Cumberland Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

Under Section 9 of Domestic Violence Crime and Victims Act 2004

OVERVIEW REPORT

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.

LIST OF CONTENTS

1 PREFACE

1.1 This Domestic Homicide Review 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.

1.2 Agnes is not the real name of the person who was killed in Carlisle in 2020; the pseudonym was chosen by her family to safeguard her identity.

1.3 This report was commissioned by North Cumbria Community Safety Partnership, the name of which changed to Cumberland Community Safety Partnership in April 2023.

1.4 The Cumberland Community Safety Partnership Domestic Homicide Review Panel would like to express its profound condolences and sympathy to Agnes's family and friends. Agnes's family accepted invitations to participate in the review.

1.5 Agnes's death met the criteria for conducting a Domestic Homicide Review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004.

1.6 The Domestic Abuse Act 2021 defines domestic abuse as:

"Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if —

a) A and B are each aged 16 or over and are personally connected to each other, and
b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following—

a) physical or sexual abuse;
b) violent or threatening behaviour;
c) controlling or coercive behaviour;
d) economic abuse;
e) psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.
"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to —

a) acquire, use or maintain money or other property, or
b) obtain goods or services.

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Definition of "personally connected". For the purposes of this Act, two people are "personally connected" to each other if any of the following applies —

a) they are, or have been, married to each other;

b) they are, or have been, civil partners of each other;
c) they have agreed to marry one another (whether or not the agreement has been terminated);
d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
e) they are, or have been, in an intimate personal relationship with each other;
f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child;
g) they are relatives."

2 INTRODUCTION

2.1 This is the Report of a Domestic Homicide Review (DHR) following the death of Agnes Thomas (pseudonym), in 2020; her son, Graham (pseudonym), was arrested on suspicion of her murder. It provides an independent overview and examination of the agency responses and support given to Agnes and Graham, residents of Carlisle, prior to the point of Agnes's death in 2020.

2.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before Agnes' death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

2.3 The review will consider agency's contact/involvement with Agnes and Graham from 2005 to 2020. The reason this date range has been 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.

2.4 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.

2.5 There is a statutory expectation that certain bodies will have regard to the Statutory Guidance for the Conduct of DHRs and that these bodies can be directed by the Secretary of State to participate in a review (section 9(2) of the Domestic Violence Crime and Victims Act 2004). Although certain bodies can be directed to participate in a review, they cannot be issued a witness summons. This means there is no legal sanction or power to enforce a request made by the Review Panel Chair that an individual attend for an interview.

3 TIMESCALES

3.1 This review was initiated following a Cumberland CSP review meeting held on 29th July 2020. An independent chair was commissioned, and the Chronology return date was set for 1st June 2021. IMRs were requested and were due for return on 20th September 2021. Some of the panel meetings had to be cancelled due to COVID as this DHR was initiated amidst the pandemic.

3.2 The Review was concluded in November 2024. Whilst it is hoped that Reviews, including the overview report, be completed where possible within six months of the commencement of the review, this was not achievable in this case.

3.3 The reasons for the delays in this case relate to the unexpected and significant ill health of the initial Chair. The ill health eventually caused the Chair the need to step down and a subsequent appointment of a new Independent Chair was required.

3.4 The second Chair did not commence appointment until September 2022. Delays were then encountered as the handover from the first Chair was not obtained by the second Chair until 2023 and full receipt of documents provided by the family were not received by the second Chair until October 2024.

4 CONFIDENTIALITY

4.1 The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. The subjects of this review will be referred to by the pseudonyms agreed with the family and these used in the report to protect their identities.

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

4.2 The victim was in her 90s at the time of her death. The suspected perpetrator was in his 60s at the time of his death. Both were White British.

4.3 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.

4.4 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.

4.5 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'.

4.6 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.

4.7 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.

4.8 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.

5 TERMS OF REFERENCE

Key Lines of Inquiry

5.1 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:

a) the communication, procedures and discussions, which took place within and between agencies;

b) the co-operation between different agencies involved with Agnes and Graham;

c) 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.

d) 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.

e) Organisations' access to specialist domestic abuse agencies, with special regard to domestic abuse in later life.

f) 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.

g) Analysis should pay particular attention to the following issues:

- Age of victim
- Financial Abuse
- Coercive Controlling Behaviour
- Agnes and Graham's relationship as mother and son

- Graham as “carer” for Agnes
- Mental Health & Physical Health

6 METHODOLOGY

6.1 On notification of the domestic homicide, all relevant local agencies were contacted. Agencies were asked to secure their files if contact was confirmed. A scoping meeting was held on 19.05.2021, chaired by Alison Bird. As a result of this meeting, the following agencies were identified as possibly having information on the family:

- North Cumbria Integrated Care NHS Foundation Trust (NCIC)[1]
- Clinical Commissioning Group (CCG)
- Cumbria County Council
- North West Ambulance Service
- Carlisle City Council[2]
- Castles and Coasts Housing Association (CCHA)[3]
- Adult Social Care (ASC)
- Cumbria Constabulary
- Department for Work and Pensions (DWP)

6.2 All agencies who had contact with individual family members have submitted a chronology. Those agencies who had significant direct contact have also supplied an Individual Management Review (IMR).

6.3 The panel were able to interview family members as part of the review and received a letter of impact from Agnes’s son and daughter in law.

6.4 Previous Domestic Homicide Reviews were also examined. This helps to ensure lessons identified in those reviews had been implemented, and learning disseminated across the partnership. This area has had 4 previous published DHRs.

6.5 The overview report is an anthology of all this information.

[1] North Cumbria Integrated Care (NCIC) NHS foundation trust acquired North Cumbria University Hospitals (NCUH) NHS Trust in October 2019.
[2] On 01.04.2023 Carlisle City Council became Cumberland Council.
[3] Castles & Coasts Housing Association was formed in July 2017 as a result of merging Two Castles (TCHA) and Derwent and Solway (D&S) Housing Associations.

7 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDERCOMMUNITY

7.1 The family had the help and support of specialist and expert advocates from AAFDA and victim support and were provided with the Home Office leaflet regarding Domestic Homicide Reviews.

7.2 The terms of reference were shared with the family to assist with the scope of the review.

7.3 The family were invited to attend panel meetings, to meet the panel and read out an impact statement to the panel.

7.4 The family have been updated regularly and have provided a tribute to Agnes as part of this review.

7.5 The family have been visited by the Chair and have reviewed the draft report in private with plenty of time to do so and had the opportunity to comment and make amendments as required.

8 CONTRIBUTORS TO THE REVIEW

Name	Role	Organisation
Patrick McDonnell	Detective Inspector, IMR author	Cumbria Constabulary
Sarah Edgar	DC, DHR SPOC	Cumbria Constabulary
Clare Stratford / Hayley Bishop	DHR Leads	Cumberland Community Safety Partnership / Cumberland Council
Alison Goodfellow	DHR Lead/ Assistant Safer Communities Manager and former DHR co-ordinator	Westmorland and Furness Council
Sarah Joyce	Service Manager Safeguarding Adults	Safeguarding Adults, Carlisle City Council (now Cumberland Council)
Anna Bates	Head of Housing, IMR author	Castles & Coasts Housing Association
Dr R Swain	Safeguarding Lead, GP	Warwick Square Group Practice
Molly Larkin	Safeguarding Designate Nurse, IMR reviewer	North Cumbria CCG
Kate Allen	Deputy Designated Professional for Safeguarding Adults	Northeast and North Cumbria Integrated Care Board
Gemma Qi	Safeguarding Advisor, IMR author	North Cumbria Integrated Care (NCIC)

Sarah Place	Senior Operations Manager	Victim Support
Bharati Dwarampudi	Advanced Customer Support Senior Leader, Cumbria & Lancashire District	Department for Work and Pensions
Katy Driver	Advanced customer support lead for Cumbria and Lancashire	Department for Work and Pensions
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
Kelly Marsden	Named Nurse for Safeguarding Adults	North Cumbria Integrated Care (NCIC)
Bridie Anderson	Independent Chair and Report Author	Better Lives Training & Consultancy

9 THE REVIEW PANEL MEMBERS

Name	Role	Organisation
Alison Bird	Independent Chair (Initial)	Solace
Clare Stratford / Hayley Bishop	DHR 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, DHR SPOC	Cumbria Constabulary
Paddy McDonnell	DI, IMR author	Cumbria Constabulary
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)
Bridie Anderson	Independent Chair and Report Author	Better Lives Training & Consultancy

9.1 All panel members confirmed they were independent of the individuals involved in the Review.

9.2 Due to the expertise and experience of Sarah Place (Victim Support) the Panel did not feel the additional contribution from a DA specialist service was required. Sarah is a qualified Independent Domestic & Sexual Violence Advisor (Safe Lives qualifications), holds Safe Lives 'Older People suffering violence and abuse' accreditation (OPVA), Safe Lives DA service manager accreditation, and has completed a Diploma in DA early intervention and prevention. Sarah manages the county's Safe lives accredited IDVA service, Lime Culture accredited ISVA service & is one of the DA expert DA Matters trainers for Cumbria Constabulary.

9.3 The panel met a total number of 7 times.

10 CHAIR AND AUTHOR OF THE OVERVIEW REPORT

10.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance[4] 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.

10.2 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.

10.3 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.

10.4 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] https://assets.publishing.service.gov.uk/media/5a80be88e5274a2e87dbb923/DHR-Statutory-Guidance-161206.pdf

10.5 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.

10.6 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.

10.7 Bridie was the substantive panel member for Surrey's DHRs/SARs, representing Surrey Police.

10.8 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.

10.9 Bridie is a trained DASH RIC Risk assessor/trainer, Stalking Risk Profile Risk Assessor, Mental Health First Aider and MARAC Chair.

10.10 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.

11 PARALLEL REVIEWS

11.1 An inquest into Anges' death was opened and postponed in June 2020. The new date was set for early 2024 for the Coroner's inquest into the death of Agnes.

11.2 The delay was due to the Coroner awaiting the DARDR report to assist in directing the inquest enquiries, at the request of Agnes' family.

11.3 The Coroner's office was provided with information received during this Review in order to assist their enquiries for the purpose of the inquest.

11.4 An inquest into Agnes' death was held in January 2025 and 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 on Agnes'.

11.5 HM Coroner accepted the cause of Agnes' death as blunt force chest trauma, concluding that Agnes was frail, emaciated, and had severe osteoporosis.

11.6 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.

12 EQUALITY AND DIVERSITY

12.1 The Equality Act 2010[5] means that it is against the law to discriminate against someone because of their:

- Age,
- disability,
- gender reassignment,
- marriage and civil partnership,
- pregnancy and maternity,
- race,
- religion or belief,
- sex
- sexual orientation.

12.2 These are known as protected characteristics. In this Review the relevant protected characteristics include **age, disability and sex.**

12.3 Agnes was in her 90's years old at the time of her death. Age seems to have had an impact on Agnes' health and presented barriers to accessing services as well as maintaining contact with family.

12.4 Due to Agnes's medical conditions, some of which were age-related, she would be considered to have had a disability in line with Section 6 of the Equality Act which defines disability as:

"[1] A person [P] has a disability if—

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities."

12.5 Victims with a long-term illness or disability, which includes physical, mental or learning disability, are particularly vulnerable to domestic abuse from partners, ex-partners and family members. Office of National Statistics analyses consistently show that both men and women with a long-term illness or disability are more likely to experience domestic abuse than those without.[6]

12.6 Sex is also a relevant characteristic in the Review as Agnes was a female who it is suspected was killed by her adult male son, Graham. Women are disproportionality more likely to become victims of domestic homicides than men and in cases of parricide the perpetrator analysis from a 2022 research piece revealed that 53 of the

[5] https://www.legislation.gov.uk/ukpga/2010/15/contents
[6] http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-violent-crime-and-sexual-offences--2013-14/rpt-chapter-4.html#tab-Intimate-violence-in-the-last-year-by-personal-characteristics

57 parricide incidents (and 55 out of 59 victims) were committed by sons (93%) [7]. This highlights how Agnes' age, disability and sex are relevant characteristics to explore during the analysis of the Review.

12.7 Agnes and Graham were both white British and spoke English as their first language. Graham worked in the construction industry and Agnes was literate as demonstrated by cards and letters written to family over the years evidencing a high level of literacy.

12.8 There is nothing in agency records to suggest Agnes did not have capacity[8]. Graham was not in paid employment and his mental capacity was never queried.

12.9 Relevant to this review and the equality aspect is the consideration of 'parricide' a term which refers to the killing of a close family member but is commonly used to describe fatal violence from children (of all ages) toward their parents.

12.10 This form of domestic homicide is under researched. In England and Wales, the number of parricide events fluctuates year on year, but averages just under 20 per year, working out at around 3% to 4% of all homicide in England and Wales *(Bojanic et al.,[9] 2020; Holt, 2017[10]).*

13 DISSEMINATION

13.1 Whilst key issues identified by the Review will be shared appropriately, the report will not be disseminated until approval has been received from the Home Office Quality Assurance Panel.

13.2 The IMRs will not be published. The DHR report will be made public, and the recommendations will be acted upon.

13.3 The content of the report and executive summary is anonymised in order to protect the identity of the victim and their family members, staff and others, and to comply with the Data Protection Act 2018 and General Data Protection Regulation (GDPR).

13.4 The report will be produced in a form suitable for publication after any Home Office approved redaction has taken place.

13.5 The family remain in consultation with the Chair to ensure that any key dates do not coincide with publication of this report, and they have access to the ongoing support of their allocated Victim Support Homicide Case Worker.

[7] Parricide, Mental Illness, and Parental Proximity: The Gendered Contexts of Parricide in England and Wales Caroline Miles, Rachel Condry, and Elspeth Windsor
[8] https://www.legislation.gov.uk/ukpga/2005/9/contents
[9] https://doi.org/10.1007/s10896-017-9939-y
[10] Holt, A. (2017). Parricide in England and Wales (1977–2012): An exploration of offenders, victims, incidents and outcomes. Criminology & Criminal Justice, 17(5), 568–587. https://doi.org/10.1177/1748895816688332

13.6 Below is a table listing the recipients of the review report.

Name	Role	Organisation
Hayley Bishop	DHR co-ordinator	Cumberland CSP / Cumberland Council
Sarah Joyce	Service Manager Safeguarding Adults	Safeguarding Adults, Cumbria County Council (now Cumberland Council)
Anna Bates	Head of Housing	Castles & Coasts Housing Association
Sarah Edgar	DC, DHR SPOC	Cumbria Constabulary
Kate Allen	Safeguarding,	North Cumbria CCG
Gemma Qi	Safeguarding Advisor	North Cumbria Integrated Care (NCIC)
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Louise Cavanagh	Domestic and Sexual Abuse Business Coordinator, Cumberland Safeguarding Hub and Children Social Care	Cumberland Council
Sarah Place	Senior Operations Manager	Victim Support
Kelly Marsden	Named Nurse for Safeguarding Adults	North Cumbria Integrated Care (NCIC)
Mary-Claire Telford	Strategic Lead for Domestic Abuse	Cumberland Council
David Allen	Cumbria's Police, Fire and Crime Commissioner	The Office of the Police, Fire and Crime Commissioner
Lynda Hodgson	Coroner's Officer	HM Coroners Service (Cumberland Council and Westmorland and Furness Council)
Dr Nicholas Shaw	HM Coroner	HM Coroners Service (Cumberland Council and Westmorland and Furness Council)
Nicole Jacobs	Domestic Abuse Commissioner (DAC)	Domestic Abuse Commissioners Office

14 BACKGROUND INFORMATION (THE FACTS)

14.1 Agnes was in her 90s and lived with her adult son, Graham, in Carlisle. They lived together in Address A and had done since moving from another area of the country in around 2005. Graham was not in paid employment and was Agnes' sole carer.

