to manage their physical or mental health, for example not attending medical appointments, accepting treatment for their illness, or taking medications prescribed for their illness.

17.3.2. Further factors which may indicate self-neglect are social isolation, inadequate housing, the threat of eviction from a rented property, environmental hazards such as living in squalor, thei involvement with an individual which cases them harm, from which they are unable to withdraw, lack of insight or will to undertake essential daily tasks.[39] Ruth's circumstances are relevant to all of these factors.

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[35]Adams, A.E, et al "Development of the Scale of economic Abuse" *Violence Against Women* 14 (5) (2008) pp.563-587

[36] Introduced into law in England and Wales through the Domestic Abuse Act 2021

[37]Sharp-Jeffs, N *A Review of Research and Policy on Financial Abuse Within Intimate Partner Relationships* London Metropolitan University (2015)

[38] Financial-Abuse-Code-2021_Updated_2022.pdf (ukfinance.org.uk)

[39]Safeguarding Self Neglect Guidance (cumbria.gov.uk) Cumbria Safeguarding Adult Board (2021)

17.3.3. Research has found a close correlation between animal neglect and self-neglect.[40] There were observations made by Home Group and the LAC regarding the strong smell of animal urine, within the context of the property's unkept state.

17.3.4. Each self-neglect case should be assessed on its own merits, and therefore self-neglect does not automatically require a Care Act s.42 enquiry. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling or moderating their own behaviour.

17.3.5. The Cumbria Safeguarding Adult Board (CSAB) Self-Neglect Guidance details risk level threshold of self-neglect. When applying Ruth's situation to the document, she is identified as high risk which would require an Adult Social care referral for a care needs assessment.[41]

17.3.6. It is vital that professionals who are in contact with vulnerable people, and especially those who access the properties of potentially vulnerable people, are aware of the signs of self-neglect, and how to respond when it is identified.

17.4. Professional curiosity

17.4.1. Professional Curiosity is the capacity and skills of communication to explore and understand what is happening for a person, rather than making assumptions or accepting things at face value.

17.4.2. There was little to no evidence of professional curiosity employed by any of the professionals working with Ruth.

17.4.3. There is no evidence that the issues of coercive control, financial abuse, or self-neglect were explored either with Ruth herself, or with colleagues.

17.4.4. From the case notes, and the language used, it appears that Ruth's lack of engagement with the DWP, and choice not to attend her GP practice, was deemed to be a failing on her part, rather than due to coercion from Bill – or due to a trauma response.

17.4.5. There is no evidence that any professionals asked Ruth what had happened to her, and how this may have affected her ability to leave the flat, to ask for help, or to attend appointments with services designed to help her.

17.4.6. Rather than the lack of police involvement since 2014 being due to violent incidents ceasing, there is a possibility that Ruth's experiences of the criminal justice system may have led her to distrust the system. Bill had been arrested for a range of high-risk offences against Ruth between 2002 and 2014 – yet he had only been prosecuted once. Ruth may have decided that the police could not protect her and chosen to no longer report incidents

[40] Lockwood, R *Making the connection between animal cruelty and abuse and neglect of vulnerable adults* The Latham Letter (23)(2002)pp.10-11

[41] CSAB Safeguarding Adults Procedure March 2021 (cumbria.gov.uk)

to them. This is not uncommon, as victims may choose to manage the risks themselves if they do not believe professionals – including police – are able to manage it for them.[42]

17.5. Multi-Agency Procedures

17.5.1. None of the police interventions during 2002 to 2014 resulted in a Multi-Agency Risk Assessment Conference referral for Ruth. This was because Ruth was not risk assessed as high risk. The MARAC criteria at the time required a high-risk assessment or three incidents within a six-month period.

17.5.2. Police only completed two risk assessments in 2012, and there is no evidence of risk assessments being either completed or considered by agencies, other than police, despite the indicators of financial abuse and coercive control being present. Professionals who have direct contact with potential victims of domestic abuse should be equipped with the tools to risk assess situations and circumstances.

17.5.3. The completion of a risk assessments, with Ruth, may have helped to raise her awareness of the risk of harm she was faced with. After many years of being subjected to domestic abuse, and coercive control, victims may normalise the behaviours. This is a coping mechanism and the completion of risk assessment questions with the victim can highlight their experiences as abuse.

