



Cumberland
**Community Safety
Partnership**

Cumberland Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

Under Section 9 of Domestic Violence Crime and Victims Act 2004

EXECUTIVE SUMMARY

In respect of the Death of Agnes in May 2020

Report by Bridie Anderson

Independent Chair and Author

November 2024

Family Tribute to Agnes

"We miss her. We miss that lovely northern lilt in her voice. We miss hearing that smile when we rang her.

She wasn't frightened to voice her opinion, even if it wasn't what you wanted to hear.

Her friends were few, her family was her life. She held some traditional northern views on a woman's place in life - they should be at home looking after their children.

She was a very private person and never discussed Graham's private life with us and indeed, rarely her own.

She was fiercely protective of her boys, but especially Graham as she felt he still needed her. She stuck by him and would never have betrayed him.

If she didn't want to visit you, or have visitors, she told you straight and we accepted her wishes.

She lived a frugal life and never spent much on herself but was generous to a fault with others. When she did buy something for herself she bought well, so that it would last longer. She looked beautiful on our wedding day and, more than 40 years later, she still had that complete outfit, all wrapped in tissue paper and boxed. She took great care of all her treasured possessions.

When they moved back up north there was no discussion with us. We were told they were going, decision made.

When we were told not to visit we never thought anything was wrong. We accepted their wishes, not suspecting anything was amiss. How wrong we were.

When we could no longer get any response from them we thought they had moved to the new flat that they had talked about and just not bothered to let us know. An uncle checked at the house and was told they didn't live there now.

We will never know the truth of what happened, but this report can shed more light on it.

So, tell the truth that you have found. We cannot change the past, but you can change the future and it might, just might, stop it happening to someone else."

The Domestic Homicide Review Panel and the members of the North Cumbria Community Safety Partnership would like to offer their sincere condolences to the family of Agnes, who have lost their loved one in tragic circumstances, and whose death has caused this Review to take place.

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1 THE REVIEW PROCESS

- 1.1 This summary outlines the process undertaken by Cumbria Community Safety Partnership domestic homicide review panel in reviewing the homicide of Agnes (pseudonym) who was a resident in their area.
- 1.2 This Domestic Abuse Related Death Review (DARDR) is being conducted in accordance with Section 9 of the Domestic Violence Crime and Victims Act 2004. The review was held in compliance with the legislation and follows the Guidance.
- 1.3 The Review Panel has obtained all family and perpetrator confidential documentation either on the basis of their consent, or in the absence of their consent, in the public interest.
- 1.4 The review aimed to be fearless, impartial, fair, balanced and thorough in its approach, challenging where necessary but also compassionate in the face of the tragedy which led to the review. The review had led to the creation of this evidence-based report.
- 1.5 The following pseudonyms have been in used in this review for the victim and suspected perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

Subject	Pseudonym
Deceased	Agnes
Deceased's son / suspected perpetrator	Graham
Deceased's other son	Frank
Ex-partner of suspected perpetrator	Sue
Eldest child of Sue	Sam
Youngest child of Sue	Alex

- 1.6 Any relevant addresses will be referred to only in general terms to protect the anonymity of those involved in order to comply with the Guidance.
- 1.7 Agnes and Graham lived at 'Address A' from 2005 to June 2020, however records show that Graham first became liable for council tax at the address in 2003.
- 1.8 In July 2010 Carlisle city council were notified by Graham that a joint tenancy with his mother Agnes had started with the Housing Association at a new address, 'Address B'.
- 1.9 Graham informed Carlisle City council in 2013 that he and Agnes had not actually moved into 'Address B' until 30th August 2013, leaving 'Address A' furnished but empty.
- 1.10 Agnes and Graham were both seen by professionals at 'Address A' but not at 'Address B'. In 2020 Graham informed professionals that he and Agnes had never moved to 'Address B'. Further details are included in the report.

- 1.11 Agnes was in her 90s at the time of her death. Graham was in his 60s at the time of his Agnes' death and was her son. Both Agnes and Graham were White British.
- 1.12 Criminal proceedings were not completed as the suspected perpetrator, Graham, died by suicide whilst the investigation was ongoing, and he was released on Police bail.
- 1.13 A postmortem was carried out on Agnes and the pathologist concluded that she died of blunt chest trauma. Agnes had numerous rib fractures as various stages of healing.
- 1.14 The pathologist concluded that in her opinion the majority, if not all, of the rib and sternum fractures were caused by at least three assaults where Agnes was punched, kicked or stamped on to the chest region. In particular the sternum fracture, which is an unusual injury, was more indicative of a stamp or kick than a punch.
- 1.15 The pattern and distribution of the injuries Agnes had sustained was deemed to be consistent with multiple assaults and to be inconsistent with falls. Most upsettingly the pathologist concluded that the injuries would have caused Agnes immense pain and suffering.
- 1.16 An inquest into Agnes' death was held in January 2025 and the pathologist gave evidence, as detailed above. Despite this evidence HM Coroner stated that he found it hard to get his head around the fact that Graham might have committed a series of violent assaults.
- 1.17 HM Coroner accepted the cause of Agnes' death as blunt force chest trauma, concluding that Agnes was frail, emaciated, and had severe osteoporosis. He stated that Agnes had sustained multiple rib and sternum fractures over a period of several weeks and that these eventually fatally compromised her ability to breathe.
- 1.18 The Domestic Abuse Related Death Review process began with an initial meeting of the Community Safety Partnership in May 2020, when the decision to hold a Review was agreed. All agencies that potentially had contact with Agnes and Graham prior to the point of death were contacted and asked to confirm whether they had involvement with them.
- 1.19 Ten of the agencies contacted confirmed contact with Agnes and Graham and were asked to secure their files.
- 1.20 The Chair would like to thank all those who have contributed for their time, patience and cooperation.

2 CONTRIBUTORS TO THE REVIEW

- 2.1 The following agencies made contributions to this DARDR:

Role	Organisation
IMR author	Cumbria Constabulary
DARDR Single Point of Contact	Cumbria Constabulary

DARDR Lead	Cumberland Community Safety Partnership / Cumberland Council
DARDRR Lead/ Assistant Safer Communities Manager	Westmorland and Furness Council
Service Manager, Safeguarding Adults	Carlisle City Council (now Cumberland Council)
Head of Housing, IMR author	Castles & Coasts Housing Association
Safeguarding Lead, GP	Warwick Square Group Practice
Safeguarding Designate Nurse, IMR reviewer	North Cumbria CCG
Deputy Designated Professional for Safeguarding Adults	Northeast and North Cumbria Integrated Care Board
Safeguarding Advisor, IMR author	North Cumbria Integrated Care (NCIC)
Senior Operations Manager	Victim Support
Advanced Customer Support Senior Leader, Cumbria & Lancashire District	Department for Work and Pensions
Advanced customer support lead for Cumbria and Lancashire	Department for Work and Pensions
Head of Homeless Prevention & Housing Services	Carlisle City Council (now Cumberland Council)
Domestic and Sexual Abuse Business Coordinator, Cumberland Safeguarding Hub and Children Social Care	Cumberland Council
Named Nurse for Safeguarding Adults	North Cumbria Integrated Care (NCIC)

- 2.2 All panel members and IMR authors confirmed they were independent of the subjects of this Review.
- 2.3 The individual management reviews all contained a declaration of independence by their authors, and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

3 THE REVIEW PANEL MEMBERS

- 3.1 All members of the panel and authors of the IMR's have complete independence from any subject in this review. Following careful consideration by the Review Chair and the Panel, it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview.