14.2 Evidence seen by the panel suggests that Graham had been both physically and financially abusing Agnes, neglecting her basic care needs and abusing by acts of both commission and omission.

14.3 It is suspected that Graham caused Agnes' death through a series of assaults where he either hit or kicked her over a period of several weeks. These assaults caused fractures to her sternum and ribs and resulted in her succumbing to respiratory failure.

14.4 Graham did not alert anyone to Agnes' death for at least 12 days, possibly longer, instead retaining her body in their house until he visited the local GP surgery in May 2020 and disclosed his mother had died. This was during the first national COVID19 lockdown.

14.5 The GP surgery contacted Police who attended Agnes' and Graham's address and located Agnes's body, fully clothed on the floor of the address and starting to decompose.

14.6 Graham was arrested on suspicion of preventing a lawful and decent burial of a dead body and conveyed to a police custody suite.

14.7 A forensic post mortem was conducted, and the cause of Agnes' death was recorded as blunt chest trauma. It was discovered that Agnes was also suffering with a hiatus hernia (stomach and intestine), which was encroaching her chest cavity. Her stomach was empty and there were visible rib fractures on 8 ribs on left side and 5 on right side as well as a fractured sternum.

14.8 Agnes' fractured ribs and sternum were further examined by a consultant musculoskeletal pathologist in order to provide a more detailed analysis of the fractures observed in the initial post mortem.

14.9 This pathologist was able to identify from the ribs a total of 22 separate rib fractures at different stages of healing, indicating they had occurred from over 16 weeks to 3-6 weeks prior to Agnes' death.

14.10 There was evidence of re-fracturing and the 10th rib on right side showed a fracture which had occurred within 24 hours prior to Agnes' death.

14.11 The pathologist concluded that based on the different features of the older fractures, there were at least 3 separate fracturing events which occurred between 4 and 12 weeks prior to Agnes' death. Agnes' sternum showed multiple fractures and refracturing.

14.12 The pathologist concluded that the rib and sternum fractures were caused by direct blunt force trauma injury or by a compressing/squeezing force applied to Agnes' chest.

14.13 The bones also showed features of severe osteoporosis which would have made them more fragile than unaffected bones. Whilst micro-fractures can occur spontaneously in such severely osteoporotic bones, the main fractures Agnes suffered on her ribs were deemed significant and would therefore have required a 'fracturing event' such as blunt force or compression. Whilst some spontaneous

fractures were identified they were described as trivial and having no part to play in Agnes' death.

14.14 Following this second post mortem the original pathologist concludes 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 to the chest region. In particular she concludes the sternum fracture, which she states is an unusual injury, is more indicative of a stamp or kick than a punch.

14.15 She was able to rule out cardiopulmonary resuscitation (CPR) as a cause of the rib and sternum fractures due to the various stages of healing. She also felt that the 22 fractures could not have been caused by Agnes being lifted onto a commode.

14.16 Due to more rib fractures occurring prior to previous ones healing, Agnes' ability to breathe would have been negatively affected due to the action of the rib cage moving whilst inhaling and exhaling.

14.17 The pathologist concludes that the final rib fracture on the 10th rib, sustained on the last day of Agnes' life, was what made breathing impossible for her when added to the multiplicity of the other rib fractures. This subsequently led to respiratory failure and death.

14.18 July 2020 toxicology results were received which indicated an anti-convulsant drug called Gabapentin was found in Agnes' blood. It was a low concentration of the drug which could suggest non recent use and played no part in her death but was notable because Agnes had never been prescribed the drug. GP records show that Graham was prescribed Gabapentin.

14.19 Agnes was described as emaciated by the pathologist and over the course of 16 years had gone from 74 kg (11 ½ stone) to just 26kg (4 stone). This is a weight loss of 48kg (7 ½ stone) for which no medical cause was identified during the post mortem.

14.20 Agnes was seen in 2015 by her other son who did not notice any significant weight loss, suggesting the majority of her weight loss occurred in the last 5 years of her life.

14.21 This vast weight loss was described as severe and excessive. Agnes' stomach contents indicated that her nutrition was severely restricted leading up to her death.

14.22 Due to the post mortem findings, the day after Graham's original arrest in 2020, he was further arrested on suspicion of the murder of Agnes and later released on police bail pending further investigative enquiries.

14.23 A few days later Police attended Graham's address as he had failed report to the police station as per his bail conditions. Upon entering the address police found Graham deceased, it was believed he had died by suicide.

14.24 An inquest was held in 2023 into Graham's death and the Coroner concluded Graham's death was due to suicide.

14.25 Graham died before the criminal investigation into Agnes' death had concluded and so no charges were brought against him or anyone else in relation to her suspected murder.

14.26 Despite their best efforts, Agnes had not been seen by other family members for several years, declining their requests to visit and asking them not to travel to see her. Agnes's son, Frank, who is disabled travelled up by train unannounced in 2015 to visit Agnes and Graham at Address A and no particular concerns were noted. Agnes' isolation from professionals had increased in the months leading up to her death.

15 CHRONOLOGY

15.1 This part of the report details the Chronology of known events between 2005 and 2020. The narrative is told chronologically and is built on the lives of Agnes and Graham based on information drawn from documents provided by agencies and the family and material gathered by the police during the homicide investigation.

15.2 **Pre scope relevant information; 1990's – 2005**

15.3 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.

15.4 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.

15.5 As part of the homicide investigation Cumbria police interviewed Sue, Sam and Alex and the following information is drawn from their testimonies.

15.6 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.

15.7 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.

15.8 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.

15.9 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.

15.10 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 this 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.

15.11 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'.

15.12 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.

15.13 Sam and Alex were often present and directly involved in Grahm's attacks on their mother and recall intervening protectively and getting injured themselves when as young as 12 years old.

15.14 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.

15.15 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.

15.16 Sue and the children describe Graham a 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.

15.17 Sue eventually escaped Graham and moved out with the children to a location unknown to him. In the years since 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.

15.18 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.

15.19 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.

15.20 **Scope of review 2005 – 2020;**

15.21 **27.03.03** Graham became liable for council tax at Address A, the property in Carlisle which he shared with Agnes, his mother, until her death.

15.22 **06.10.03** Agnes began claiming Pension Credit from the Department for Work & Pensions (DWP)

15.23 **22.07.04** Agnes was fitted with hearing aids following a referral made by her GP to Audiology. This indicates Agnes was back in Cumbria.

15.24 **Scope of review 2005 – 2020;**

15.25 **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 when they move to Carlisle.

15.26 **08.03.06** Police have contact from Graham for a parking matter which is unrelated to this review, but indicates he was living at Address A at this point in time.

15.27 **17.10.06** 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.

15.28 **17.11.07** 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.

15.29 **15.07.08** Request received from Local Authority requesting a full breakdown of Agnes's benefit entitlement. This was completed and returned to the local authority.

15.30 **26.08.08** 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.

15.31 **09.04.09** Castles and Coasts housing association (CCHA) receive an application for housing from Graham and Agnes.

15.32 **07.04.10** Call to Police from Graham relating to nuisance parking, Graham gave his address as that of the house he shared with Agnes at the time of her death, Address A. This confirms his connection to that address at this time, however neither he or Agnes were seen by Police as there was no reply when address was attended and no need for follow up due to nature of the report.

15.33 **16.06.10** Castles and Coasts housing association confirm that a tenancy agreement on Address B will commence in relation to Graham and Agnes on 05.07.10.

15.34 **05.07.10** Carlisle city council are notified by Graham and Agnes that a joint tenancy has started with Castles and Coasts (then and up until 2017 known as "Two Castles") 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.

15.35 **02.08.10** Graham emailed Castles and Coasts housing association about services to the address (gas supply) and stated they had not moved into Address B yet.

15.36 **28.09.10** 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.

15.37 **05.10.10** 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.

15.38 Police attended the Address A several times, last visiting on the **07.10.10**, but still got no answer. They left notes for Graham asking him to call in to police but took no further action. This demonstrates a lack of safeguarding response or information sharing/seeking with any other agency driven by a professional curiosity around the welfare of possible adult at risk.

15.39 **30.12.10** Council tax bill for Address B included a declaration that it had been 'unoccupied and unfurnished' between 27.06.10 and 06.12.10.

15.40 **17.01.11** A letter was sent to Graham and Agnes at Address B asking if they had moved in, due to the declaration on the council tax bill CCHA had seen on 30.12.10. A letter was also sent to the local authority to notify them of the tenancy start date for Address B.

15.41 **04.02.11** Graham calls CCHA to say that he has moved into Address B and will contact the local authority to let them know.

15.42 **06.09.11** A letter is sent to Graham and Agnes at Address B by CCHA as they had accrued some rent arrears.

15.43 **11.10.11** Agnes is seen by primary care due to pruritus ani. It is noteworthy as it can be caused by ongoing diarrhoea or infections.

15.44 **06.01.12** Agnes seen by primary care with a middle ear infection.

15.45 **13.01.12** Agnes has a standard chest x-ray, and mild COPD is noted as well as a hiatus hernia.

15.46 **24.02.12** CCHA send Graham and Agnes a rent increase letter in relation to Address B.

15.47 **20.03.12** Agnes attends a respiratory medicine clinic appointment and is accompanied by Graham.

15.48 **24.04.12** Agnes attends a Respiratory medicine CT scan.

15.49 **21.05.12** Agnes attends a Respiratory medicine clinic appointment**.**

15.50 **21.05.12** CCHA receive a report that Address B looked untidy and empty.

15.51 **25.05.12** A visit is made to Address B by CCHA to investigate the report that the property looked untidy and unoccupied.

15.52 **29.05.12** Respiratory medicine clinic appointment for a spirometry test.

15.53 **14.06.12** CCHA send a letter to Graham and Agnes at Address B to let them know they will be visiting their 'previous' address (Address A) on 19.06.12.

15.54 **19.06.12** CCHA record a 'File Note' stating that Graham never moved in to Address B as his mother was too ill. 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.

15.55 Graham agreed to liaise again with CCHA on 11.07.12 to see how he would like to progress. No mention of arrears on the note, despite arrears letter being sent on 06.09.11, some 9 months earlier.

15.56 **03.07.12** 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.

15.57 A check on the listed occupants of Address A was carried out which 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.

15.58 **10.07.12** Male identifying himself as Graham calls police to report that a vehicle has blocked his garage preventing access in the small lane opposite his address (Address A). He asks for an officer to attend but says he does not know who the vehicle belongs to. No further contact with Graham and no attendance at the house by police.

15.59 **11.07.12** Graham did not attend the arranged appointment with CCHA to discuss the tenancy at Address B.

15.60 **12.07.12** CCHA send a termination letter to Graham and Agnes at Address B as the arranged appointment on 11.07.12 was not kept. The letter advised that the tenancy would be ended on 06.08.2012.

15.61 **01.08.12** CCHA record a file note explaining that Graham called them and claimed to have no recollection of earlier conversation (19.06.2012) 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 moving in. Due to this call the tenancy for Graham and Agnes at Address B was reinstated.

15.62 **07.09.12** 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.

15.63 **21.09.12** Agnes missed an appointment booked for her at the respiratory medicine, the clinic notified her GP. There is no record that GP practice acted on this information at all such as calling or visiting the address to check on their patient, Agnes.

15.64 **20.12.12** Intelligence received by Police that a male (not Graham) was seen inside Address A running electrical cables from one room to another and the presence of a strong smell of cannabis was coming from the same address. Checks were carried out on Police systems which showed Agnes and Graham registered as living at the address. The male named on the report was a neighbour and so it was assumed the informant had reported the wrong address, no further action was taken.

15.65 **07.01.13** CCHA send another rent arrears letter out in relation to Address B.

15.66 **12.02.13** CCHA send Graham and Agnes a rent increase letter in relation to Address B.

15.67 **27.02.13** Call to Police by Graham complaining of a parking issue at Address A. Graham was not seen, and address was not attended by police.

15.68 **01.06.13** CCHA send letter to Address B requesting Graham and Agnes contact them in relation to non-occupancy.

15.69 **30.08.13** Graham claims in a later council tax declaration form that this is the date he and Agnes moved out of Address A and into Address B to care for his mother.

15.70 **24.03.14** 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 so the account had 25%

carers discount disregard applied, as a declaration form was completed with proof of the relevant benefit (attendance allowance). In addition, as it was advised that the other property Graham owned in Carlisle, Address A, was furnished but empty, a class J exemption was also awarded. This exemption applies when a person is living elsewhere to provide personal care and means that Graham did not have to pay council tax on Address A.

15.71 Subsequent annual reviews were undertaken in line with expected practice, where exemption review forms were sent to both Graham and Agnes; these were returned with no changes recorded on the annual declaration forms and proof of relevant information returned, therefore exemptions remained in place.

15.72 In **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.

15.73 **08.06.16** Call to Police from neighbour of Address A due to complaint of loud noise. Caller stated they could hear the TV through the walls and believed the occupant is an 'older male'. No police attendance as it was deemed not a police matter.

15.74 **05.09.16** Graham attended A&E at Cumberland Infirmary via ambulance. Graham had sustained a head injury following alcohol consumption. Graham stated he had fallen backwards and banged his head. Graham had a laceration and possible loss of consciousness.

15.75 Graham subsequently left the hospital prior to having a CT scan and treatment. A&E staff contacted rapid response to attempt to locate him. They got no answer at his home address.

15.76 **05.09.16** Call to police at around 20.00 hours from Cumberland infirmary to say that Graham had walked out of the department prior to a CT scan at 17.15hrs. They were requesting police attend to conduct a welfare check on Graham, but this was declined as it was deemed not to be a Police matter.