17.5.4. The completion of risk assessments by the LAC or the Home Group housing officer, may have led to a MARAC referral. This would have provided an opportunity for information sharing, whereupon the GP and ASC could have been alerted to the situation.

17.5.5. There was also a lack of referral into specialist services for Ruth. As has already been mentioned above, the LAC or the Home Group housing officer could have raised a safeguarding concern due to self-neglect.

17.5.6. A multi-agency response to the complex needs - such as those experienced by Ruth - can bring together expertise and different perspectives, to develop a more robust response to the risks.

18 Lessons to be Learnt

18.1. The following section provides an overview of changes in policies, procedures and responses which have been made since the scoping period for this review, along with further lessons to be learnt following the review of Ruth's experiences.

18.2. Home Group

[42]Monckton-Smith. J, Williams, A and Mullane, F *Domestic Abuse, Homicide and Gender: Strategies for Policy and Practice* (2014)

18.2.1. Home Group have introduced a system for logging all safeguarding incidents. The management team review this monthly at to identify any lessons learned.

18.2.2. Home Group have made Safeguarding Vulnerable Adults, and Children eLearning mandatory for all staff.

18.2.3. Home Group now have designated Housing Managers to manage around 300 properties. All Housing Managers know how to make relevant referrals to partner agencies.

18.2.4. There are now vulnerability markers on the Home Group internal housing system and diary notes are kept up to date on tenancy screens. All information is kept digitally, so can be updated and/or accessed from any location – which allows for better information sharing.

18.3. Cumbria County Council – Adult Social Care

18.3.1. Home Group staff made two referrals to Adult Social Care, one in 2013 and one 2014 which Adult Social Care do not have record of. Both referrals highlighted the poor living conditions Ruth was enduring at that time and that she was in danger of losing her tenancy. Both reports also referred to domestic abuse. Such was the procedures pre care act 2014, coupled with Ruth's reluctance to engage with the agencies, that the case was not elevated to safeguarding status but signposted to Let Go, Domestic Violence agency at the time. On both occasions the case was closed on the basis that Ruth "did not meet the requirements".

18.3.2. Since that time, CCC have changed their policy and procedures to be more proactive in engaging with victims of domestic abuse. They are members of MARAC and engage in all inter-agency communications. Staff at all levels are trained in looking for the signs of domestic abuse and not to ignore such signs. Had Ruth been referred to ASC after these changes were introduced, then her case would almost certainly have taken a higher priority.

18.4. Primary Care

18.4.1. Ruth's situation should have prompted concerned curiosity when she did not order repeat medication and did not attend follow up appointments.

18.4.2. Since the scoping period for this review, all Primary Care practices have introduced a "vulnerable family meetings" whereby individuals of concern can be discussed in a multi-professional meeting. The purpose is to share information and consider next steps to ensure they receive the appropriate care and support.

18.5. The ICB have also introduced an "Adult not Brought" process, which includes the use of a clinical flag,[43] placed on the electronic primary care system, which describes adults who miss an appointment, yet cannot attend independently due to lack of capacity or capability. This should peak concerned curiosity, and lead to discussions at the vulnerable family

[43] This is a SNOMED code

meeting. Previously, missed appointments were all coded as “did not attend” and staff could not differentiate between not attending and those who were not brought.

19. Recommendations

19.1. The following recommendations have been made by the panel following a re-write of the review. These recommendations consider the current service provision, policies and general responses to domestic abuse and self-neglect, rather than the status quo during the scope of the review.

	Paragraph	Recommendation	Organisation
1.	19.2	Ruth’s review will be developed into an accessible case study and will include a visual training tool. These resources will raise awareness of coercive control, economic abuse, and self-neglect. The resources will be shared by CSP and CSAB to partner agencies for training and will be available on their websites for all organisations to access.	Cumberland Community Safety Partnership
2.	19.3	Home Group will produce a specific self-neglect policy and will raise awareness of the CSAB escalation policy. Launch of the new policy will include training in self-neglect awareness and referral pathways and raise awareness of how to escalate concerns following safeguarding or MARAC referrals.	Home Group
3.	19.4	Professional curiosity training to be further rolled out across all partner agencies. This began in 2022, will continue and will be monitored for impact.	Cumberland Community Safety Partnership
4.	19.5	Victim Support’s Domestic Abuse Awareness training will be made widely available to partner agencies. This includes coercive control awareness, older people and domestic abuse, and homicide timeline research.	Victim Support