Name	Role	Organisation
Alison Bird	Independent Chair (Initial)	Solace
Clare Stratford / Hayley Bishop	DARDR Co-ordinator	Cumberland Community Safety Partnership / Cumberland Council
Sarah Joyce	Service Manager Safeguarding Adults	Safeguarding Adults, Cumbria County Council (now Cumberland Council)
Andrew Davis	Safeguarding Adults	Safeguarding Adults, Cumbria County Council (now Cumberland Council)
Anna Bates	Head of Housing	Castles & Coasts Housing Association
Sarah Edgar	DC, DARDR SPOC	Cumbria Constabulary
Paddy McDonnell	DI, IMR author	Cumbria Constabulary
Sarah Wydall	Professor in Criminology (Domestic abuse in later life; Domestic abuse and care that is dangerous)	Swansea University
Kate Allen	Safeguarding	North Cumbria CCG
Gemma Qi	Safeguarding Advisor	North Cumbria Integrated Care (NCIC)
Sarah Place	Senior Operations Manager	Victim Support
Tammie Rhodes	Head of Homeless Prevention & Housing Services	Carlisle City Council (now Cumberland Council)
Louise Cavanagh	Domestic and Sexual Abuse Business Coordinator, Cumberland Safeguarding Hub and Children Social Care	Cumberland Council
Katy Driver	Advanced customer support lead for Cumbria and Lancashire District	Department for Work and Pensions
Kelly Marsden	Named Nurse for Safeguarding Adults	North Cumbria Integrated Care (NCIC)

- 3.2 The CSP review meeting was held on 29th July 2020. Following agreement that this case met the criteria for a Domestic Homicide Review (now known as a Domestic Abuse Related Death Review) an independent Chair was commissioned.

- 3.3 The Review panel met a number of times, and the family attended some of the early panel meetings. All panel meetings were conducted online and took place on the following dates; 19th May 2021, 7th July 2021, 27th February 2023 and 23rd April 2024.
- 3.4 Thanks are extended to all who have assisted and contributed to this review with their valued time and cooperation.

4 CHAIR AND AUTHOR OF THE OVERVIEW REPORT

- 4.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 set out the requirements for review chairs and authors. In this case the chair and author were the same person.
- 4.2 Bridie Anderson was commissioned by Cumberland CSP to independently chair this DHR and author the Overview Report following the previous DHR Chair needing to step down for medical reasons. Bridie successfully completed the 'Conducting a domestic homicide review: online learning' course from the Home Office and the 'AAFDA DHR Chair Training' in July 2021.
- 4.3 Bridie is/has been commissioned as an Independent Chair and Report Author for a total of 7 DHRs across the UK since completing her training.
- 4.4 Bridie is currently commissioned by specialist domestic abuse charity ESDAS to provide service manager support, multi-agency training, MARAC attendance and Chairing. Bridie regularly completes IMRs and chronologies for DHRs and SARs in Surrey on behalf of ESDAS. These have included deaths by both suicide and homicide.
- 4.5 Bridie is a former police officer having served across two different forces before leaving the service in 2020. For the last 8 years of her service with Surrey Police, Bridie was the Surrey Police 'Force Advisor for Domestic Abuse, Stalking & Harassment' in the Public Protection Support Unit.
- 4.6 This role allowed Bridie to develop a range of specialist skills, training and qualifications in the complex and challenging area of Public Protection. It allowed opportunities for Bridie to work closely with numerous statutory agencies and NGOs to better understand a 360-degree perspective of domestic abuse, the experience of victims and the behaviour of perpetrators.
- 4.7 Bridie was the substantive panel member for Surrey's DHRs/SARs, representing Surrey Police.

- 4.8 Bridie is a qualified and practiced Family liaison Officer (FLO) having worked in this role with Hertfordshire Constabulary, supporting bereaved families in an investigative role for both traffic and crime fatalities in several tragic cases.
- 4.9 Bridie is a trained DASH RIC Risk assessor/trainer, Stalking Risk Profile Risk Assessor, Mental Health First Aider and MARAC Chair.
- 4.10 Bridie has not worked for any agency involved in this Review and is fully independent of, and has no connection to, the North Cumbria Community Safety Partnership.

5 TERMS OF REFERENCE FOR THE REVIEW

5.1 Key Lines of Inquiry

5.2 In order to critically analyse the incident and the agencies' responses to Agnes and/or Graham, this review considered the following points and were asked to analyse:

- the communication, procedures and discussions, which took place within and between agencies;
- the co-operation between different agencies involved with Agnes and Graham;
- the opportunity for agencies to identify and assess domestic abuse risk with special regard to domestic abuse in later life. If domestic abuse was not known about, then to consider how the agency might have identified the existence of domestic abuse from other issues presented to them. Consider if there were policies and procedures in place for direct, routine or clinical questioning on domestic abuse and how they were followed in this case.
- Agency responses to any identification of domestic abuse issues including the nature of assessments, decision making and responses and whether they met the expected standards of practice and procedures.
- Organisations' access to specialist domestic abuse agencies, with special regard to domestic abuse in later life.
- How well-equipped practitioners were in responding to domestic abuse. How staff were supported to respond to issues of domestic abuse through policies, procedures, training, supervision, management and sufficient resources available at the time.

5.3 Analysis should pay particular attention to the following issues:

- Age of victim
- Financial Abuse
- Coercive and Controlling Behaviour

- Agnes and Graham's relationship as mother and son
- Graham as "carer" for Agnes
- Mental Health & Physical Health

6 SUMMARY CHRONOLOGY

- 6.1 This section provides a summary of the key facts from the background and combined chronology of agency interaction with Agnes, Graham including what was done or agreed. This summary aims to give context to Agnes and Graham's story and for the key issues arising from the review.
- 6.2 This Review considered agency's contact/involvement with Agnes and Graham from 2005 to 2020. The reason this date range was chosen is because it marks the year that Graham and Agnes returned to Carlisle from living nearer family in the midlands and when their contact with family started to significantly reduce.
- 6.3 Some information provided to the panel has also been included in order to provide relevant background and context for the events within the scope period.
- 6.4 **Pre scope relevant information; 1990's – 2005**
- 6.5 In the 1990s to the early 2000s Graham lived in a four-storey house in the midlands with his mother Agnes and his father, Agnes' husband.
- 6.6 Graham began an intimate relationship with Sue and after about 18 months together, Sue and her two children from a previous relationship, Sam and Alex, moved into the family home with Graham.
- 6.7 As part of the homicide investigation Cumbria police interviewed Sue, Sam and Alex and the following information is drawn from their testimonies.
- 6.8 Sue describes Graham as being a 'prince charming' and sweeping her off her feet when they first met. He offered her the world and promised to look after her, he was also very attractive.
- 6.9 Not long after moving in with Graham, Sue noted a change in his behaviour towards her and his controlling nature came to the fore. He was obsessed with cleanliness and order and expected Sue and the children to follow the very strict rules he set. If these rules were broken, he would get angry and violent.
- 6.10 Sue describes the violence from Graham as disparate incidents at first, but by the end of their relationship, which lasted over a decade, she describes herself as being his 'punchbag'; being hit on a weekly basis, mainly at weekends.