15.77 **06.06.17** Call made to Cumbria Constabulary with concerns for Agnes from a neighbour of Address A, caller reports that Graham had previously been verbally abusive to Agnes on 03.06.17. Neighbour reports hearing, "*YOU FUCKING BITCH, I FUCKING HATE COMING HERE AND NOT BEING ABLE TO SEE MY GIRLFRIEND*".

15.78 Caller states that they believe 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'.

6.1 **01.11.17** 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 PACE 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.

6.2 Graham was aggressive and confrontational and referred to himself as Agnes' registered carer.

6.3 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.

15.79 **14.02.18** 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.

15.80 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. An x-ray completed on this visit diagnosed Agnes with osteoarthritis.

15.81 **02.11.18** 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.

15.82 **10.01.19** 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 that an occupational therapy review would be needed initially to assess Agnes prior to such an aid being fitted.

15.83 **01.04.19** Carlisle City Council note that the council tax was paid in full, and an exemption class F was placed on both Address A and Address B.

15.84 **24.04.19** 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.

15.85 **30.04.19** 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 was due for review by a GP. Phone calls and house visits had been made but Agnes was never seen/spoken to.

15.86 **01.05.19** Police officers 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'.

15.87 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.

15.88 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.

15.89 **30.05.19** Graham returns CCHA calls to say he was in the midlands due to a family matter and would contact them on his return.

15.90 **03.06.19** Graham calls CCHA and requests a shower and stair lift for his mother at Address B, again he is told he will need to request an Occupational Therapy (OT) assessment via the GP.

15.91 **07.06.19** CCHA record that a Gas Service and boiler check was completed at Address B. Access was gained to the CCHA property by the contractor to complete this.

15.92 **10.10.19** An annual exemption review form (for 2019/20) was sent to Address B, addressed to Graham, in relation to the exemption applied to Address A.

6.4 **01.11.19** 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.

15.93 **13.11.19** A further review form was sent to Graham at Address B by Carlisle City Council Revenues and Benefits department.

15.94 **14.11.19** Graham calls CCHA to say that he could not make an appointment to replace the fire doors at Address B that they had scheduled in for 18.11.19 as he would be in Derby due to a bereavement and said he would contact them when he was back.

15.95 **19.11.19** 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.

15.96 **03.12.19** 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.

15.97 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.

15.98 **04.12.19** Review form was returned with no changes noted in line with previous forms returned, i.e., Address B was Graham and Agnes' residency, and Address A remained unoccupied.

15.99 **15.01.20** 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.

15.100 **23.03.20** UK goes in lockdown due to the COVID19 pandemic.

15.101 **31.03.20** 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.

15.102 **31.03.20** Police attended following information from ASC, 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[11]. Agnes was located upstairs, in bed, watching TV. No concerns identified for her. Graham was described as not cooperating, being abusive, and swearing at officers.

15.103 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.

15.104 **01.04.20** ASC receive the Police referral, it was screened by a Social Worker and closed with no further action.

15.105 **02.04.20 – 24.04.20** 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.

15.106 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

[11] Section 17 PACE 1984 (https://www.legislation.gov.uk/ukpga/1984/60/section/17)

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.

15.107 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.

15.108 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.

15.109 Agnes had coins placed over her eyes, secured with tape which was wrapped around her face. Graham stated he put the coins on her eyes as it was traditional, and he had put the tape around her face as she had died with her mouth open. Agnes had shoelaces tied around her legs. Graham stated he did this to keep her legs together.

15.110 Graham stated that his mother had died a couple of weeks earlier at around 0600 hours, he described being unable to wake her. Graham stated Agnes had died on the couch however he had moved her onto the floor following her death and he had changed the clothes that she was wearing at the time she died.

15.111 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.

15.112 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.

15.113 Paramedics attended and recorded 'time of death'. Paramedics contacted the SPA Line to get background information on Graham. They also attempted to assist Graham, but he said he felt he would deal with the situation in his own way. The paramedics did make contact with the family GP around Graham's presentation and to ensure some further support was provided for him.

15.114 Graham was arrested at 15.01 hours on suspicion of preventing the lawful and decent burial of a dead body. At 16.10hrs the duty Pathologist was called by the Senior Investigating Officer (SIO) and attended the address.

15.115 When Graham was taken to custody following his arrest, he stated to the custody Liaison & Diversion (L&D) team worker that he was taking antidepressant medication and stated that this was prescribed many years ago due to a breakup with his partner in the midlands.

15.116 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. Graham agreed to work with L&D.

15.117 The following day due to information from the post mortem conducted on Agnes; Graham was arrested on suspicion of her murder.

15.118 Graham 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.

15.119 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, at 11.00 hours.

15.120 The day after his release from custody Graham did not attend to sign on at the police station as his bail conditions required, therefore a welfare check was conducted at Address A. Police found Graham deceased and his cause of death was suspected suicide as he had left a note. In this note he claimed to have loved his mother and not harmed her.

16 OVERVIEW

16.1 Cumbria Constabulary, Castles and Coasts housing association, Carlisle City Council Revenues and Benefits department, the GP surgery (Warwick Square Group practice) and medical staff at NWAS and the Cumbria infirmary, as well as Adult Social Care were all involved to one degree or another in terms of primary or secondary contact with, or in relation to, Agnes between 2005 and her death in 2020.

16.2 The information known to agencies about Agnes and Graham indicated that they were residing together as mother and son, and that Graham had described himself as his mother's carer. They had two different addresses (Address A and Address B) and there was confusion amongst agencies around which address they were permanently resident in due to conflicting information provided by Graham.

16.3 Address A was a house owned with a mortgage by Graham and Address B a housing association property acquired by Graham as a tenant.

16.4 There was information received by Castles and Coasts Housing Association from the Revenues and Benefits visiting officer that a bolt was visible at the top of the front door on the exterior at Address B, seen via Google street view. When the CCC IMR author investigated this, it was confirmed that this information was shared in order to report the abandonment.

16.5 The visiting officer also confirmed that had there been any concerns in relation to safety / safeguarding then the police would have been contacted and asked to undertake welfare checks at the property.

16.6 There were no concerns identified by them, as it was clear that no one was living at the property, and the neighbours had already confirmed this at the visit. The external bolt was considered in relation to Address B being a visibly unoccupied/abandoned property, rather than arousing any suspicions about someone being locked inside or having reason to develop safeguarding concerns. This was immediately reported to the landlord (CCHA) as a case of suspected abandonment and demonstrates good practice on this front as well as the fact a visit was made as checks are usually paper based and follow up completed by phone calls if letters sent are not responded to.

16.7 The fact a visiting officer attended both addresses was highlighted as an example of discretionary effort, above what would have been reasonably expected of them when completing council tax checks.

16.8 Medical professionals held information that Agnes had health conditions including a hiatus hernia, osteoarthritis, pruritus ani, impaired hearing, lower back pain, a middle ear infection and COPD[12] over the course of time between October 2011 and February 2018. Graham informed the housing association that he had not moved into Address B in 2012 because his mother was 'too ill'. Agnes began to claim attendance allowance for her care and support needs in 2006.

16.9 No medical professional saw Agnes after February 2018 up to the discovery of her as deceased in May 2020, over 2 years later.

16.10 The GP surgery had notified Cumbria Constabulary on 30.04.19 of their concerns regarding the loss of contact with Agnes and the numerous calls and a home visit made by them, in an attempt to see or speak to her, having been unsuccessful.

16.11 Police had attended Address A and seen Agnes on two separate occasions prior to this call from her GP. Once on the 06.06.17 due to a neighbour reporting a domestic where Graham was heard shouting and swearing at Agnes, neighbour also reported concerns around Graham neglecting Agnes.

16.12 At this police attendance Agnes walked to the top of the stairs and told the police she was fine; officers were being prevented from entering by Graham at the front door.

16.13 The second occasion that Agnes was seen by police officers was again at Address A and was on 01.11.17, some 5 months later. On this occasion Graham was present and he refused entry to police. Agnes was seen from the doorstep and told officers that she was fine.

[12] https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/

16.14 Following the concerns raised by the GP practice on 01.05.19 Police attended Address A, and Agnes was again seen by officers, this was 18 months after their last visit.

16.15 On this occasion Agnes was seen with a meal, sat on the downstairs sofa. Graham was also present and described as shouting and being aggressive and obstructive towards officers. No concerns were noted, and no further action taken.

16.16 Just under a year later on 31.03.20, following a referral from ASC who had received information from a neighbour with concerns for Agnes, Police attended Address A again for the fourth time in just under 3 years.

16.17 Agnes was seen by officers lying in bed upstairs. She was covered with the bedding so only her face and arms were visible. Officers did not deem there to be any safeguarding concerns for her based on this attendance.

16.18 There were several missed opportunities by professionals to better understand Agnes and Graham's circumstances by being professionally curious and by considering additional powers to enter Address A and speak to Agnes alone and without Graham being present or within earshot.

16.19 These opportunities appear to have been missed because protocol relating to police attendance at domestic incidents was not followed, this seems to have happened because the relational dynamic officers were confronted with, was that of mother and adult son, rather than intimate partners.

16.20 Intimate partner abuse is the far more common and widely understood form of domestic abuse, and so this may have contributed to the officer's not recognising or investigating the situation as a potential domestic and adopting a more proactive approach to verifying Agnes' welfare away from Graham.

16.21 There may also have been some bias and assumptions around Agnes' age and the way she presented being age-related rather than due to fear, coercion, or intimidation due to abuse from Graham.

16.22 Graham experienced episodic depression which he was medicated for at various points throughout his adult life. Graham had chronic osteoarthritis and back pain, for which he had been taking pain relief since 2005.

16.23 It is known that Graham consumed alcohol and might binge drink at times, however, this alcohol consumption increased significantly after the death of his father in 1999. Some 17 years later Graham attended A&E at Cumberland Infirmary via ambulance on 05.09.16 having sustained a head injury following alcohol consumption. He stated he had fallen backwards and banged his head resulting in a laceration and possible loss of consciousness after drinking.

16.24 Family members report that Graham was unmarried and had no children of his own. He had been in several long term relationships with women over the years, at least one of which involved Graham being reported to the police by his partner for

domestic abuse in another county. No formal action was taken against Graham in relation to these reports.

16.25 Graham was not known to Cumbria Mental Health services and denied involvement with any such service before. He was prescribed an antidepressant drug (Amitriptyline) several years before Agnes's death due to reported stress relating to the end of a relationship with his partner. This is believed to have been a partner from the area he used to live in, whom he tried to sustain a long distance relationship with when he and Agnes moved back to Cumbria in 2005.

16.26 Graham was in significant financial difficulty; the house he owned, Address A, was in a very poor state but he reported being unable to afford the necessary repairs. He had not made the mortgage payments on Address A for around 18 months at the time of Agnes's death. He had been ignoring the letters sent to him about this from the mortgage company.

16.27 Graham had accrued significant debt over the 20 years before Agnes' death, taking out loans and credit cards. There were two repossession orders against him, one for Address A and one for Graham's previous address in the midlands.

16.28 Graham appeared to have used his sister in law's maiden name to mislead, as a letter was sent to him using that surname and another letter found at Address A, but the recipient was listed as his sister-in-law. He had also lied to a finance company by claiming that it was Frank who managed the house and the finances and falsely stated his sister-in-law had taken Agnes to a medical examination in relation to an insurance claim.

16.29 This strongly indicates that Graham was financially abusing Agnes, a fact further supported by the lack of Agnes' belongings in Address A when the family went to clear it out. Many of Agnes's items and treasured possessions were not found and so it is possible Graham either sold them or disposed of them for some reason.

16.30 An accredited financial investigator within Cumbria Constabulary examined the bank accounts of Agnes and Graham in July 2020 and concluded that Graham resided with his mother Agnes at Address A and that they have lived off cash debits from Agnes' accounts. There was no indication that any payments were made from the accounts in relation to food or clothing purchase etc.

16.31 This was indicative of everything being paid for in cash, taken out regularly from cash points. The accredited financial investigator suggests that Graham had lived off Agnes' benefits, as he appeared to have saved his own benefits as shown in his statement where he had amassed a total more than £6000.

16.32 Graham claimed to have a very close relationship with Agnes, describing her as his best friend. He acknowledged becoming estranged from his brother (Frank) and sister-in-law but blamed them for not wishing to visit. This is contrary to the reality of family trying repeatedly to stay in touch and visit when possible.

16.33 Graham described Agnes and himself withdrawing themselves from family and society over the years, presenting it as a choice Agnes had a part in making.

16.34 Frank and his wife tried repeatedly to arrange to visit, maintain contact and stay connected to Agnes and Graham after they moved back to Carlisle in 2005, but they were repeatedly dissuaded from travelling up, with Agnes often saying she was not well enough or Graham telling them, or Agnes herself telling them, that she did not wish to see them.

16.35 The family, who would often visit them whilst they lived in the midlands, were told in no uncertain terms they were not welcome. This wasn't out of the ordinary as even when they lived more local to family, Agnes would often decline their visits.

16.36 This resulted in the extreme isolation of Agnes from anyone other than Graham, and significant barriers being put in place preventing the family from remaining involved and informed about the wellbeing of either Agnes or Graham.

16.37 Despite this, Frank travelled up unannounced by train in 2015, in an effort to ensure both his mother and brother were safe and to try to understand what was causing their refusal to be seen.

16.38 Frank banged on the front door repeatedly and phoned to try gain entry, he was about to leave after about 30 minutes, assuming no one was there, when he saw a curtain inside the property move. Graham was there and Frank waved, leading Graham to eventually letting him inside. There was nothing observed during this visit which caused too much concern. The house was messy and in need of some maintenance but not in a state of disrepair.

16.39 Following Agnes' death 5 years after this visit, Frank discovered that Address A had no heating, no hot water, the boiler had been condemned at some point before Agnes's death, there were unsafe electrics, mould and holes in floors and ceilings.

16.40 Graham had said that Agnes had lost a lot of weight in the months preceding her death and he believed she had 'given up', she had apparently been saying she was 'too old'. He stated he had been concerned about her health since January 2020 but had not sought her any medical attention.

16.41 Graham stated he had been paying rent on Address B for years, but he and Agnes had never got around to moving in or found the 'motivation' to move. He reported that both he and Agnes were living and sleeping downstairs at Address A as Agnes was unable to use the stairs.

16.42 This contradicts information provided by police who attended Address A in March 2020 and reported seeing Agnes upstairs in her bed.

16.43 Graham was described as looking unkempt when seen in custody in May 2020, so there may have been indicators of self-neglect; he reported when in custody following his arrest that he had not been taking care of himself recently and had lost weight.

17 ANALYSIS USING THE TERMS OF REFERENCE

17.1 This part of the report examines how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It considers whether different decisions or actions may have led to a different course of events.

17.2 This section addresses the terms of reference and the key lines of enquiry within them, detailed under each subheading. It is also where examples of good practice are highlighted.

17.3 **Terms of reference 1 and 2: The communication, procedures and discussions, which took place within and between agencies and the co-operation between different agencies involved with Agnes and Graham;**

17.4 There was very little evidence of inter-agency communication or co-operation taking place in this case.

17.5 The earliest evidence of cross agency contact was on **28.09.10** when a letter from the CCC Revenues and Benefits visiting officer was sent to CCHA advising of complaints about Address B not being lived in/used as principal home**.** There is no record available to indicate whether any response was made to this information, or any action taken in relation to it by CCHA.

17.6 A third party report to police was made on **05.10.10** of a potential threat of harm to Graham. The third party explained that he had received several silent phone calls that evening from a withheld number. On the last call he had said to the caller that he was 'monitoring the call'. A male voice then said, "tell your friend Graham that he is going to get his legs broken". No other context was provided. The third party told police that he had not actually spoken to Graham for about three years. He was particularly concerned however as Graham lived with his elderly mother who was ill. The informant had tried to ring Graham directly, but the phone was answered and then put down. The incident was flagged by Police as a 'concern for welfare' at address A and repeated efforts to check in on and speak with Graham were undertaken by Police, none of which were successful. This culminated in a note being left at the address asking Graham to call Cumbria Constabulary if there were any issues.

17.7 Upon analysis of the circumstances the response by Police was deemed proportionate by the IMR author, considering the overall information provided. The officers' observations led them to conclude that someone was living within Address A due to internal lights being on one occasion and off on another that officers attended, suggesting that residents were active and thus removing the potential for using their powers under section 17 of PACE to force entry. The grounds for believing they were entering in order to save life or limb and or prevent serious damage were simply not made out.

17.8 The third party report was never able to be corroborated by officer enquiries due to the inability to gain a response from Graham or anyone at Address A.

17.9 Officers left notes asking for Graham to call back, but he never did, and the incident log was closed without Graham or Agnes ever being seen. This demonstrates a potential lack of robust safeguarding or further information sharing/seeking by the police with any other agency. This could have been an opportunity to gather more information from the informant and potentially make enquiries with Adult Social Care, neighbours of Address A via house to house enquiries, or the Council's Revenues and Benefits units who could have provided full details of the occupants so that further checks could have been made on systems against their names and Address B provided to Police for checks to be made there.

17.10 Had these enquiries been conducted for then they may have been able to identify a second address, Address B, to try and locate Graham at as he had been granted a joint tenancy at Address B with Agnes on 05.07.2010.

17.11 It remains unlikely that any further action would have been taken as it is likely he would not have engaged with enquiries as per his behaviour displayed in all future contacts with Police he had.

17.12 It is concerning that this expression of concern for Agnes by a third party is some 10 years before her death and leads to the drawing of worrying conclusions that she had potentially spent many years receiving inadequate care and support or potentially being neglected and/or at risk of harm for a lengthy period of time. The nature of the call and threat made to Graham is also suggestive of him keeping dangerous company or being involved in activities which attract such threats of violence to be made towards him and thus by proxy posing a potential is of serious harm to Agnes also.

17.13 A letter was sent by CCHA to the CCC to notify them of the tenancy start date for Address B in relation to Agnes and Graham on **17.01.11**, this ensured the local authority were aware of the address and could link it to Agnes and Graham on their records.

17.14 CCHA receive a report on **21.05.12** that Address B looked untidy and empty and on **25.05.12** a visit was made to Address B by CCHA to investigate the report that the property looked untidy and unoccupied. Despite this there is no further information to suggest any further action was taken, safeguarding concerns raised, or information shared. Expectation that CCHA officer would follow it up, that didn't happen, but it would now – abandonment policy is in place.

17.15 A call is made to Cumbria Constabulary on **03.07.12** by a workman at a neighbouring property to Address A claiming a male from the address was being threatening, abusive and aggressive towards them.

17.16 The caller felt the male was angry due to the noise they were making whilst working. It is suspected this male was Graham as he went back into Address A before the call

to police ended. A check was made by police which listed occupants of Address A as Graham and a female as living there.

17.17 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 despite the caller describing the male as being aggressive, and this was corroborated by aggressive shouting heard in the background of the call by the police call handler.

17.18 Address A was not visited and the male, suspected to have been Graham, was never spoken to about this behaviour.

17.19 Had a safeguarding enquiry been made, this would have shown on the system and may have added additional concerns prompting a check on the address as there had previously been a call regarding an elderly/ill mother residing there less than 2 years earlier in October 2010. As it was no one saw or spoke to Agnes or Graham, and the matter was put down to non-crime Anti-Social Behaviour.

17.20 Agnes' clinic appointment with Respiratory medicine was cancelled by 'patient' on **07.09.12**, it remains unclear if this was Agnes or Graham calling on her behalf. The clinic notified Agnes' GP. Agnes also missed an appointment booked for her at the respiratory medicine on **21.09.12**, and again they notified her GP. It is unknown whether the GP practice acted on this information by making a call or visit to the address to check on their patient, no record of this being done was provided to the panel.

17.21 Graham attended A&E at Cumberland Infirmary via ambulance on **05.09.16** having sustained a head injury following alcohol consumption. Graham stated he had fallen backwards and banged his head. Graham had a laceration and possible loss of consciousness. Graham left the department prior to having a CT scan and treatment. A&E staff contacted rapid response to attempt to locate Graham but there was no answer at his address. As the medical staff had been unable to locate Graham, at 19.50 hours they contacted Cumbria Constabulary and asked them to conduct a welfare check.

17.22 This indicates that information was shared with police in relation to concerns for Graham, but there is no mention of any routine enquiry around DA being made during triage or connection to Graham being a carer and thus the risk that anyone he cared for may be at due to his drinking and absence from the address.

17.23 Cumbria Constabulary declined the request to conduct a welfare check for Graham as it was deemed not a Police matter. No systems checks were made by police on Graham by name or address as the request was not progressed in anyway due to it not being suitable for Police deployment. Had they been, this may have alerted the call taker to the concern raised in October 2010 by a third party about Graham and his elderly mother, as the log would have been linked to Graham 's address.

17.24 This may in turn have prompted some professional curiosity around a potential adult at risk, particularly if her 'carer' was drinking himself to unconsciousness and injury

requiring hospital attendance. This is not guaranteed however and is unlikely to realistically have resulted in any Police intervention.

17.25 It is far more relevant for ASC to be made aware of the potential concerns, but these concerns were never developed as the hospital did not have the information about the welfare concern. As police did not check their systems following the request from the hospital, the opportunity to consider any safeguarding issue and initiate the onward sharing of information with these concerns to ASC was not created.

17.26 Had ASC been made aware by the hospital or police there were potential concerns, they could have made enquiries in the community regarding his Graham's carers status and the well-being of the cared for, Agnes. These enquires would not necessarily have met the criteria for Section 42 Care Act safeguarding enquires. The ASC approach at the material time, should have involved the offer of an assessment of need for Agnes and a carers assessment for Graham. However, ASC were not aware of Graham or that he had Care Act eligible needs or that he was a carer for his mother Agnes at that point. The first contact ASC had in relation to Agnes was not until 2020.

17.27 No follow up was made by any agency and the next information sharing opportunity comes some 9 months later on **06.06.17** when a call is made to Cumbria Constabulary with concerns for Agnes from a neighbour at Address A.

17.28 The caller reports that Graham had been verbally abusive to Agnes on a few days earlier, they reported hearing Graham shouting, "*YOU FUCKING BITCH, I FUCKING HATE COMING HERE AND NOT BEING ABLE TO SEE MY GIRLFRIEND*"

17.29 The caller also stated that they believe that the son (Graham) worked away from home and returned every few weeks to see his mother (Agnes). They were concerned that Agnes may need more care than she was receiving.

17.30 The fact that Graham was heard to say he 'hated coming here' is indicative of the fact he may not permanently reside there, perhaps having moved into Address B alone, and leaving Agnes living in Address A alone and visiting her potentially quite irregularly.

17.31 Given Agnes' medical conditions and age it seems reasonable that the neighbour should have concerns for her welfare, especially if the one person who did attend to see her, Graham, was abusing her verbally as reported.

17.32 Officers attended the address and, after a period of unsuccessful attempts to gain entry, Graham eventually answered the door but refused entry to the officers and didn't believe there was a need for them to be there. He made comments such as "*what you doing here?*" and "*you're not coming in*". He said that his Mother Agnes was deaf, which is why he would be heard shouting, so that he can communicate with her.

17.33 Agnes is reported by officers to have come to the top of the stairs, having walked there herself. Agnes then reportedly spoke with the officers from the top of the

stairs, as they remained on the doorstep, given Graham wouldn't allow them in. This contradicts entirely Graham's version of events, as if Agnes was indeed so deaf he had to shout, then she would have been unable to communicate with officers who were outside the address from the top of the stairs. This does not seem to have been acknowledged or questioned at all by the officers in attendance and again represents a lack of any professional curiosity or verifying of facts and accounts given by Graham.

17.34 Officers report that Agnes came across well and stated she couldn't understand the concern. Police did not gain access to the address and the log was closed as a 'malicious call' and that there were 'no concerns'.

17.35 This is not a satisfactory response given the nature of the words overheard and shared by the neighbour, regardless of volume used to convey the words, the words themselves demonstrate a concerning disregard for and aggression towards a potentially vulnerable older person. Therefore, Graham's justification of the incident being because Agnes was deaf does not explain the content of what was said and thus does nothing to alleviate any concerns around him being abusive towards Agnes.

17.36 The fact that Graham had said he had to shout because Agnes was deaf, yet officers spoke to her from the doorstep whilst she was at the top of the stairs, does not seem to have been identified as a real time contradiction to his account.

17.37 As per the definition in place at the time, this was a domestic incident and more should have been done to ensure Agnes was not simply responding under duress and telling the officers everything was fine, when in fact she may have been in fear of Graham and what he may do.

17.38 Agnes may well have feared Graham's actions causing her harm, but also his inaction; she was so dependent and isolated by this point that should Graham withdraw his support totally she may well have been unable to attend to her own basic care needs in relation to hydration, nutrition and hygiene. This would have been a realistic fear for Agnes and so her statement made in Graham's presence should not have been taken at face value, as Graham's explanation of the shouting was.

17.39 The fact that Graham refused entry and was so hostile and aggressive to officers should also have raised questions with those officers as to the reasons for this. The officers seem to have simply taken everything Graham said as fact and even gone to the extent of recording the incident as a 'malicious call' by the neighbour. This was an incredibly influential statement to make as it had the potential to influence further officers' views of the circumstances and risk at future attendances.

17.40 Another five months go by until **01.11.17** when a neighbour calls police in relation to noise, banging, shouting and a possible domestic at Address A.

17.41 Police attend and there was no answer to attempts to gain access. Officers therefore use their powers under Section 17 PACE and begin to force entry. At this point

Graham shows up at a window, initially angry, and describes himself as the property owner, who lives with his elderly mother. He said he hadn't heard the knocking as he had headphones in.

17.42 Graham is described as being aggressive and confrontational. Graham described himself as Agnes' registered carer. Graham tells the officers that he had been 'evicting 2 lodgers' due to non-payment of rent and them smoking weed, hence the noise reported by the neighbour.

17.43 Agnes was spoken to by police, but she was not assessed as being at risk. She was described as being alert, hard of hearing but able to understand why police were there.

17.44 The officer's judgement was likely skewed by the link to the previous log where the attending officer had resulted the incident as a 'malicious call' from neighbours.

17.45 No professional curiosity or probing questioning was shown, and all information given by Graham and Agnes was taken at face value. No further checks to test Graham's account were made by officers. No probing or questioning around the reasons for him presenting so aggressively have been completed either. Graham effectively went unchallenged and was again able to cease further enquiry and police involvement as on each previous occasion.

17.46 Agnes not spoken to away from Graham by police. This case appears to have been treated, and therefore subsequently assessed, mainly as a concern for welfare for Agnes and when she is found as presenting well to officers they have been satisfied there is no need for further police involvement or safeguarding action.

17.47 The officer did not submit a safeguarding adult form (SAF) on this occasion as whilst they did consider it, they felt it was not a domestic incident and not a Vulnerable Adult incident because when the officer read the pro-forma with the reasons when a SAF submission should be made, they felt Agnes did not fit the criteria.

17.48 The pro forma used at the time listed the following criteria;

17.49 "*Which of the following applies (delete as applicable)*

1. *The person referred has needs for care and support from the local authority (whether or not these are being met)*

   is experiencing, or is at risk of abuse (including financial abuse) or neglect, AND

   as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

2. *The person is in need of care or support services but does not appear to be currently at risk of, or suffering abuse or neglect*

3. *The person appears to have mental health issues and is not currently receiving services*

4. *The person is open to services, and this is reported for their information only (name the service here)*

5. *None of the above - if this is the case it is unlikely a VA is required, why are you submitting a VA?*

   Does the person appear to have the capacity to understand and make decisions about keeping him or herself safe in this situation?

   Who is their GP?

   What is the best safe means of contact? (e.g. own phone, through relative, through a nominated person) enter name and accurate contact number."

17.50 As the officer did not feel any of the listed criteria applied to Agnes and did not submit a SAF, no other agency was made aware of the call, or the concerns expressed by the third party about the threat made to Graham and what risk that may also put Agnes in.

17.51 Current guidance on the criteria for a SAF completion states;

"The person has care and support needs (whether they are being provided or not) AND is experiencing OR is at risk of abuse or neglect AND the person is unable to protect themselves from either the risk or the actual experience as result of those care and support needs."

17.52 Also included in the guidance is the following text to help better direct the decision making of frontline officers;

"Officers are encouraged to use professional curiosity, and to look at the whole picture/circumstance.

Self-neglect is an increasingly prevalent occurrence seen in calls for service, and a person's deemed 'capacity' to live in that way is being perceived as a blocker to submission of a SAF – for all incidents involving vulnerability/adult at risk of harm, please consider the following: if the person in question was your friend/ family member, would you consider that intervention/support was necessary/appropriate to keep them safe? If the answer is YES then a VA must be submitted.

A person does NOT have to consent to a VA submission, consent can be overridden in the Safeguarding Hub if there is deemed to be a risk of harm.

There are dedicated Safeguarding detectives within each area CID, and also in the Safeguarding Hub – please speak to them, or a supervisor, if you are unsure around submission of a SAF VA."

17.53 This additional guidance, had it been present at the time, may have helped the officer who did attend to make a different decision about submitting a SAF, or at least seeing additional advice from a safeguarding detective.

17.54 As the officer did not gain entry to the address on this occasion, they were unable to comment on the state of the property or offer much detail around how Agnes or Graham looked.