- 6.11 Graham would drink heavily and regularly and this would escalate his violence and aggression in the home, not just towards Sue, but towards the two children.
- 6.12 Graham would dictate what Sue was to wear, when she could go out and who she could and couldn't see. This control extended to his stepchildren, who describe being grounded more than allowed out and isolated from friends and family as Graham would not allow anyone over to the house.
- 6.13 Sue describes being 'petrified' of Graham and would often hide herself and the children in rolls of carpet in the loft when he returned from the pub of an evening to escape his temper and violent outbursts which Sue, Sam and Alex describe as having become 'the norm'.
- 6.14 Graham perpetrated numerous injurious assaults on Sue, including kicking her down the stairs causing her a broken foot, throwing objects including a heavy glass ashtray at her head, stabbing her behind the ear with a fork, kicking her to the face, dragging her around by her hair, punching her to the head and threatening her with knives.
- 6.15 Sam and Alex were often present and directly involved in Graham's attacks on their mother and recall intervening protectively and getting injured themselves when as young as 12 years old.
- 6.16 Sue felt that she became 'broken' during the relationship and did not disclose to anyone the abuse she was suffering as she felt they wouldn't believe her. She recalls Agnes did not challenge or intervene when Graham was violent, and believes whilst she loved him dearly, Agnes was also living in fear of her son.
- 6.17 Sue and the children all describe Agnes being scared of Graham. She did everything for him, cooking, cleaning, ironing, and even if he didn't get home until 3am, she would still get up and cook him a meal. They recall Graham shouting at Agnes a lot and Sam remembers one occasion of Graham slapping Agnes across the face. Agnes had been trying to stop him arguing with Sue and this was Graham's response. Agnes did not react; she simply took herself out of the room.
- 6.18 Sue and the children describe Graham as being a 'ticking time bomb' and all of them recount their experience like 'walking on eggshells', never knowing what may set Graham off or turn him to anger and violence.
- 6.19 Sue eventually escaped Graham and moved out with the children to a location unknown to him. In the years after leaving him she and the children, now adults, had encountered him in pubs on occasion and he would threaten and use violence towards them regardless of the public environment.
- 6.20 Sue, Sam and Alex all report living with the trauma from this period of their lives and say it still affects them all to one degree or another some 30 years on.

- 6.21 Whilst outside of the scope of the Review time period, this is significant information to include as it demonstrates Graham's propensity towards anger, controlling behaviour and extreme violence within the home. It also gives context to the relationship between Agnes and Graham and demonstrates how, decades before her death, she was potentially living in fear of her son and normalising, even excusing his volatile and dangerous nature.
- 6.22 **Scope of review 2005 – 2020;**
- 6.23 **2005** Graham and Agnes move from the midlands back up to Carlisle, where they were originally from. Graham purchases Address A with the help of a mortgage and lived there with Agnes until her death. Frank and his wife live in the midlands and so see less of Graham and Agnes from this point.
- 6.24 **2006** Police have contact from Graham for a parking matter which is unrelated to this review but indicates that he was living at Address A at this point in time. Agnes begins receiving Attendance allowance. Attendance allowance is a benefit to help with extra costs if someone has a disability severe enough that they need someone to help look after them. This indicates that Agnes may have had some care and support needs.
- 6.25 **2007** It was established by the DWP that Agnes was not entitled to the extra amount of Attendance Allowance for Severe Disability as she lived in her son's household and one of the qualifying criteria is that the recipient must live alone. This indicates they were living together in Carlisle.
- 6.26 **2008** Agnes received the flu vaccine, but despite annual invites, she never again attends to receive one, records show that Agnes indicated the vaccine made her poorly.
- 6.27 **2009** Castles and Coasts housing association (CCHA) (then, and up until 2017, known as "Two Castles") receive an application for housing from Graham and Agnes.
- 6.28 **2010** CCHA confirm that a tenancy agreement on Address B will commence in relation to Graham and Agnes on 05.07.10.
- 6.29 Carlisle city council are notified by Graham and Agnes that a joint tenancy has started with Castles and Coasts Housing Association at a new address, Address B. It is not believed that they moved into this address as it was not until 2013 that Graham informed Carlisle City Council's Revenues and Benefits Services that he and Agnes were moving in.
- 6.30 Letter from Housing Officer sent to CCHA advising of complaints about Address B not being lived in/used as principal home. There is no record that any response was ever made to this information, or any action taken in relation to it by CCHA.

- 6.31 **October 2010** Third party report to police relating to concerns for Graham and his 'elderly mother' (Agnes), nonspecific but concerns around risk to her as she lived with him and he had been threatened, so request made for police to conduct a welfare check at their home address.
- 6.32 Police attended Address A several times but still no answer. They left notes for Graham asking him to call in to police but took no further action and Graham never called in.
- 6.33 **2011** Graham calls CCHA to say that he has moved into Address B and will contact the local authority to let them know.
- 6.34 Agnes is seen by the GP due to a condition called pruritus ani. It is noteworthy as it can be caused by ongoing diarrhoea or infections. The following month Agnes is again seen by her GP due to a middle ear infection.
- 6.35 **2012** Agnes has a standard chest x-ray, and mild COPD¹ is noted as well as a hiatus hernia. Agnes attends several a respiratory medicine clinic appointments, accompanied by Graham.
- 6.36 CCHA receive a report that Address B looked untidy and empty. A visit is made to Address B by CCHA to investigate. CCHA record a 'File Note' stating that Graham never moved in to Address B as 'his mother was too ill'.
- 6.37 CCHA contact Graham regarding the status of Address B and he is described as angry as 'he did not understand why they were chasing him as he was paying the rent'. Graham informed CCHA that he hoped to move in to Address B in July 2012 with his mother, and if not agreed that the tenancy would end.
- 6.38 Graham did not attend the arranged appointment with CCHA to discuss the tenancy at Address B and is sent a termination letter. The letter advised that the tenancy would be ended the following month.
- 6.39 Graham called CCHA and claimed to have no recollection of earlier conversation about the tenancy on Address B and said that he did not want to terminate it. He said he would pay 2 weeks rent and advise them when he would be moving in. The tenancy for Graham and Agnes at Address B was therefore reinstated.
- 6.40 Call to Cumbria Constabulary from workman at a neighbouring property to Address A claiming a male from the address was being threatening, abusive and aggressive towards them. A check on the listed occupants of Address A was carried out which

¹ Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties. COPD is a common condition that mainly affects middle-aged or older adults who smoke. Many people do not realise they have it. The breathing problems tend to get gradually worse over time and can limit your normal activities, although treatment can help keep the condition under control.
<https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/>

listed Graham and a female as living there. A PCSO went to the area but did not speak to anyone from Address A and the incident was closed with no further action or enquiry.