17.55 It was three months later, on the **14.02.18** that Graham telephoned Agnes' GP surgery after '*attempting to treat her back pain*'. This potentially could have been when Graham administered his own Gabapentin to Agnes, as per the post mortem toxicology results. Gabapentin is primarily classed at an anticonvulsant medicine but can be used to treat nerve pain.

17.56 This call by Graham resulted in Agnes attending A&E at Cumbria Infirmary, via urgent care ambulance, due to severe upper thoracic back pain she had experienced for the last 4 days. It was noted by NWAS that Agnes was stood at the door with her son, Graham, on their arrival and that Grham helped escort Agnes to the ambulance. Graham tells the medical staff that he had given Agnes over the counter Anadin to treat the pain, but this had not helped. Agnes was pale and nauseous with a low temperature and pain upon inhaling breath. Graham accompanies Agnes to the hospital.

17.57 The GP booked an ambulance response via the Health Care Professional (HCP) admission protocol. This is an enhanced clinically appropriate service for admission of patients. It allows for the transport of patients who have a non-life-threatening condition within a clinically appropriate timescale which meets their needs which is determined by the HCP assessment. This can be from 1-4hrs.

17.58 The response that was allocated were an Urgent Care crew who are effectively an enhanced patient transport service. They have minimal medical training unlike Paramedics and Emergency Medical Technicians. The skill set include basic life support, oxygen therapy, clinical observations with physiological scoring. They are trained to level 2 in safeguarding and expected practice would be to follow the NWAS vulnerable person policy and procedure should safeguarding concerns be highlighted during contact.

17.59 The crew would not expose and examine a patient as a Paramedic/EMT would assess the source/area of the pain and conclude a differential diagnosis. The crew have documented clinical concern in terms of temperature being low which would have been handed over to receiving hospital staff on arrival at the Emergency Department. This would have been viewed as a routine call for transport.

17.60 The GP had no concerns and shared no information during the booking process in relation to using medication that was not prescribed to Agnes. A possible cause/diagnosis was given by the GP as collapsed vertebrae. The crew have attempted to ask questions around her symptoms, and they had documented that trauma etc was denied. Graham displayed no behaviour towards Agnes or in sight of crew that have raised concerns.

17.61 It is not unusual for family members/carers to support patients to hospital in these circumstances as although it is a recognised routine transport to the service it is not

a routine call for the patient and would likely be quite a worrying event for Agnes given her age and likely frailty. There was no reason for the crew to request to enter the home as medical assessment has been completed by the GP and decision already made to attend hospital for further treatment.

17.62 At hospital an x-ray was completed on this visit which diagnosed Agnes with osteoarthritis. Less than 4 hours later Agnes was discharged with patient transport and referred to her GP for management.

17.63 No evidence of mistreatment or domestic abuse was found or recorded during this contact with medical staff. In the information seen by the panel there does not appear to have been any query around the day-to-day care and support needs of Agnes or the capacity and ability of Graham to meet those needs.

17.64 Had consideration for section 9 or 10 Care Act assessment been given, and a referral made to ASC, then this may have been an opportunity for the relevant service to gain a better understanding of the circumstances in which Agnes was living and if there were any unmet needs or risks posed to her as an adult at risk of abuse.

17.65 It is 9 months later, on **02.11.18**, that 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.

17.66 Despite this information indicating that Agnes had care and support needs and some form of disability affecting her mobility, it does not seem that any further enquiries of Graham or with Agnes, were made or any onward referrals initiated to adult social care. Given the circumstances, and the fact it was a general needs tenancy, there were no specific care and support needs, or risk identified.

17.67 Had a referral to ASC been made, it is highly likely to have been rejected as it would not have reached the threshold for any further action, it would effectively simply have been information that a Stairlift was required in one of their nearly 7000 general needs tenancies.

17.68 Graham again visits the CCHA office two months later, on **10.01.19** to make a further request for a rent statement and the fitting of a stairlift for his mother at Address B. He was again advised that an occupational therapy review would be needed initially to assess Agnes prior to such an aid being fitted. There again does not appear to have been any safeguarding considerations made here in relation to Agnes and Graham, or whether either of them would benefit from a carer's or needs assessment by a social worker. No information was shared with any other agency on either occasion.

17.69 No request for a disabled facilities grant was made to the relevant department in the council in relation to a stairlift to be fitted at Address B. This indicates that no follow up was ever made by Graham in relation to progressing this request or following CCHA's advice to get an assessment by an OT.

17.70 On **30.04.19**, three months after Graham requests a stairlift for a second time for Address B, the practice manager from Agnes' GP surgery called Cumbria Constabulary to raise concerns about Agnes as she was last in contact with the surgery on 19th February 2018, 14 months previously.

17.71 They were also concerned as in January 2019 her medication was due for review by a GP, but this had not taken place. They explained that phone calls and house visits had been made but Agnes was never seen/spoken to. The practice manager went on to explain that after these attempts, Graham had attended the surgery to say that his mother, Agnes, had moved to another county nearly 200 miles away, to live with her other son. Graham refused to provide details to them of her address. The surgery made checks, and Agnes wasn't registered with a GP elsewhere in the country.

17.72 This was a lie told by Graham, Frank had not seen his mother since 2015 and there was never any mention of her moving back down to be near him. It is still unclear as to what motivated Graham to lie, other than to prevent medical professionals from seeing and speaking with Agnes and keep her isolated.

17.73 The surgery also informed police that in March 2019 Graham had told them that text messages they had sent to his mother were unnecessary and she was '*living on borrowed time*', and that any blood tests would not be possible as she couldn't get to the surgery.

17.74 The district nurse going to the address to take the blood and see Agnes was considered, but it was then explained to Graham that if Agnes was able to get to this other county, then she may not fit the criteria as 'housebound'. Graham appears to have become sarcastic to this, replying "*she didn't walk there*". He then said how his mother wouldn't want the tests; it was explained to Graham that they would need to hear this from Agnes herself. Graham said his mother would be back in Carlisle in 2 weeks, and he would tell her to call the surgery, however this never happened, hence the call to Police.

17.75 The police made checks with adult social care who informed them that Agnes and Graham were not known to them.

17.76 Police attended Address A and spoke with a neighbour who stated they heard a TV on in the property recently, but that they hadn't seen Agnes for years at that point.

17.77 The Single Point of Access (SPA) line was called to see if they held any information. Nottinghamshire Police and Derbyshire Police were emailed with requests for checks to be carried out there.

17.78 It was not until the following day that officers managed to speak with Graham, **01.05.19**, after numerous attempts of knocking at the door and windows since the time of the initial call from the GP surgery.

17.79 Graham refused entry to the officers and was described as very agitated. Officers gained entry to the address using powers under Section 17 PACE[13], in pursuance of 'saving life or limb'. Upon entering they report seeing Agnes sat on the sofa, eating a meal that Graham had apparently prepared for her.

17.80 Agnes said she was well and not scared and didn't want to engage with the officers. She swore at the officers and told them to leave. Because Agnes was angry at the officers being there, they left.

17.81 This behaviour was again taken at face value, and all occurred within the presence of Graham. Despite this it appears that no consideration of coercive control or a power imbalance being present which was causing Agnes to align with Graham through fear, love, duty or a combination of all of those factors and feelings.

17.82 Graham is described as constantly shouting and swearing at officers throughout, even when inside the property, yet officers stated that Agnes didn't appear scared of her son Graham and wasn't confused.

17.83 The house was described by the officers who entered as warm, but cluttered and in the words of one officer like that of a 'hoarder.' A Cumbria Safeguarding Adults Board Multi-agency Hoarding Protocol and Toolkit published in October 2022 highlights the fact that;

"*An 'adult at risk' may be living with the hoarder in the property. There may be a safeguarding concern about that adult if they are at risk of harm due to the living circumstances. If you have concerns that an adult is at risk you should contact the Single Point of Access to raise a concern.*'[14]

17.84 Whilst not available at the time of the incident described above, it is good to know that the issue had been recognised and addressed through the creation of a practitioners toolkit specifically focused on hoarding by the Cumbria SAB.

17.85 Hoarding can be an indicator of self-neglect so an Adult Social Care referral for Graham and Agnes was appropriate in the circumstances and officers completed and submitted one detailing their visit. However, as there was no consent to share the information given by Agnes or Graham, the safeguarding hub did not share the SAF with other agencies. At the time, 3 years prior to the hoarding tool kit's existence, it was not common practice to override consent for self-neglect / hoarding cases where an individual is deemed to have capacity.

17.86 That said, the risk to Agnes posed by Graham's self-neglect extends to her as potential neglect as he had positioned himself as her sole carer. Photographs of the property (Appendix 1) taken just a year later show the degree to which the house was hazardous to health and effected by lack of maintenance, repair or upkeep. The sharing of information where another person (Agnes) is being put at risk by the behaviour, acts of commission or omission by someone in a position of trust

[13] https://www.legislation.gov.uk/ukpga/1984/60/section/17
[14] https://cumbria.gov.uk/elibrary/Content/Internet/327/949/4484610307.pdf

(Graham) should have been actioned, regardless of consent, as we know that consent is often not provided where the power dynamics of domestic abuse related fear and attachment are in play.

17.87 There should also have been consideration given to the possible presence of coercive and controlling behaviour and domestic abuse. Had the relationship dynamic been that of intimate partners rather than mother and son, it may have resulted in a different approach and outcome.

17.88 It is more likely to have been viewed through a domestic abuse lens and Agnes spoken to completely separately from Graham and given an opportunity to disclose any fears or concerns she had, or at least for officers to spend more time observing the surroundings, living conditions and assessing whether they were truly adequate or suitable for someone with vulnerabilities like Agnes.

17.89 The officers did not complete any follow up on Graham's claims made to the GP surgery about Agnes moving to another county and not requiring blood tests. This should have been asked of him and the information he provided clarified, checked and the informant at the surgery informed of the outcome. There is no information to suggest any of this was done, so this represents another missed opportunity to potentially challenge Graham and protect Agnes.

17.90 This lack of an investigative mindset and professional curiosity had meant that Graham went unchallenged in his lies and potentially feeling able to act with growing impunity, particularly when he behaves aggressively and intimidates professionals who do attend the address.

17.91 By not probing Graham and Agnes based on the information received and by not fully utilising the opportunity where entry was gained at the address, a chance to safeguard Agnes had been lost.

17.92 The good practice here was the fact that officers did recognise and use their powers to force entry to the address, but the opportunity this provided was swiftly lost when a superficial and minimal enquiry was made once inside and what they were told was taken at face value. There seems to have been no reasonable suspicion aroused or recognition that contradictory information had been provided by Graham.

17.93 Had these enquiries been made there may have been enough suspicion developed to arrest Graham for an offence contrary to Section 76 of the Serious Crime Act 2015 of Controlling or coercive behaviour in an intimate or family relationship[15] and remove him from the property, enabling Agnes to be seen and spoken to without him present, and perhaps for her to start to see alternatives for her ongoing care as realistic.

[15] https://www.legislation.gov.uk/ukpga/2015/9/section/76/enacted

17.94 Seven months after this, on 03.12.19, the Carlisle City Council Revenues & Benefits Visiting Officer visited both Address A and Address B again and had no response at either address. This officer noted that both properties appeared unoccupied.

17.95 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.'

17.96 This information suggests that at some point Agnes may have been at Address B, several years previously. The other alternative is that the 'lady' referred to was not Agnes but may have been a female associate or partner of Graham's. Due to the fact that Address B was never fully furnished it is highly unlikely that Agnes was ever resident there.

17.97 CCC then notified CCHA of this visit and the fact that a large grey bolt was seen on the external front door of Address B and that neighbours report the property had not been occupied for months.

17.98 At the time of this report, CCHA checked and saw that the rent account on the property was £848.52 in credit. This may have meant that no safeguarding considerations were made as the account was not in deficit. No further action was taken to explore why it appeared unoccupied and what had happened to the elderly lady (Agnes) who was supposedly living there with her son (Graham) as her carer, or why an external lock was on the door.

17.99 There seems to have been a lack of professional curiosity, and no safeguarding considered here by CCHA, no referrals, further enquiries or communications with other agencies were undertaken, despite circumstances giving cause for reasonable concern.

17.100 It is some three months later on **31.03.20** that Adult Social Care (ASC) receive a report raising concerns for 'the elderly lady' at Address A. The informant told ASC that the son used to live with his mother but had moved out and not been seen for some time. Cumbria Constabulary were informed by ASC.

17.101 Cumbria Constabulary attended Address A and Graham answered the door, he initially refused police entry and was described as very agitated. Entry past Graham had to be forced under Section 17 PACE[16] and Agnes was located by officers upstairs, in bed, watching TV.

17.102 The officer with Agnes stated that they were unable to gauge comprehensively the physical condition of her. She had been sat up in bed under the bedclothes with only her arms on show. The officer considered her to be elderly and frail but not unexpectedly so for a woman in her nineties based on what he could see; no concerns were identified for her.

[16] Section 17 PACE 1984 (https://www.legislation.gov.uk/ukpga/1984/60/section/17)

17.103 Officers described the house as cluttered and messy, but not dirty, and they didn't feel Agnes was being neglected. This is in stark contrast to how Address A was just several weeks later after the deaths when family described it as filthy. Family highlight that Graham was not a competent cleaner and had even previously asked Frank's wife how to dust and what items he should to buy to clean with.

17.104 Agnes was assessed by police in attendance on 31.03.20 as having capacity and had a conversation with one officer upstairs, whilst another officer spoke with Graham downstairs.

17.105 Graham was described as not cooperating, being abusive, and swearing at officers. Officers left the address and submitted a Medium Risk[17] SAF in relation to the incident.

17.106 The overall police contact analysed shows that when Police attended the home of Agnes and Graham, they submitted a SAF to the Safeguarding Hub which was subsequently shared with ASC on just one occasion, the 31.03.20, assessing the situation as Medium Risk.

17.107 Section 42 of the Care Act 2014[18] provides that where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support, whether or not that is provided by the local authority
- is experiencing, or at risk of, abuse or neglect and
- as a result of those needs is unable to protect him or herself from either the risk of, or the experience of, abuse or neglect.

17.108 They must make whatever enquiries are necessary to decide what action, if any, is required and, if so, by whom. A Section 42 enquiry may result in a referral to the police for further investigation.

17.109 Whatever the origin of the investigation, where it concerns suspected abuse by a familial carer, officers should consider that the case may be domestic abuse from the outset. This was not what happened in this case and is a point of learning identified for Cumbria Constabulary.

17.110 Between 02.04.20 and 24.04.20 CCHA attempted 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.

[17] Medium Risk definition - Vulnerable adult may be at risk of harm, but no immediate action required to safeguard. (e.g. the vulnerable adult has sustained minor injuries without any clear explanation.) Consideration of the requirement for a strategy / multi-agency response is necessitated.