- 6.41 Agnes' clinic appointment with Respiratory medicine was cancelled by 'patient', unclear if this was Agnes or Graham on her behalf. The clinic notified Agnes' GP. Agnes then missed an appointment booked for her at the respiratory medicine, the clinic again notified her GP.
- 6.42 **2013** CCHA send letter to Address B requesting Graham and Agnes contact them in relation to non-occupancy. Graham, however, claims in a later council tax declaration form that he and Agnes moved out of Address A and into Address B in August 2013.
- 6.43 **2014** Graham completes a council tax declaration form stating that Address B had been empty until 30th August 2013 when both he and Agnes moved into the property. Graham stated he was a carer for Agnes and advised that the other property Graham owned in Carlisle, Address A, was furnished but empty.
- 6.44 **2015** Frank travels up unannounced to Carlisle by train and visits Graham and Agnes at Address A as all attempts to arrange a visit have all been rebuffed. He describes the house being in a bit of a mess, still some unpacked bags around, but generally fine.
- 6.45 **2016** Graham attended A&E at Cumberland Infirmary via ambulance due to a head injury sustained following alcohol consumption. Graham stated he had fallen backwards and banged his head. Graham had a laceration and described possible loss of consciousness.
- 6.46 Graham subsequently left the hospital prior to having a CT scan and treatment. A&E staff contacted rapid response to attempt to locate him, but they got no answer at his home address. At 19.50 hours Cumbria Constabulary were contacted and were asked to perform welfare check as the hospital had been unable to locate Graham, but this was declined as it was deemed not to be a Police matter.
- 6.47 **2017** Cumbria Constabulary receive a call with concerns for Agnes from a neighbour of Address A. They report that Graham had been verbally abusive to Agnes 3 days earlier, he had been heard shouting; *"YOU FUCKING BITCH, I FUCKING HATE COMING HERE AND NOT BEING ABLE TO SEE MY GIRLFRIEND"*.
- 6.48 The neighbour believed that the son worked away from home and returned every few weeks to see his mother. Police attended and saw Agnes from the doorstep as Graham refused them entry. Police simply recorded this as a 'malicious call' and the attending officer reported 'no concerns'.

- 6.49 **November 2017** A neighbour of Address A calls police due to hearing noise, banging, shouting and a possible domestic at Address A. Graham did not allow officers to enter, so Section 17 PACE² was enacted when Graham suddenly then showed up at window, initially angry, and described self as property owner. He said he lived with his elderly mother.
- 6.50 Graham was aggressive and confrontational and referred to himself as Agnes' registered carer.
- 6.51 Graham reports he was 'evicting 2 lodgers' due to non-payment of rent and them smoking weed. Agnes spoken to by police but not assessed as at risk. She was described as alert, hard of hearing but able to understand why police were there. No further police action was taken.
- 6.52 **2018** Graham telephoned Agnes' GP surgery after '*attempting to treat her back pain*'. This call resulted in Agnes attending A&E at Cumbria Infirmary, via ambulance for lower back pain.
- 6.53 Less than 4 hours later Agnes was discharged with patient transport and referred to her GP for management. No evidence of mistreatment or domestic abuse was found or recorded during this contact by professionals. An x-ray completed on this visit diagnosed Agnes with osteoarthritis.
- 6.54 Graham visits the CCHA office to request a rent statement and the fitting of a stairlift for his mother at Address B. He was advised that an occupational therapy review would be needed initially to assess Agnes prior to such an aid being fitted.
- 6.55 **2019** Graham again visits the CCHA office to request a rent statement and the fitting of a stairlift for his mother at Address B. He was advised, again, that an occupational therapy review would be needed initially to assess Agnes before a stairlift could be fitted.
- 6.56 CCHA received a query from a contractor asking if Address B was 'void' as they had seen a padlock on the external side of the front door. CCHA confirm the property is not 'void' and that they will send a letter to the registered occupants.
- 6.57 The practice manager from Agnes' GP surgery called the Police to raise concerns about Agnes as she was last in contact with the surgery on 19th February 2018, 14 months previously and in January 2019 her medication had been due for review by a GP. Phone calls and house visits had been made by the practice but Agnes was never seen/spoken to.

² Section 17 PACE 1984 (<https://www.legislation.gov.uk/ukpga/1984/60/section/17>)

- 6.58 Police officers attended Agnes' address and managed to speak with Graham after numerous attempts of knocking at the door and windows. Graham refused entry to the officers and was described as 'very agitated'.
- 6.59 Officers gained entry to the address using powers under Section 17 PACE. Upon entering they report seeing Agnes sat on the sofa, eating a meal that Graham had prepared for her.
- 6.60 Agnes said she was well and not scared and didn't want to engage with officers. She swore at the officers and told them to leave. Because Agnes was angry at the officers being there, they left.
- 6.61 Graham calls CCHA and requests a shower and stair lift for his mother at Address B, for a third time he is told he will need to request an Occupational Therapy (OT) assessment via the GP before this can happen.
- 6.62 A response to the annual exemption review form was received from Graham stating that Address A was furnished and occupied by both he and Agnes and had been since 2004. The officer reading the form assumed this was a mistake and that the two properties had been mixed up; the officer referred this case to a visiting officer to clarify the position.
- 6.63 At the end of the year the Revenues and Benefits department visiting officer attended both of Graham's addresses, Address A and Address B, with no reply at either address, contact cards were left at both properties.
- 6.64 The Carlisle City Council Revenues and Benefits department visiting officer attended both Address A and Address B again and had no response at either address. This officer noted that both properties 'appeared unoccupied'. In order to make further enquiries, the visiting officer spoke to a neighbour at Address B who stated she had not seen the lady who lived there for several years but that a man visited the address on occasion, though she had never spoken to him.
- 6.65 CCC then notified CCHA of this visit and that a large grey bolt was seen on the external door and that neighbours report the property had not been occupied for months. At the time of this report, CCHA check and see that the rent account on the property was £848.52 in credit.
- 6.66 **2020** Graham left a voicemail message for the Revenues and Benefits department visiting officer apologising for not being in touch and stating he would call back to explain what was going on with the two properties. No further calls were received from Graham following this, however.
- 6.67 UK goes in lockdown due to the COVID19 pandemic in March.

- 6.68 In March Adult Social Care (ASC) received a report raising concerns for 'the elderly lady' at Address A. ASC state that their informant told them that the son used to live with her but had moved out and not been seen for some months. Police were informed and were asked to complete a welfare check.
- 6.69 Police attended and Graham answered the door and initially refused police entry. He was described as very agitated. Entry past Graham had to be forced under Section 17 PACE.
- 6.70 Agnes was located upstairs, in bed, watching TV. No concerns for her were identified by the attending officers. Graham was described as not cooperating, being abusive, and swearing at officers.
- 6.71 A medium risk 'Vulnerable Adult' Safeguarding Form (SAF) was completed by officers who attended and was reviewed in the Safeguarding Hub and shared with ASC.
- 6.72 ASC receive the Police referral following their visit and it was screened by a Social Worker and closed with no further action.
- 6.73 CCHA attempt to contact Graham and Agnes for a welfare check multiple times over the phone with no response. They also send out a 'welfare check' letter to Address B. This is during the first UK lockdown due to the COVID19 pandemic.
- 6.74 In **May 2020** Graham attended his GP surgery and stated that his mother, Agnes, had been deceased since Easter (*Easter Sunday was 12th April in 2020*). He went on to say that Agnes was now decomposing at their home, Address A. Graham said he had pulled the blanket back covering her and has seen this. The GP surgery called this into Cumbria Constabulary and stated that Graham did not have any mental health issues, and that Agnes was registered with the surgery.
- 6.75 They explained that Agnes had not been seen by the practice since **February 2018** or been in contact with them for some time, so they had written her letters and phoned her but not had any replies. Graham said he had not told anyone else about Agnes having died.
- 6.76 Cumbria Constabulary attended Address A and Graham has opened the door to them. The house was very messy, Agnes was found deceased, decomposing and lying on the floor on some cushions.
- 6.77 Graham stated that his mother had died a couple of weeks earlier. There was a sleeping bag next to Agnes' body on the floor and Graham said he could not come to terms with her passing and described how he had been sleeping next to her.
- 6.78 Graham stated that his mother had been unwell 4 months prior to her death (*making it early January 2020*) and said that they had not sought medical attention.

- 6.79 Graham was arrested on suspicion of preventing the lawful and decent burial of a dead body. When Graham was taken to custody following his arrest, he told the custody Liaison & Diversion (L&D) team worker that he was taking antidepressant medication which had been prescribed many years ago due to a breakup with his partner in the midlands.
- 6.80 He highlighted he was having financial issues, saying that he owned Address A but that he had not paid the mortgage in approximately 18 months despite getting letters from the mortgage company.
- 6.81 The following day due to information from the post mortem conducted on Agnes which suggested she died from blunt force chest trauma; Graham was arrested on suspicion of her murder. He denied killing or harming Agnes in any way and chose to provide 'no comment' during some of his police interviews. Graham speculated that Agnes sustained her cumulative and eventually fatal injuries through falls or when he was placing her on the commode.
- 6.82 Graham was released on conditional Police Bail until June 2020 and required to sign on at his local police station the following day (Saturday) and every Tuesday and Saturday until his bail return date.
- 6.83 The day after his release from custody Police found Graham deceased at Address A by suspected suicide, he had left a note. In this note he claimed to have loved his mother and not harmed her.

7 KEY ISSUES ARISING FROM THE REVIEW

- 7.1 The key issues that have presented throughout this lengthy and detailed Review process are listed below and relate to cross-professional/organisational concerns identified by the panel and family;
- Lack of identification, awareness and understanding around the dynamics and risks of familial domestic abuse (DA).
 - Lack of identification, awareness and understanding around DA experienced by those in later life.
 - Lack of professional curiosity and appropriate challenge; presence of over optimism/assumption by professionals.
 - Lack of identification and consideration of coercive control involving isolation and financial abuse.
 - Lack of understanding of duties were under the Care Act 2014 regarding adults at risk.

- 7.2 These issues presented barriers to Agnes and Graham accessing support and to being adequately seen, heard and understood in a trauma-informed and person-focused way. A complete picture of their lives, needs and the risks inherent within their relationship was therefore never fully understood by professionals.

8 CONCLUSIONS

- 8.1 This section of the report brings together an overview of the main issues identified, and conclusions drawn from them which will translate into the detailing of lessons learnt in the next section.
- 8.2 Agnes suffered a drawn out, painful and extremely challenging death. She was a victim of suspected injurious assaults perpetrated by her sole carer, her adult son Graham. She was experiencing multiple, co-occurring health conditions which greatly impacted on her ability to provide any self-care and was thus reliant on Graham for almost everything.
- 8.3 Agnes was isolated from family members and professionals by Graham over many years; he refused entry to anyone requesting they see and speak with her, including police, and even lied to her GP practice in telling them that she had moved out of the area.
- 8.4 Before his own death by suicide, Graham did not provide any explanation for these lies or explain why he refused both professionals and family access to Agnes on multiple occasions or why he did not seek medical treatment for her despite claiming that her health had been deteriorating since January 2020.
- 8.5 A lack of professional curiosity was shown around the wellbeing and care and support needs of those who may be vulnerable to abuse such as Agnes, across agencies.
- 8.6 Agnes was never seen by police without Graham being in the address and no questions were asked of her that focused on coercive control or domestic abuse; she was seen primarily as an older person being looked after by her son, rather than a potential victim of domestic abuse at risk of serious harm.
- 8.7 The links between domestic abuse and abuse of those in later life were not demonstrably understood by any agency involved in contact with Agnes as no recognition or reference to them were provided in the information seen by the panel or indicated by any of the actions taken.
- 8.8 Had professional curiosity and better information sharing been employed in this case, it is possible that Agnes may have been able to be properly assessed, both medically and by a social worker, and her poor state of health and various care and support needs addressed prior to her death.

8.9 In an inspection report by HMICFRS³ in 2019⁴ concerns about adult safeguarding arrangements were identified. The below extract from the report highlights some of the findings which are pertinent to this Review.

8.10 *“In this inspection, for the first time, we assessed adult safeguarding arrangements. Our findings are of grave concern. Adult safeguarding was described to us as the ‘poor relation’ of safeguarding arrangements, with inconsistent local partnership work to consider what protections or support might need to be put in place for vulnerable adults.*

Forces told us of a focus on children over adults, and we found a lack of understanding of what their duties were under the Care Act 2014 regarding adults at risk.

We found that from national policy and training, through to safeguarding practice in forces, much work is needed to make sure that older people, and adults at risk more generally, receive a consistently good service, and that the police work effectively with others.

The Care Act 2014 placed statutory safeguarding duties on the police for the first time. As a result, the police are required to work with local authorities and clinical commissioning groups to safeguard any adult who:

- *has needs for care and support (whether or not the authority is meeting any of those needs);*
- *is experiencing, or is at risk of, abuse or neglect; and*
- *as a result of those needs is unable to protect himself or herself against abuse or neglect or the risk of it.*

The police don’t always identify older people who need safeguarding. They don’t always share information in effective ways, and sometimes they don’t work very well in partnership with other organisations offering help and support.

Some of these problems aren’t the sole responsibility of the police. We found some reluctance from partners to become as fully involved with the police in adult safeguarding arrangements as they are in those for children. This is unacceptable.”⁵

8.11 This extract seems truly relevant to this review and helps focus the learning identified onto improving adult safeguarding arrangements across all agencies, particularly when people in later life and with care and support needs are involved.

³ Her Majesty’s Inspectorate of Constabularies and Fire and Rescue Services.

⁴ <https://assets-hmicfrs.justiceinspectores.gov.uk/uploads/crimes-against-older-people.pdf>

⁵ <https://assets-hmicfrs.justiceinspectores.gov.uk/uploads/crimes-against-older-people.pdf>

- 8.12 With such little direct evidence to really understand what Agnes and Graham's life was like, the panel have had to rely on the evidence presented by witnesses, family and professionals throughout the course of this Review. This information points to several key facts that can be reasonably deducted;
- a. Graham had a history of perpetrating domestic violence and abuse against an intimate partner and stepchildren. He demonstrated a propensity to anger, control, and violence which escalated when he consumed alcohol.
 - b. Graham deliberately and repeatedly isolated Agnes from all family, neighbours and professionals increasingly over many years.
 - c. Graham was financially abusing Agnes by spending her money rather than his own and failing to make mortgage payments on the house he lived in with Agnes.
 - d. Graham declared himself as Agnes' sole carer yet left her alone for long periods of time. He neglected her basic needs including nutrition and hygiene and a safe home environment.
 - e. Graham failed to seek necessary medical treatment for Agnes despite him acknowledging her deteriorating health.
 - f. Agnes was vulnerable due to her age, multiple health conditions which impacted her mobility, strength and self-efficacy; she was entirely reliant on Graham to meet her all of her needs, which he failed to do.
 - g. Graham caused multiple injuries to Agnes over a period of months through suspected intentional assaults causing her cumulative injuries which eventually resulted in her death.