[18] Section 42 of the Care Act 2014

17.111 Despite these concerns for welfare there is no information to suggest they made any safeguarding referrals or shared information with any other agency despite the fact they had now had no contact with Graham since 15.01.20 when he left them a voicemail saying he would call back to explain what was happening with Address B.

17.112 CCHA held information that an adult with care and support needs (Agnes), including mobility issues and poor health was being cared for by her adult son (Graham), and had been unable to ascertain residency for in a flat which had been allocated in 2010, a decade earlier.

17.113 Had information relating to this, alongside the concerns about the external lock on Address B, been articulated and shared with another relevant agency, then it is possible that a safeguarding enquiry may have been initiated and more robust attempts to see and speak with Agnes and conduct a needs assessment may have been made.

17.114 When Graham lived in the Nottingham area prior to 2005, he was reported to Police for domestic related offences against his partner at the time. These offences occurred before the implementation of the 'Domestic Abuse, Stalking, Harassment and Honour Based Violence' Risk Indicator Checklist (DASH)[19] across policing to identify, assess and manage risk in a domestic case.

17.115 Whilst DASH was not implemented in 2005, it is possible that Nottingham Police were using a risk assessment tool for domestic abuse cases such as 'SPECS' (acronym for high risk factors Separation, Pregnancy, Escalation, Control, Sexual assault) as other police forces were using a variety of different risk assessments prior to the roll out of DASH in approximately 2010.

17.116 The reports also pre-dated the introduction of Multi-Agency Risk Assessment Conferences (MARACs). This means that there would have been no 'MARAC to MARAC' transfer of information, regarding the allegations against Graham, between Nottingham and Cumbria. This would only have taken place in any event if Graham had been assessed as posing a High Risk of serious harm to his partner, which it appears he was not.

17.117 There is no suggestion that Graham was considered high risk, and the reported offences resulted in 'no further action' (NFA) by police, meaning there was not enough evidence against Graham to proceed to charge him with any criminal offences relating to the allegations made.

17.118 The police would not have known that Graham had moved to Cumbria and would therefore not have been able to notify the local force area of his previous involvement with them. There was no requirement for Graham to notify anyone in the police of his new address or that he was relocating.

[19] https://proceduresonline.com/trixcms/media/6627/dash-risk-assessment.pdf

17.119 Had this intelligence, regarding previous domestic abuse, somehow been known to Police and Adult Social Care in Cumbria, it would not necessarily have precluded Graham from becoming a carer for Agnes.

17.120 It would perhaps have informed any risk assessments made in relation to him, had any been completed, but given the fact that no charges were brought against him, and it was around two decades prior to Cumbria Constabulary first contact with Graham and Agnes in 2017, it is unlikely to have been viewed with much relevance or significance in terms of assessing the risk posed then.

17.121 The definitions of Risk that the Police would have used had a DASH[20] been completed with Agnes are as follows;

Standard: Current evidence does not indicate likelihood of causing serious harm.

Medium: There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

High: There are identifiable indicators of risk of serious harm. The potential event could happen at any time, and the impact would be serious.

17.122 It is therefore not unreasonable that this information was not known to Cumbria Constabulary or Cumbria Adult Social Care at the time Agnes and Graham became known to them post 2005. It is also reasonable to surmise that had it been known it is unlikely to have changed the course of events which occurred based on actions taken by agencies.

17.123 Since the period in time when Graham was reported for domestic abuse against his partner, systems have been put in place nationally which better capture and convey this type of intelligence. This includes the Police National Database (PND) and 'flags' or 'qualifiers' added to information held on Police and agency systems which highlights any case or incident where domestic abuse is a factor.

17.124 It is still likely, however, that a PND check would not have been conducted upon Graham based on the involvement Cumbria Constabulary had with him.

17.125 Some forces do take the view that a PND check should be conducted for all Domestic Abuse related incidents, but this is not a national policy, and the College of Policing guidance suggests that domestic abuse related intelligence should be kept as up to date as possible and uploaded onto local intelligence systems and national databases, particularly the Police National Database (PND), without delay.[21]

17.126 A theme of lack of adequate, timely and relevant information sharing has presented throughout this review. The chronological narrative demonstrates missed

[20] https://DASH+2009+2024.pdf

[21] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/leadership-strategic-oversight-and-management#domestic-abuse-and-the-intelligence-process

opportunities where sharing of information between agencies may have provided an enhanced response to Agnes as a victim of neglect and abuse.

17.127 **<u>Term of reference 3:</u> The opportunity for agencies to identify and assess domestic abuse risk with special regard to domestic abuse in later life.**

17.128 There were several opportunities presented to agencies to identify and assess the DA related risk, particularly regarding the fact Agnes was the suspected victim and in later life. These were not seized however, and no risk assessment was ever completed with Agnes, nor was any consideration seemingly given to triggering the domestic abuse policies and procedures as the matter was simply not viewed in those terms.

17.129 **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.**

17.130 Whilst domestic abuse was never overtly disclosed by Agnes to any professional, the fact that she was so isolated, elderly and dependent on her son and the fact there had been several concerns raised over the years by neighbours about him neglecting and abusing her, it is reasonable to suggest that it should have been identified.

17.131 College of Policing Approved Professional Practice (APP) states that "Police officers are accustomed to dealing with intimate partner abuse, which is what is traditionally thought of as domestic abuse. Familial (non-intimate partner) abuse poses some different challenges in terms of finding the appropriate response. It can be less easily recognisable as domestic abuse, yet it falls within the definition and should be treated as such."[22]

17.132 Child to parent abuse can, of course, be committed by adult children of any age on parents and in all cases, parents may be frightened, ashamed or simply not know how to effectively address the situation and should be offered support.

17.133 It seems apparent from the information provided to the panel in this case that just one incident was initially flagged as Domestic Abuse related by Cumbria Constabulary, yet even that soon became re classified as a 'concern for welfare' and so no routine domestic abuse protocols were followed such as separation of the parties, risk assessment completion with the suspected victim, arrest or other form of disruption of the suspected abuser.

17.134 APP guidance[23] also details that as with other domestic relationships, older victims are often dependent on their abuser and that dependence generally increases with age for health reasons. This makes the prospect of the victim gaining independence from their abuser less likely than for other domestic abuse victims.

[22] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/understanding-risk-and-vulnerability-context-domestic-abuse
[23] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/understanding-risk-and-vulnerability-context-domestic-abuse

17.135 Abuse can occur where the abuser has taken on a carer role towards the older person. If the adult child has formally taken on the role, abuse may result from tensions caused by the carer relationship or as a means of maintaining control. When the presenting issue seems to be abuse by the carer, officers should consider whether it also constitutes domestic abuse.

17.136 Despite several risk indicators being present and domestic abuse even being highlighted upon one of the police incident logs, it does not seem to have been approached in this way by any attending officer.

17.137 Graham, on every interaction with police, had demonstrated aggression, hostility and a reluctance to allow officer's entry to the address of his mother, Agnes. This does not appear to have raised reasonable concerns or prompted any professional curiosity as to why he was behaving in such a manner, what he may be wishing to prevent them from seeing, or his motives behind such a demonstrative lack of engagement with their very reasonable and justified requests.

17.138 **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.**

17.139 At the time there was not a policy in place for routine enquiry about domestic abuse at the GP practice who state it was not used in Primary Care within Cumbria at the time of contact with Agnes.

17.140 There is no evidence that any questions were asked of Agnes when she attended A&E or any of her outpatient appointments. Plans for a routine enquiry pilot to be commenced in NCIC acute and community services to ensure all patients are asked routine questions in relation to domestic abuse were underway at the time of the NCIC IMR being completed.

17.141 **<u>Term of reference 4:</u> 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.**

17.142 The only agency that had recorded any reference to domestic abuse in this case was Cumbria Constabulary. On the 06.06.17 the police call handler created an incident log and requested officers attend and try and ascertain if any 'domestic incidents' had occurred following a call from a neighbour. It is clear that the call handler has recognised the domestic related part of the abuse and documented it as such. This is an example of good practice by the call handler, recognising domestic abuse from what they were told within the call and recording it as such.

17.143 The Human Rights Act 1988 (HRA) places an obligation on police officers to take reasonable action, within their powers, to safeguard the human rights of all victims of crime, including but not limited to:

- Right to life (under Article 2 ECHR);

- Right not to be subjected to torture or to inhuman or degrading treatment (under Article 3 ECHR);
- Right to liberty and security of person (under Article 5 ECHR);
- Right to respect for private and family life (under Article 8 ECHR).

17.144 The requirement to take action to safeguard vulnerable adults from abuse must meet human rights standards and be proportionate and necessary to the perceived level of risk and seriousness.

17.145 It must also have a basis in law, for example, acting with the informed consent of a victim or in the best interests of an adult lacking capacity in accordance with the Mental Capacity Act (MCA) 2005, acting under a duty of care or in the public interest, for example, protecting other vulnerable adults from abuse.

17.146 The requirement to take safeguarding action incurs obligations at every stage of the police response. These obligations begin from receipt of the initial alert throughout the whole process of investigation and extend to the multi-agency process for safeguarding vulnerable adults.[24]

17.147 This review has found evidence to suggest that safeguarding actions were not always taken when they should or could have been during police contact with Graham and Agnes, even though 'domestic abuse' was recorded as concern on the call log.

17.148 This meant that no risk assessments relating to the domestic aspect of the situation were completed and the expected standards of response and practice were not met. Had domestic abuse been properly accounted for and applied to the situation, then it is far more likely that the decision making, and response could have differed and increased the likelihood of more robust, assertive and intrusive actions being taken.

17.149 These actions would have challenged Graham's power and offered an opportunity for Agnes to be seen and supported away from his presence.

17.150 This may or may not have resulted in a better approach to safeguarding Agnes, but the opportunity to find out was missed.

17.151 **<u>Term of reference 5:</u> Organisations' access to specialist domestic abuse agencies, with special regard to domestic abuse in later life.**

17.152 This was not considered by any agency involved with Agnes or Graham and so no such support was offered or sought for advice.

17.153 There are several national organisations who can provide specialist support and advice for victims and professionals however the panel has seen no evidence to suggest these were known about or accessed in relation to this case.

[24] https://library.college.police.uk/docs/acpo/vulnerable-adults-2012.pdf

17.154 This appears to be because DA was not really recognised as a potential factor and because of the hostility shown by Graham and compliance to Graham's narrative by Agnes, it appears no concerns around DA were identified.

17.155 **<u>Term of reference 6:</u> 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.**

17.156 There is a lack of information to suggest that frontline, or second line staff were adequately equipped at dealing with DA because it was never recognised as a risk or concern in this case. This indicates that more training and provision of accessible and operationally appropriate guidance is needed to highlight the links between domestic abuse and adults at risk, as well as the abuse experienced by those in later life.

17.157 Victim Support Cumbria introduced the 'Older Persons DASH Risk Assessment' in late 2018 and it was shared at a multi-agency Domestic Abuse steering group a number of times before Cumbria Constabulary agreed to include the bespoke risk assessment on the MARAC referral portal. This does not however seem to have been used and it may be that whilst specialist departments or strategic units may be aware of such developments, the frontline response staff may not have been.

17.158 Victim Support Cumbria later went on to develop the combined 'Older Persons DASH Risk Assessment' with Professor Jane Monckton Smith's homicide timeline research[25] and this upgraded tool was approved for national use across Victim Support in January 2022. It was also adopted by Cumbria Domestic Abuse Partnership as a practice standard in mid-2022.

17.159 Whilst there were also some national, open source resources and guidance available, because the links weren't recognised, it is likely that these resources would not have been accessed.

17.160 The level of staff training in each agency indicates both safeguarding and domestic abuse is covered, but the evidence of cross agency action and inaction in this case demonstrates that it was not sufficient in terms of the level of professional curiosity employed or the understanding of domestic abuse in the familial, rather than intimate partner, dynamic.

[25] Monckton Smith, J. (2020). Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide. *Violence Against Women*, *26*(11), 1267-1285. https://doi.org/10.1177/1077801219863876

17.161 **<u>Term of reference 7:</u> Analysis should pay particular attention to the following issues:**

17.162 **Age of victim:** A Domestic Homicide Review Case Analysis Report completed in 2016[26] found that ageist assumptions led to missed opportunities, as older people were considered at low risk for victimisation by practitioners.

17.163 The Report also found that just one of the eight adult family homicide victims had been subject to a domestic abuse risk assessment before the murder. One was never completed with Agnes as the familial dynamic of mother and son and social dynamic of carer and older person seems to have distracted professionals from the possibility of risk related to domestic abuse.

17.164 It appears from the evidence gathered during the course of this Review that it was never grasped that Agnes was at risk of serious harm from her son, Graham. This aligns with findings from the 2016 Report suggesting that *"risks to mothers from violent sons needs to receive more attention, both in risk identification, assessment and management and in access to support."*

17.165 Initial data analysis from a domestic homicide project established by National Police Chiefs' Council and the College of Policing in May 2020[27] suggests there were more older victims (aged 65+) of domestic homicide during the pandemic compared with previous years.

17.166 Older victims were killed both by intimate partners and by adult children/grandchildren. Victims were most often female, whilst suspects were most often male.

17.167 'Covid insights' suggest that disrupted support services to older couples and family members with caring responsibilities during the pandemic may have increased their risk of harm, including homicide.

17.168 The project advised that agencies should be aware that older (female) victims of domestic abuse seemed to be at greater risk of homicide during the pandemic and social restrictions. Agencies should ensure risk assessment tools sufficiently recognise the risk posed to older victims of intimate partner and adult family abuse.

17.169 Bows' (2019) analysis of ninety domestic and family homicide among older people also found that older women (aged over 60) are more at risk of being killed by their child compared to older men."[28]

17.170 Whilst agencies were aware of Agnes's age this actually seemed to hinder safeguarding considerations and recognition of domestic abuse rather than heighten

[26] https://repository.londonmet.ac.uk/1477/1/STADV_DHR_Report_Final.pdf
[27] https://www.vkpp.org.uk/assets/Files/Older-Victims-Spotlight-Briefing-Feb-2022-AC.pdf
[28] https://academic.oup.com/bjsw/article/49/5/1234/5211414

them. Her age may have been seen as a factor in her poor health and environment ahead or in place of any suspicions around neglect and abuse.

17.171 Analysis of the information reviewed by the panel suggests that every agency would benefit from regular training and consistent internal messaging around the links between age and domestic abuse and organisations such as Age UK[29], and Hourglass[30] are referenced and accessed for specialist advice and training to enhance the recognition of victims in later life and the additional barriers they may face to accessing support.

17.172 This needs to include a focus on age-related biases that may present, potentially unconsciously, when engaging with people in later life and their family members and/or carers.