9 LEARNING IDENTIFIED

- 9.1 What follows is a summary of lessons which are to be drawn from this case and how those lessons were translated into recommendations for action.
- 9.2 All early learning identified during the review process is detailed here along with whether this has already been acted upon.
- 9.3 Due to the time between Agnes' death and the Review completion, the vast majority of actions which were identified were completed prior to report submission, as part of the Review process. The summary has been divided into subheadings by agency.
- 9.4 **Victim Support**
- 9.5 Victim Support Cumbria identified that primary care settings would benefit from additional training and tools to help identify domestic abuse. They are currently in liaison with a GP surgery in North Cumberland to implement a shorter triage risk assessment process for completion with patients. Professor Jane Monckton Smith's

'5 critical questions risk assessment'⁶ was the basis for the development of a triage risk assessment tool⁷ for anyone who declined to complete a full DASH (27 questions).

9.6 Once completed with either a GP or a Safeguarding nurse at the surgery, the hope is to bring in an IDVA on a set surgery date to meet and complete a more comprehensive risk assessment with any patients the surgery has identified as at risk of harm due to Domestic Abuse.

9.7 This remains in the planning stage at time of writing but promises innovative practice in accessibility and availability of DA specialist support from a primary health perspective.

9.8 **Adult Social Care (ASC)**

9.9 The scope of involvement with Agnes was limited to a request for police to complete a welfare check following reports from a concerned neighbour, who hadn't seen Agnes for months. Graham was not known to ASC.

9.10 ASC has taken some practice learning and reflections from their involvement and have made some internal points of learning, to be implemented through the Cumbria County Council Adult Social Care Practice Learning Group.

9.11 This resulted in a reflective learning session which was facilitated by former Cumbria County Council Principal Social Worker Officer with practitioner's involved at the time. The session explored;

- the 2014 Care Act duties of Section 9⁸ and Section 11⁹
- the role of carers,
- the importance of exploring carer's needs and
- the need for application of professional curiosity around potential of familial older person's abuse.

9.12 A welfare visit was undertaken by the police on 31.03.20 and Agnes was found to be '*safe and well in bed*'. The police report notes that it did not look like Agnes was being neglected. The police report was shared with the ASC duty worker who decided, based on the information provided, that no further action was required.

9.13 Due to this event learning was identified that staff needed a better awareness of abuse of people in later life and a Practice Learning Group internal monthly bulletin

⁶ 1. Is this a pattern of behaviour? 2. Is this making you/someone change their behaviour? 3. Is this making you/someone afraid? 4. Has there been any kind of physical abuse or violence? 5. Is there a separation?

⁷ <https://www.cumbria.gov.uk/eLibrary/Content/Internet/537/6683/6687/7008/38413/4485912455.docx>

⁸ Section 9 of the Care Act 2014 requires local authorities to assess people who may need care and support. This assessment is called a needs assessment.

⁹ Section 11 of the Care Act 2014 outlines what happens when an adult or carer refuses to have an assessment.

briefing highlighted awareness of Abuse in the older population was published. At the same time the DASH risk assessment tool was updated to emphasise focus on older people.

- 9.14 The outcome of the police welfare visit did not enable ASC to fully discharge their duties under the Care Act, as there was no follow up offer of a Care Act assessment or, Carer's assessment. This highlighted that there should be a clear distinction between a police 'welfare visit', which is not the duty of the local authority and a 'Care Act assessment' which is to offer a Care Act assessment to anyone who appears to require care and support, regardless of their likely eligibility for state funded care.
- 9.15 During this review period a 'First Contact Guidance' was developed and implemented. This guidance supports Single Point of Access (SPA) officers and duty professional practitioners around decision making on offering and pursuing an assessment where consent is not provided. As well as outlining the need for face to face visits, where neglect or self-neglect may be a feature, as per self-neglect strategy.
- 9.16 It is necessary to ascertain whether each referral and, in this case, the Safeguarding Adult Form (SAF), indicated any 'needs for care and support'. Whilst the SAF for Agnes did not indicate this explicitly, the 'Family carer' and 'cared for' relationship should have been considered. It would also be important for the SAF to clearly indicate whether the adult has any care and support needs or identify any safeguarding concerns. Neither of these were explicitly stated on the SAF.
- 9.17 A new Self neglect strategy¹⁰ has been developed and several interactive sessions delivered by Advanced Practice Leads to support the implementation of the strategy across frontline practitioners.
- 9.18 The date of the SAF is important as it was at a time when face to face visits were limited and thus being prioritised by need, due to the associated risks around the COVID 19 pandemic. Therefore, this is likely to have had an impact on the offer of an assessment, coupled with the outcome from the police welfare visit highlighting no concerns. However, initial enquiries into care and support needs could have been made by ASC remotely, either by telephone or, by other virtual means.
- 9.19 An ASC presentation delivered in March 2022 to the Police Safeguarding Hub aimed to enhance the quality of information shared on the SAF. This included guidance on the identification of 'Care Act eligible needs' and when to make a safeguarding adults referral.

¹⁰ <https://www.cumbria.gov.uk/eLibrary/Content/Internet/327/949/43214103754.pdf>

9.20 **North Cumbria Integrated Care Board (NCIC)**

- 9.21 At the start of this Review process NCIC recognised that a focus needed to be brought to ensure the increased use of routine enquiry when attending their services.
- 9.22 The implementation of routine enquiry for all patients attending the emergency care department was needed, alongside improvements in identifying, signposting and supporting victims.
- 9.23 Four years on, at the completion of the Report, vast progress has been made by the NCIC and partners, this is detailed below.
- 9.24 NCIC have developed a routine enquiry project, and DA training package called “*how safe do you feel?*” which was formulated in response to the significant amount of domestic abuse related deaths in Cumbria.
- 9.25 “How safe do you feel?” is based around normalising asking people about their safety in the same way as health professionals ask about other aspects of people’s lives.
- 9.26 NCIC have embedded a routine enquiry pilot into all accident and emergency departments as well as all integrated community services. These areas were chosen to pilot the initiative as are the ‘front door services’ where a spike in DA cases involving older adults within the community had been noted.
- 9.27 There are four questions which form part of the assessment, these are;
- How safe do you feel (framing questions)?
 - Do you have caring responsibility for anyone on a regular basis? For example, wife / daughter/ grandchildren.
 - Does anyone care for you on a regular basis? For example, spouse / child / neighbour / friend.
 - What services are you open to, or which professionals support you?
- 9.26 NCIC also developed a package alongside the communications team which incorporated both patient and staff facing promotion of the campaign as well as having coverage in local press promoting NCIC services as a safe space to seek support for this experiencing abuse.
- 9.27 The training was put in place to give NCIC colleagues the tools to be able to complete routine enquiry and recognise and respond to survivors whilst ensuring they provide support and make referrals to specialist services.

- 9.28 The training is a multi-agency led offering incorporating police, Women’s community matters, Victim Support and NCIC.
- 9.29 It is a full day session covering the “how safe do you feel?” campaign and the reasons the project was created.
- 9.30 NCIC also now deliver an interactive ‘victim’s voice’ session called “Sadie’s story” and talk about support for not only patients but colleagues recognising that health professionals are disproportionately affected by DA.
- 9.31 NCIC also introduced an ‘employers toolkit’ which was created to support colleagues experiencing abuse to remain in work whilst promoting their safety. This includes a work-based safety plan which has proven very effective in promoting colleagues safety and welfare and helping them feel empowered within the workplace.
- 9.32 A representative from ‘Women’s community matters’ then covers what domestic abuse is, the Domestic Abuse Act 2021¹¹, signs and prevalence, trauma-informed approaches, perpetrator behaviours and the 8 Stage Homicide Timeline.¹²
- 9.33 Victim Support representatives then cover victim advocacy and the role Victim Support play, safety planning, ‘Turning the spotlight’ and perpetrator management, disruption and information on their children and young people services and referral routes.
- 9.34 Police representatives then support with covering information around the VAWG agenda, control and coercion, so called ‘honour’ based abuse, Domestic Violence Disclosure Scheme (DVDS), Domestic Violence Protection Orders (DVPOs), information sharing and the police role in managing risk.
- 9.35 The sessions cover a wide range of subjects and have been well received by delegates. NCIC have, as of June 2024, delivered this training to over 800 employees including GPs and other trusts who have attended with the aim of adopting the model.
- 9.36 Feedback from the training sessions also led to NCIC commissioning Victim Support Cumbria to deliver two Domestic Abuse Stalking Harassment & Honour based abuse Risk Indicator Checklist (DASH) training sessions. These took place in November 2023 and saw around 30 health professionals attend across two hospital sites.
- 9.37 NCIC have adopted the Victim Support version of the DASH risk assessment which incorporates the homicide timeline.
- 9.38 **Castles and Coasts Housing Association (CCHA)**
- 9.39 Early learning identified from this Review and following recommendations from a previous DHR both Safeguarding and Domestic Abuse cases are shared as case

¹¹ <https://www.legislation.gov.uk/ukpga/2021/17/contents>

¹² <https://www.homicidetimeline.co.uk/what-is-the-homicide-timeline.php>

studies during bi-monthly safeguarding meetings to ensure lessons are learned and knowledge / best practice is shared.

- 9.40 All CCHA staff must now complete annual online Safeguarding training levels 1 and 2. CCHA are commencing the process for DAHA accreditation.
- 9.41 When a gas service is carried out at a CCHA property now, the contractor is made aware of how to make a Safeguarding referral and CCHA are working on a new 'good practice process', which has already been implemented by Northumberland County Council, where upon the completion of any repair within a property, the contractor is not able to complete the job on the system until they have answered either 'everything seems ok' or 'something is not right'. CCHA has a Safeguarding Team who work on a duty rota basis to pick these referrals up.
- 9.42 Whilst the CCHA property in this case was a General Needs tenancy, with no care and support package, CCHA do have a trained Safeguarding Team in place now with a Safeguarding Champion in each department across the organisation. They also have two dedicated Tenancy Sustainment and Safeguarding roles, who deal with complex tenancies, and CCHA state that if this case were to happen today, there would be enough flags on the property that it would have been looked into further.
- 9.43 In 2019, whilst there were policies in place which were not followed, and this was dealt with through an HR process, CCHA do now have a lot of additional measures in place to identify and support complex tenancy issues.
- 9.44 **Warwick Square Group Practice**
- 9.45 The Practice did not use a routine enquiry approach when they had contact with Agnes. It is not used in Primary Care within Cumbria. No signs of domestic abuse were picked up by any of the Practice staff.
- 9.46 The Practice intend to introduce routine enquiry with an emphasis of asking the question without the carer / relative present.
- 9.47 The Practice were aware of signs of self-neglect and how to raise safeguarding concerns and there was evidence that they had reported a concern when it was noted that they had not seen Agnes for a period of time.
- 9.48 The team did raise a safeguarding concern, however when feedback was not received in relation to the concern, they did not routinely follow this up. The practice plans to establish and embed a routine request for feedback from referrals to safeguarding and adult social care.
- 9.49 The practice plan to continue using case studies within training which reaches all Practice staff.
- 9.50 Another lesson identified was to focus on is strengthening relationships with Primary Care admin and Practice managers via the existing networks to raise awareness of support and help options.

9.51 **Cumbria Constabulary**

9.52 There are some lessons that need to be and have already been learned by Cumbria Constabulary relating to the way it has worked to safeguard victims and promote their welfare.

9.53 The main lesson that has been drawn from the case centres on why police officers had not identified the potential for domestic abuse of an elderly female. This abuse was in the form of abusive language within the home, controlling and coercive behaviour and neglect.

9.54 Raising internal awareness more widely around issues facing people in later life and what officers and police staff should consider in relation to self-neglect, neglect and domestic abuse is required.

9.55 Recognition and management of DA perpetrators who may be obstructive and hostile to police identified learning around enhancing professional curiosity and not taking anything at face value when there are safeguarding concerns raised.

9.56 Domestic abuse (DA) accounts for 25% of crime in Cumbria. The constabulary wanted to understand more about DA especially in rural areas, so it secured a £176,000 grant from the Home Office Star fund and conducted a significant research project with Leeds University. The recommendations generated by this project were adopted by the constabulary and the two newly created Community Safety Partnerships.

9.57 The research has enhanced partnership understanding and approaches to DA. Internally the findings have led to the creation of the Multi Agency Tasking and Coordination (MATAC) team which was noted in the HMICFRS PEEL inspection¹³ of the constabulary and is a proactive, suspect-focussed initiative;

“The constabulary has introduced a multi-agency tasking and co-ordination (MATAC) process to safeguard adults and children at risk of harm from domestic abuse perpetrators. The constabulary maintains a matrix of domestic abuse perpetrators who are considered for inclusion in the MATAC process. Police and partner agencies then work with those offenders to reduce the risk they present and to divert them from further offending.”

9.58 Cumbria Constabulary were graded as ‘GOOD’ in the category of ‘Protecting Vulnerable People’ and it was noted by Inspectors that; *“During our inspection, we found the constabulary had implemented a range of initiatives aimed at reducing violence against women and girls. These initiatives all work towards the aims of Cumbria Constabulary’s violence against women and girls strategy and are consistent with the National Police Chiefs’ Council’s strategy. The constabulary works*

¹³ <https://hmicfrs.justiceinspectorates.gov.uk/publications/peel-assessment-2023-25-cumbria/>

closely with partner organisations to implement an action plan to reduce this type of harm.”

- 9.59 The constabulary has also made several other improvements contributing to such a positive inspection report and DA remains a priority in the monthly Strategic Performance Board where the deputy chief constable holds senior police leaders to account for their performance around DA.
- 9.60 Each command has created a ‘DA improvement plan’ where performance issues are identified, and work is being done to address them.
- 9.61 The constabulary is currently one of the best performing forces within the VAWG framework and DA remains a priority for the constabulary.
- 9.62 **Oversight:** If staff have assessed an incident as a case of ‘concern for welfare’ rather than a possible domestic related issue, then the question for the force to consider is whether there are enough checks and balances in place to ensure that any offences or safeguarding opportunities have not been missed.
- 9.63 To address this the force now uses the new ‘Right Care Right Person’ decision making toolkit for Concern for Welfare reports, which went live on 14.05.2024, and assists with ensuring offences or safeguarding risks aren’t missed. and reduces the risk of this happening.
- 9.64 **Risk assessment:** The Safeguarding Adult Form (SAF) does not include an integral risk assessment. Both the domestic abuse and a vulnerable child safeguarding form do have one. Public protection senior management have been sighted on this concern and are fully supportive of a risk assessment tool being incorporated into the form.
- 9.65 This change will require a change to the software currently used. This involves a significant number of logistical issues that means that despite the will to make the changes it is envisaged to take some time to implement [2021].
- 9.66 **Training:** The Safeguarding element of the student officer training at Cumbria Constabulary has been updated to include specific focus on the area of domestic abuse experienced by older people. Including one role play which covers a parent / child abuse scenario.
- 9.67 There are learning points around the way in which officers’ dealings with Graham and Agnes had not identified him earlier as a potential domestic abuse perpetrator.
- 9.68 There have been several implications for the way that the force trains staff, which will include supervisors (especially those of front-line officers), with regard to elder abuse. This has already commenced and, in places, completed such as updating the student officer training program to incorporate the specific elements of elderly domestic abuse.