17.173 Some research[31] commissioned by the constabulary with Leeds University found that *"Cumbria has a larger proportion of older residents than nationally, and it is set to rise…Obstacles to accessing support may include a lack of knowledge about services, feelings of stigma and shame, and a lack of financial independence."* This highlights the increased importance of professionals in this area being aware of such barriers as working collectively to remove or decrease them through enhanced awareness, improved accessibility of services and targeted campaigns.

17.174 **Coercive Controlling Behaviour:** From the evidence reviewed by the panel it appears that there is likely to have been coercive and controlling behaviour used by Graham against Agnes, resulting in her almost total isolation from the outside world, her deteriorating health, her living conditions and financial situation.

17.175 This was not recognised or considered however by any professional or agency who had contact with Graham or Agnes and so was never investigated, meaning it cannot unequivocally be determined as fact. It does however remain a significant consideration made as part of this review given the information obtained and analysed.

17.176 The most commonly identified antecedent risk factors for all suspects in domestic homicides include[32]:

- Coercive controlling behaviour (CCB);
- Mental ill health;
- Alcohol and drug misuse, and;
- (threat/fear of, or actual) Relationship ending/separation

17.177 When considering Agnes and Graham's case, most of these factors were present. Graham had a history of episodic depression which impacted his mental health, he

[29] https://www.ageuk.org.uk/information-advice/health-wellbeing/
[30] https://wearehourglass.org/
[31] https://eprints.whiterose.ac.uk/204108/
[32] https://www.vkpp.org.uk/assets/Domestic-Homicides-and-Suspected-Victim-Suicides-Year-3-Report_FINAL.pdf

misused alcohol and reported drinking heavily, Agnes was very elderly so it is probable that Graham feared her death in some way as it would mean an 'end' to his relationship with his mother or separation from her.

17.178 Part of the coercive control that information seems to indicate was being exerted by Graham over Agnes involves a degree of economic abuse. Graham was in a high level of debt, not helped by the fact that he was financially responsible for two properties.

17.179 When Graham applied for the tenancy on Address B, current policies and procedures within CCHA dictate that the applicant is required to confirm that they do not own any other property and that if they do, confirm that it is up for sale by signing a specific declaration form.

17.180 This does not appear to have been the case as there is no record on CCHA systems of Address A still being owned by Graham and the staff involved in approving the tenancy were not still employed at the time the IMR was completed.

17.181 Had this step been taken then it may have resulted in the tenancy not being approved and the debt accrued by Graham over the years less significant.

17.182 It would be reasonable to surmise that this debt caused a significant amount of stress to Graham and may have been a factor in his excess use of alcohol. This drinking is then likely to have increased the risk he posed to Agnes as it acts in a disinhibitory way and dulls the senses. If Graham was intoxicated through alcohol then it is hard to imagine that it did not impact on his ability to provide safe personal care to Agnes, and this potentially contributed to his neglect of her over several years.

17.183 **Agnes and Graham's relationship as mother and son:** The Crime Survey for England and Wales does not routinely measure child-to-parent violence yet overall, a quarter of domestic homicides in the United Kingdom involve a victim aged 60 and over, even though this age group accounts for 18% of the population.

17.184 There are also differences in the types of perpetrators that commit the offences for example, more homicides are committed by family members.[33]

17.185 Parricide is when a parent (including adoptive or stepparent) is killed by their child, either through a single incident or a culmination of abuse/neglect.[34]

17.186 Research into Parricide was conducted for a paper titled 'Parricide in England and Wales (1977-2012): An exploration of offenders, victims, incidents and outcomes' by Dr Holt. Using the Home Office Homicide Index[35], Dr Holt was able to identify 693 incidents between 1977 and 2012, equating to around 19 each year. In 670 of those

[33] https://assets-hmicfrs.justiceinspectorates.gov.uk/uploads/crimes-against-older-people.pdf
[34] CCJ_Pre_Published_Holt2017.pdf (roehampton.ac.uk)
[35] Home Office Homicide Index

incidents, the life of one parent was claimed, in 23 cases both parents were killed. That's at least one parent killed every 19 days in England and Wales.

17.187 Around 90% of the suspects were male and ranged in age from 11 to 69. In terms of victims, 49% of those killed were mothers and ranged in age from 25 to 101. 84% were white. This fits with the demographic of Agnes and Graham.

17.188 The most common methods were using a blunt or sharp instrument (60%), strangulation (16%), kicking or hitting (10%), and shooting (7%). It appears that the relational dynamic of mother and son seemed to cause professionals in this case to either err away from, or not even consider, assessing the risk in a domestic abuse context.

17.189 **Graham as "carer" for Agnes:** From the information seen by the panel it is apparent that Agnes had a substantial long-term impairment that prevented her from carrying out normal day-to-day activities and therefore she had a disability under the Equality Act. She was becoming increasingly less mobile and was seemingly reliant on Graham to feed, wash and dress her and support with her personal care needs. It is suspected that Graham's neglect of Agnes' basic care and support needs, potentially coinciding with repeated injurious assaults, led to her death.

17.190 Graham informed Carlisle City Council Revenues & Benefits team in March 2014, and Cumbria Constabulary during initial interview in May 2020, that he was Agnes's registered carer. Graham qualified for and was awarded a 25% carer's discount on his council tax bill. The NHS describe being a carer for someone as;

"…looking after someone regularly because they're ill, they're an older person or they're disabled – including family members.

Carers help with:

- washing, dressing or taking medicines
- getting out and about and travelling to doctors' appointments
- shopping, cleaning and laundry
- paying bills and organising finances"[36]

17.191 The SCIE[37] outline that a carer's assessment is a critical intervention which supports a local authority to determine whether a carer has a need for support to help them live their day-to-day life and to continue providing support to an adult.

17.192 Any carer who is 'ordinarily resident' can request an assessment and the local authority has a duty to undertake the assessment. Graham did not request a carers assessment and may not have known he was able to do so.

[36] https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/carer-assessments/
[37] https://www.scie.org.uk/care-act-2014/care-act-factsheet-4-legal-duties-for-a-carers-assessment/

17.193 Information provided to the panel suggests that Graham was never offered or accessed a carer's assessment under Section 10[38] and may have refused one if the offer had been made to him. The Care Act states that where a carer refuses a carer's assessment, the local authority concerned is not required to carry out the assessment.

17.194 If a carer does decline a carer's assessment then some degree of professional curiosity must be employed to understand the cause of the declination, as this could present a desire to isolate the 'cared for' or indicate potential unmet care and support needs.

17.195 Section 10 of the Care Act states that;

A carer's assessment must include an assessment of—

a. whether the carer is able, and is likely to continue to be able, to provide care for the adult needing care,
b. whether the carer is willing, and is likely to continue to be willing, to do so,
c. the impact of the carer's needs for support on the matters specified in section 1(2),
d. the outcomes that the carer wishes to achieve in day-to-day life, and
e. whether, and if so to what extent, the provision of support could contribute to the achievement of those outcomes.

17.196 Agnes never received a needs assessment under Section 9 of the Care Act 2014[39] which informs that local authorities must:

- carry out an assessment of anyone who appears to have needs for care and support, regardless of whether those needs are likely to be eligible;
- focus the assessment on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve;
- involve the person in the assessment and, where appropriate, their carer and/or someone else they nominate;
- provide access to an independent advocate to support the person's involvement in the assessment, if required;
- consider other things besides care services that can contribute to the desired outcomes (e.g. preventive services, community support).

17.197 The 'Care and support statutory guidance' updated 28 March 2024 provides a definition of 'wellbeing' is to accompany Section 1 of the Care Act 2014. It explains that 'wellbeing' is a broad concept, and it is described as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)

[38] https://www.legislation.gov.uk/ukpga/2014/23/section/10
[39] https://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted

- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society

17.198 The individual aspects of wellbeing or outcomes above are those which are set out in the Care Act 2014 and are most relevant to people with care and support needs and carers. There is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round.

17.199 Many of these outcomes were denied to Agnes and as such her wellbeing, as statutorily recognised, was significantly compromised.

17.200 Agnes could have refused a needs assessment had one been offered to her, however, under Section 11[40] Care Act, where an adult refuses a needs assessment, the local authority concerned is not required to carry out the assessment unless;

(a) the adult lacks capacity to refuse the assessment and the authority is satisfied that carrying out the assessment would be in the adult's best interests, or

(b) the adult is experiencing, or is at risk of, abuse or neglect.

17.201 This review considered whether there was evidence to suggest that Agnes should have been recognised as at risk of abuse or neglect and a Section 9 Care Act assessment completed. Given her intersecting identities as a woman, in later life with a disability and whose care and support needs were reliant upon being met by her adult son, Agnes was statistically at higher risk of abuse and neglect.

17.202 **Mental Health & Physical Health:** The Homicide Index (HI) data (1996-2012) show that 35% of offenders were intoxicated at the time of the killing(s). For offenders, this is almost double the proportion found in all homicides in England and Wales (Miles, 2012) and it raises important questions about the unique context of parricides that make them distinct from other homicides.[41]

17.203 Both Agnes and Graham had physical health conditions which would have caused pain and discomfort and required medication and or other treatment to manage.

[40] https://www.legislation.gov.uk/ukpga/2014/23/section/11
[41] CCJ_Pre_Published_Holt2017.pdf (roehampton.ac.uk)

17.204 Part of the neglect and abuse Agnes suffered encompassed the lack of access to appropriate medical care when she was in dire need of treatment and expert clinical intervention.

17.205 As described by Dr Armor in the post mortem report Agnes suffered multiple, layered rib fractures, reasonably believed to have been caused by injurious assaults on several separate occasions.

17.206 The collective impact these injuries would have had on Agnes' ability to breath and find positional comfort is significant. Her health needs may well have proven a point of contention and bitterness for Graham, as indicated in his abusive narrative to Agnes overheard by a neighbour when he declared he 'hated coming here'. It may have been the responsibility for his mother's care was just too great for him, yet he refused to access any formal or informal support from professionals or family members.

17.207 This refusal to allow anyone in to his and Agnes' home and world presents as a form of denial, similar to his ever-growing debt and avoidance of addressing this issue despite numerous warnings, letters from courts and repossession orders.

17.208 Whilst not formally diagnosed with any mental ill health other than situational depression, the combination of the mounting debt, the squalid condition he had allowed the house to deteriorate into, and his alcohol misuse is likely to have impacted negatively on his frame of mind.

18 CONCLUSIONS

18.1 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.

- 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.

- 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 and even lied to her GP practice in saying she had moved out of the area.

- Before his own death by suicide, Graham did not provide any explanation for these lies or explain why he refused access to Agnes by professionals and family on multiple occasions or why he did not seek medical treatment for her despite claiming that her health had been deteriorating since January 2020.

- 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.

- Agnes was never seen by police without Graham being in the address and no questions which focused on coercive control or domestic abuse were asked of her; she was seen primarily as on older person being looked after by her son, rather than a potential victim of domestic abuse at risk of serious harm.

- 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.

- 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.

18.2 In an inspection report by HMICFRS in 2019 [42] concerns about adult safeguarding arrangements were identified. The below extract from the report highlights some of the findings which are pertinent to this Review.

18.3 *"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*

[42] https://assets-hmicfrs.justiceinspectorates.gov.uk/uploads/crimes-against-older-people.pdf

- *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."[43]

18.4 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.

18.5 With such little evidence to really understand what Agnes' and Graham's life was like, all the panel can do is rely on the evidence presented, and this points to the fact that Graham was abusing Agnes financially by spending her money rather than his own, by neglecting her basic needs, her medical requirements and by suspected intentional assaults causing her cumulative injuries which eventually resulted in her death.

19 LEARNING IDENTIFIED

19.1 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.

19.2 All early learning identified during the review process is detailed here along with whether this has already been acted upon.

19.3 Due to the time between this homicide and the report completion, the vast majority of actions were identified and completed prior to report submission, as part of the review process. The summary has been divided by subheadings into relevant agency.

19.4 **Victim Support**
Victim Support Cumbria 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' was the basis for the development of a triage risk assessment tool for anyone who declined to complete a full DASH (27 questions).

19.5 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. This remains in the planning stage at time of writing

[43] https://assets-hmicfrs.justiceinspectorates.gov.uk/uploads/crimes-against-older-people.pdf

but promises innovative practice in accessibility and availability of DA specialist support from a primary health perspective.

19.6 **Adult Social Care (ASC)**
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.

19.7 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.

19.8 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 9[44] and Section 11[45] of the Care Act, alongside 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.

19.9 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.

19.10 Following this, a Practice Learning Group internal monthly bulletin briefing highlighted awareness of Abuse in the older population. At the same time the DASH risk assessment was updated with a focus on older people.

19.11 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.

19.12 During this review period a 'First Contact Guidance' has been 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.

19.13 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

[44] 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.
[45] Section 11 of the Care Act 2014 outlines what happens when an adult or carer refuses to have an assessment.

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.

19.14 A new Self neglect strategy[46] has been developed and a number of interactive sessions delivered by Advanced Practice Leads to support the implementation of the strategy across frontline practitioners.

19.15 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.

19.16 An ASC presentation, in March 2022, to the Police Safeguarding Hub was delivered 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.

19.17 **North Cumbria Integrated Care Board (NCIC)**
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. The implementation of routine enquiry for all patients attending the emergency care department was needed, alongside improvements in identifying, signposting and supporting victims.

19.18 Four years on, at the completion of the Report, vast progress has been made by the NCIC and partners, this is detailed below.

19.19 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 DHRs in Cumbria.

19.20 'How safe do you feel?' is based around normalising asking people about their safety in the same way as health professionals we ask about other aspects of people's lives.

19.21 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 these are the 'front door services' where a spike in DA cases involving older adults within the community had been noted.

19.22 There are four questions which form part of the assessment, these are;

- How safe do you feel (framing questions)?

[46] https://www.cumbria.gov.uk/eLibrary/Content/Internet/327/949/43214103754.pdf

- 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?

19.23 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.

19.24 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.

19.25 The training is a multi-agency led offering incorporating police, Women's community matters, Victim support and NCIC.

19.26 It is a full day session covering the "how safe do you feel?" campaign and the reasons the project was created.

19.27 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 disproportionally affected by DA.

19.28 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.

19.29 A representative from 'Women's community matters' then covers what domestic abuse is, the Domestic Abuse Act 2021[47], signs and prevalence, trauma informed approaches, perpetrator behaviours and the 8 Stage Homicide Timeline.[48]

19.30 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.

19.31 Police representatives then support with covering information around the VAWG agenda, control and coercion, so called 'honour' based abuse, Domestic Violence

[47] https://www.legislation.gov.uk/ukpga/2021/17/contents
[48] https://www.homicidetimeline.co.uk/what-is-the-homicide-timeline.php

Disclosure Scheme (DVDS), Domestic Violence Protection Orders (DVPOs), information sharing and the police role in managing risk.

19.32 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.

19.33 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.

19.34 NCIC have adopted the Victim Support version of the DASH risk assessment which incorporates the homicide timeline.

19.35 **Castles and Coasts Housing Association (CCHA)**
Early learning identified from this Review and following recommendations from a previous DHR both Safeguarding and Domestic Abuse cases are shared as case studies during bi-monthly safeguarding meetings to ensure lessons are learned and knowledge / best practice is shared.

19.36 All CCHA staff must now complete annual online Safeguarding training levels 1 and 2. CCHA are commencing the process for DAHA accreditation.

19.37 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.

19.38 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.

19.39 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.

19.40 **Warwick Square Group Practice**
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. The Practice intend to introduce routine enquiry with an emphasis of asking the question without the carer / relative present.

19.41 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.

19.42 The team did raise a safeguarding concern, however when feedback was not received 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.

19.43 The practice plan to continue using case studies within training which reaches all Practice staff.

19.44 Another lesson 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.

19.45 **Cumbria Constabulary**
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 the victim and promote their welfare.

19.46 The main lesson that has been drawn from the case centres on why police officers have 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.

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

19.48 The way in which the force has assessed and managed the risk posed by the perpetrator has shown no significant structural or procedural areas of concern.

19.49 Previous area DHR recommendations have been considered to determine if there were previously identified areas of learning that have failed to be addressed fully. On review there are no recommendations relating to the identification of domestic abuse of elderly persons that had been made prior to Agnes's death.

19.50 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.

19.51 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 inspection[49] 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."

19.52 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 closely with partner organisations to implement an action plan to reduce this type of harm."*

19.53 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.

19.54 Each command has recently created a 'DA improvement plan' where performance issues have been identified, and work is being done to address them. The constabulary is one of the best performing forces within the VAWG framework and DA remains a priority for the constabulary.

19.55 **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.

19.56 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.

[49] https://hmicfrs.justiceinspectorates.gov.uk/publications/peel-assessment-2023-25-cumbria/

19.57 **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.

19.58 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].*

19.59 **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.

19.60 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.

19.61 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.

19.62 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.

19.63 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].*

19.64 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.

19.65 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.

19.66 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.

19.67 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.

19.68 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.

19.69 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.

19.70 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.

19.71 The HQ PPU DA team (DC, DS and DI) are carrying out weekly reviews into Outcome 15 & 16[50] 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.

19.72 Training has again been updated, and 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.

19.73 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.

[50] **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.

19.74 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.

20 RECOMMENDATIONS

20.1 Panel members were asked to ensure recommendations were focused and specific, and capable of being implemented.

20.2 These recommendations reflect the learning identified throughout the Review process and the conclusions drawn.

20.3 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.

20.4 **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 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.

20.5 **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).

20.6 **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.

20.7 **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.

20.8 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.

ANNEX A

DARDR in relation to the death of Agnes in 2020

ACTION PLAN

AGENCY	ACTION	DATE SET	CURRENT STATUS
Recommendation 1	The force should review their procedure for managing 'concern for welfare' calls for service and improve their ability to identify crimes and abuse upon initial call. This should be done in partnership with the relevant agencies.		
Cumbria Constabulary	Implementation of a structured question set for use in the closure of 'concern for welfare' logs.	21.09.21	07.10.24 **Complete;** Since this review started the "Right Care Right person" (RCRP) approach has been adopted by Cumbria Police and deals with all "concern for welfare" incidents. There is a structured set of questions for this within this approach. Full details can be found on the Cumbria Constabulary website.[51] RCRP decision making toolkit is a structured question set that ensures crimes and abuse are not missed when the initial call relates to 'concern for welfare'.
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).		
Cumbria Constabulary	Update all DA training to include specific focus on abuse in later life and child to parent/familial abuse.	21.09.21	22.04.24 **Complete;** Force wide DA Matters training implemented in 2022.

[51] https://www.cumbria.police.uk/advice/advice-and-information/concern-for-welfare/right-care-right-person/

			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.
Cumberland Community Safety Partnership	Multi-agency DA Awareness package be commissioned.	21.09.21	09.2024 Complete; All partners have access to the SafeLives accredited 'Responding Well to Domestic Abuse' training (held on licence by Cumberland and Westmorland and Furness Councils). There has also been access to DA Awareness training commissioned by the Councils, delivered by Victim Support in 2022/23.
Carlisle City Council Revenue and Benefits Team	Implement additional information for staff and standalone training module concerning Domestic and Abuse in later life.	15.09.21	23.09.24 **Complete;** Actions confirmed as completed in 21/22 following the internal review as part of the DHR process
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 ensure professionals have a common understanding of the risk factors, risk level and risk management for each case.		
Cumbria Constabulary	Inclusion of an integral risk assessment to the 'Safeguarding Adult Form' (SAF).	21.09.21	April 2024 **Complete;** New IT system commenced which includes the DARA[52] risk assessment in DA forms, a risk assessment in both VC and VA forms and the option to include a DASH risk assessment if needed for secondary risk assessment. Circulations also put out to officers advising that if it is a child / parent DA relationship to submit a DA

[52] https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-2022.pdf

			and not a VA, as a DA can still be referred to relevant adult services.
Warwick Square Group Practice	By December 2022 work with partners to develop a home visit welfare check list and launch it by December 2022. To ensure that every home contact counts and risks are shared and acted upon without delay	16.02.21	09.10.24 **Complete and Ongoing;** Work on this is ongoing by the Wellbeing and Safeguarding Lead for NCPC (covering Eden and Warwick Square) and Clinical Director for Carlisle Network PCN works closely with the Carlisle Network PCN Frailty team. There was an Integrated Neighbourhood Team meeting held in October 2024, which included Carlisle Healthcare PCN and the ICB where this case was used as a learning example.
	Review safeguarding referral processes to include feedback to referrers to ensure that any risks mitigations and plans are known to those who provide services to individuals.	16.02.21	09.10.24 **Complete;** General practice does recontact Social Care to follow up the outcome of any referrals made. The feedback received is variable.
North Cumbria Integrated Care (NCIC)	DASH assessments to be completed on all patients where domestic abuse is identified or disclosed to ensure risk management plans can be implemented and appropriate referrals completed.	15.09.21	03.10.24 **Complete;** NCIC staff are requested to complete DASH assessments on all patients disclosing Domestic Abuse. DASH training has been provided and commissioned via Victim Support and will be incorporated into workshops as part of the new training plan. DASH assessments are readily available on the trust intranet site as is safety planning guidance and information on support services. NCIC now have a Health's ISDVA who works one day per week in the Emergency Department of CIC, providing support

			around DASH and risk management plans with survivors.
Castles & Coasts HA (CCHA)	Bi-monthly safeguarding meetings to include a Cascade out to teams to ensure an ongoing reminder of the importance of responding to communications from other agencies / any reports of concern.	13.09.21	19.9.24 **Complete;** Action both completed and marked as an ongoing action, now embedded as usual practice.
Carlisle City Council Revenue and Benefits Team	To ensure landlords are contacted in cases where occupancy cannot be confirmed and ensure there are appropriate information sharing mechanisms in place to support this.	15.09.21	23.09.24 **Complete;** Actions confirmed as completed in 21/22 following the internal review as part of the DHR process
Recommendation 4	Routine enquiry around domestic abuse to be introduced to health care settings and health pathway to be devised for practitioners to follow should a positive disclosure be made.		
North Cumbria Integrated Care (NCIC)	Routine enquiry to be provided to all patients attending NCIC emergency care departments; to be piloted with support from North Cumbria CCG.	15.09.21	03.10.24 **Complete**; NCIC are undergoing an audit on a sample pool of contacts from Emergency Care departments and the findings are being reviewed at time of writing.
	Domestic abuse health pathway to be devised informing NCIC staff of process should a positive disclosure be made following routine enquiry.	15.09.21	03.10.24 **Ongoing**; This remains ongoing with roll out being on a priority basis across the organisation. Policies and guidance remain in place to support colleagues.
	ED staff supported to shadow Safeguarding team to MARAC	15.09.21	03.10.24 **Complete**;

	meetings to understand the significance of the DASH checklist and MARAC process.		A small group of ED staff have been supported to shadow meetings which has been positive and enabled them to see the effectiveness of information shared via DASH for risk mitigation. This offer is open to all NCIC staff, and sexual health and community teams have also been attending.
Warwick Square Group Practice	Re energise the project group which is leading on the plan to implement "Routine enquiry" by April 2022 across Health services in Cumbria resulting in a managed process of identifying how to effectively implement this and escalate delays to ensure this results in mobilisation during 2022.	16.02.21	09.10.24 **Complete;** The ICB included the role of Domestic Abuse champion in the 2023-2024 Incentive scheme for all North Cumbria practices. As part of the scheme the champion had to attend the NCIC domestic abuse training sessions. The practice also has a domestic abuse champion. Routine enquiry 'pop up' is activated at the General Practice, the ICB receives quarterly updates on usage. The pop up reminds General Practice staff to ask personal safety and domestic abuse questions.
Recommendation 5	Consider working towards a DAHA[53]accreditation; the UK benchmark for how housing providers should respond to domestic abuse in the UK.		
Castles & Coasts HA (CCHA)	DAHA accreditation to be applied for as a process over the next 3 years (written 09.2021).	13.09.21	21.11.24 **Complete;** This accreditation journey was started and is still ongoing with good progress having been made. CCHA are committed to continuing through to the completion of DAHA accreditation. CCHA's Tenancy Sustainment and Safeguarding Partners are co-ordinating this process and work closely with e

[53] The Domestic Abuse Housing Alliance's (DAHA) mission is to improve the housing sector's response to domestic abuse through the introduction and adoption of an established set of standards and an accreditation process. Launched in September of 2014, DAHA embeds the best practice learned and implemented by its 3 founding partners and has established the first accreditation for housing providers.

			Regional Co-ordinator from DAHA. Policy reviews have been completed, and all ongoing actions are logged on the DAHA portal.
	To internally review the information governance process concerning information retention held following the closure of email accounts after a staff member leaves.	15.09.21	23.09.24 **Complete**; Actions confirmed as completed in 21/22 following the internal review as part of the DHR process.

ANNEX B

GLOSSARY

CCG	Clinical Commissioning Group
CSP	Community Safety Partnership
DHR	Domestic Homicide Review[54]
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
SAB	Safeguarding Adults Board
SIO	Senior Investigating Officer
SPA	Single Point of Access (referral route for agencies)
L&D	Liaison & Diversion – support team accessed via police custody
PPU	Public Protection Unit
RCRP	Right Care Right Person
AAFDA	Advocacy After Fatal Domestic Abuse; a specialist charity supporting families bereaved by domestic abuse

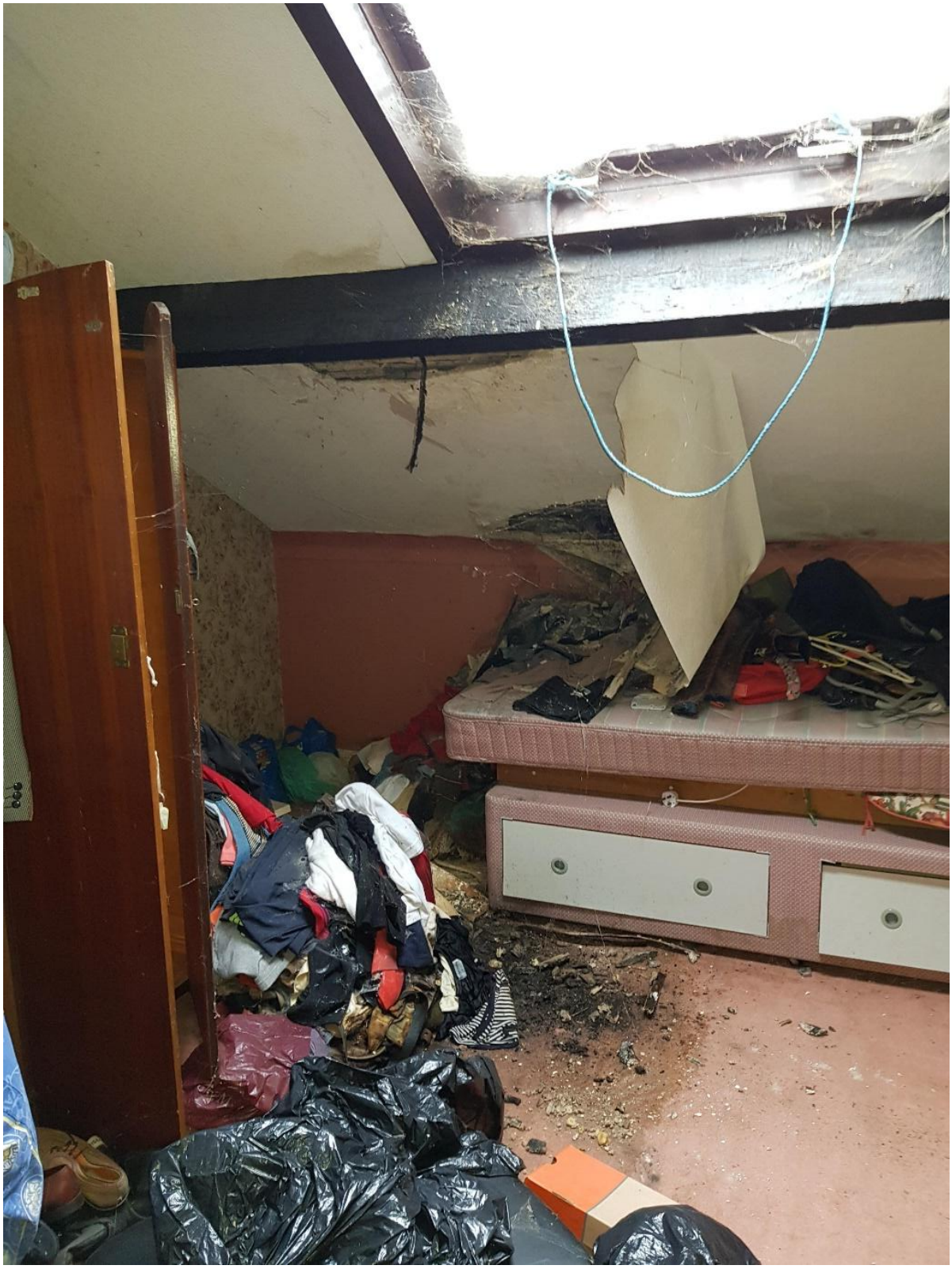
[54] Now known as Domestic Abuse Related Death Reviews (DARDRs) https://www.gov.uk/government/news/fatal-domestic-abuse-reviews-renamed-to-better-recognise-suicide-cases

ANNEX C

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

PHOTOGRAPH 1

PHOTOGRAPH 2



PHOTOGRAPH 3

PHOTOGRAPH 4

PHOTOGRAPH 5