- 9.69 The training of existing staff is also under way throughout the month of September for officers during the two hour training window they have once every five weeks. The training is bespoke domestic abuse training with the sessions covering investigations, risk assessments, risk management and child on parent violence.
- 9.70 The violence toward a parent area specifically covers that this can be adult children and elderly parents and not just young children. Completion of Domestic Abuse and Vulnerable Adult forms are covered in this training. This training is for all front-line officers in the force. [2021].
- 9.71 Cumbria Police commissioned 'Domestic Abuse Matters' training which commenced in 2022. This training is mandated to cover 75% of public facing officers and staff and was jointly delivered by Safe Lives and Cumbria police trainers. The remaining 25% will be trained by Cumbria police trainers and local IDVAs, after having attended the Safe Lives 'train the trainer' event. This helps address the learning need around the officer subjective assessment of what constitutes domestic abuse.
- 9.72 Other updates to training provision across the force include DASH training, revamp of training to include input from DA subject matter advisors. The force's DA subject matter advisor co trains the student officer DA courses.
- 9.73 Victim Support Cumbria were invited by Cumbria Constabulary training department to provide DA awareness training to new entry route CID officers as part of their core training across Autumn/Winter 2024. Significant risk, victim response, abuse typologies, victim's code & the homicide timeline stages are all included in the training.
- 9.74 There has also been an update of the DA 'Evidence Review officer's' (ERO) role and the training they receive. Further training around achieving evidence led prosecutions (ELPs) has also been completed.
- 9.75 Also implemented during the review period was the initiative for the Head Quarters Public Protection Unit (PPU) team to complete force wide 'DA drop in clinics' in area stations including, Workington, Whitehaven, Kendal, Barrow, Penrith and Carlisle.
- 9.76 This involves a member of the DA team (DC, DS or DI) being present in a briefing room to speak to officers about various policing factors relevant to domestic abuse call outs and investigations including; DASH risk assessing, enhancing Evidence Lead Prosecutions (ELPs), taking positive action, Safeguarding, minimum standards of investigation and 'outcome 15 & 16' investigation closures.
- 9.77 This initiative was designed to help dispel any myths around domestic abuse, such as it being 'intimate partner' only, and assist frontline officers and staff in recognising and managing risks to improve outcomes for victims.

- 9.78 The HQ PPU DA team (DC, DS and DI) are carrying out weekly reviews into Outcome 15 & 16¹⁴ DA crimes to establish if 'Res Gestae' hearsay gateway could be used, if fear is an element, and if all necessary and proportionate lines of enquiry are carried out.
- 9.79 Training has again been updated, and the DA lead will be co-delivering the training all DA courses with the student officer trainers and upcoming plans include providing inputs with tutor constables to ensure they are sharing the most relevant and current practice with their student officers.
- 9.80 Cumberland policing area are running drop-in clinics at rural GP surgeries, alongside Victim Support. This involves a community officer and an IDVA in 2 rural locations, 1 in north and 1 in west Cumbria to enable people who may only have access to go to a GP, can speak to a police officer and or IDVA about DA.
- 9.81 Westmorland and Furness policing area are looking to begin this too. Although Agnes did not attend the GP surgery, the presence of police and IDVA in the surgery is more likely bring DA to the forefront of people's minds, including surgery staff.

10 RECOMMENDATIONS FROM THE REVIEW

- 10.1 Panel members were asked to ensure recommendations were focused and specific, and capable of being implemented.
- 10.2 These recommendations reflect the learning identified throughout the Review process and the conclusions drawn.
- 10.3 Most of these recommendations have been actioned and completed and were not halted by the delays within the DHR/DARDR process. They have been addressed and embedded within organisational practice throughout the course of this Review and overseen by the panel members, with feedback provided to the independent Chair.

10.4 Recommendation 1

Cumbria Constabulary

The force should review their procedure for managing 'concern for welfare' calls for service and improve their ability to identify crimes and abuse upon the initial call. This should include ensuring that when responding to calls for service from partner agencies it is made clear whether the police are being asked to lead or respond

¹⁴ **Outcome 15** A Home Office classification used by the police to describe the finalisation of an investigation where the suspect was identified and the victim supported police action, but evidential difficulties prevented further action.

Outcome 16

A Home Office classification used by the police to describe the finalisation of an investigation where the suspect was identified, but the victim doesn't support (or has withdrawn support for) police action.

directly to these incidents or if they are being asked to provide appropriate support to partner agencies. This should be done in partnership with the relevant agencies.

10.5 Recommendation 2

All agencies to review their training provision and policy around Domestic Abuse to ensure there is specific focus on abuse in later life and familial abuse, including case examples to enhance the learning. This training should focus on professional curiosity, multi-agency working and local procedures for sharing information (e.g. MARAC, SPA etc).

10.6 Recommendation 3

Agencies to review their inter-agency referral/safeguarding forms and processes to ensure presence of adequate information around risk and risk assessment. This should be sufficient to ensure that professionals have a common understanding of the risk factors, risk level and risk management plan for each case.

10.7 Recommendation 4

North Cumbria Integrated Care (NCIC)

Routine enquiry around domestic abuse to be introduced to health care settings and a health pathway to be devised for practitioners to follow should a positive disclosure be made of domestic abuse.

10.8 Recommendation 5

Castles & Coasts HA (CCHA)

Consider working towards a DAHA accreditation; the UK benchmark for how housing providers should respond to domestic abuse in the UK.

APPENDIX 1

GLOSSARY

CCG	Clinical Commissioning Group
CSP	Community Safety Partnership
DHR	Domestic Homicide Review ¹⁵
GP	General Practitioner
IMR	Individual Management Report
ISDVA/IDVA	Independent Sexual & Domestic Abuse Advisor / Independent Domestic Abuse Advisor
SCIE	Social Care Institute for Excellence
TOR	Terms of Reference
SAF	Safeguarding Form
APP	Approved Professional Practice (College of Policing official guidance)
ASC	Adult Social Care
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking, Harassment and Honour Based Violence Risk Indicator Checklist
CCHA	Castles and Coasts Housing Association
CCC	Cumbria County Council
SIO	Senior Investigating Officer
SPA	Single Point of Access (referral route for agencies)
L&D	Liaison & Diversion – support team accessed via police custody
SAB	Safeguarding Adults Board
PPU	Public Protection Unit
RCRP	Right Care Right Person
AAFDA	Advocacy After Fatal Domestic Abuse; a specialist charity supporting families bereaved by domestic abuse

¹⁵ Now known as Domestic Abuse Related Death Reviews (DARDRs)

<https://www.gov.uk/government/news/fatal-domestic-abuse-reviews-renamed-to-better-recognise-suicide-cases>

APPENDIX 2

Photographs showing the shocking condition of Address A, taken shortly after the deaths of Agnes and Graham.

PHOTOGRAPH 1



REDACTED

PHOTOGRAPH 2



PHOTOGRAPH 3



PHOTOGRAPH 4



RESTRICTED

PHOTOGRAPH 5

