Cumberland Community Safety Partnership

Domestic Abuse Related Death Review
Pamela/February 2021
Executive Summary

Author: Dr Liza Thompson

Commissioned by: Cumberland Community Safety Partnership

Review completed: February 2025

Contents

1. The Review Process

1.1 This Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Pamela a resident of Town A, prior to her death in February 2021.

1.2 On 25th January 2021, Pamela's husband called for an ambulance for Pamela because she had become unresponsive. He stated that she had been sitting on the sofa, refusing to move, eat or drink, for two weeks. He reported that prior to this, her health had been declining. Pamela's husband stated on the phone, "it has got too much now, we can't go on now", referring to Pamela's refusal of food or fluids. He stated to the call handler that "she looks like a prison of war".

1.3 On 26th January 2021, Pamela's husband and son were both arrested on suspicion of the ill treatment/neglect of a person lacking mental capacity.[1]

1.4 Pamela passed away a week later. Pamela's husband and son were charged with gross negligence manslaughter, and in February 2024 both defendants were convicted by jury, of gross negligence manslaughter. Her husband was handed a three-year prison sentence, and her son a sentence of two years and eight months.

1.5 Pamela's son passed away in September 2024, whilst in prison. It is thought this was from an illness. At the time of writing this report, the Prisons and Probation Ombudsman were investigating Pamela's son's death whilst in custody.

1.6 This DARDR examines the involvement that organisations had with Pamela, who was a white British woman in her early seventies, her husband Roy, a white British male in his late fifties, and her son Frank, a white British male in his early fifties.

2. Contributors to the Review

2.1. Each of the following organisations contributed to the review.

Agency/ Contributor	Nature of Contribution
North Cumbria Integrated Care (NCIC)	Report using IMR template
Adult Social Care and Housing (ASC&H)	Report using IMR template
Cumbria Constabulary	Summary report
North East and North Cumbria Integrated Care Board	Summary report

[1] S.44 Mental Capacity Act.

Department for Work and Pensions (DWP	Summary report
Cumberland Council	Summary report

3. Review Panel Members

3.1. The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Pamela, Roy, or Frank.

3.2. The members of the panel were:

Agency	Name	Job Title
	Liza Thompson	Independent Chair and Author
Cumberland Council, Community Safety Partnership	Hayley Bishop	Area Planning Manager
Cumberland Council – Housing Team	Amanda Starr	Head of Housing and Inclusion
Cumbria Constabulary	Sarah Edgar Fae Dilks	Detective Constable Detective Inspector
Cumberland Council, Adult Social Care	Sarah Joyce	Service Manger
DWP	Bharati Dwarampudi	Advanced Customer Support Service Leader
North East and North Cumbria Integrated Care Board	Leesa Stephenson	Designated Nurse Safeguarding All Age and Children Looked After.
North Cumbria Integrated Care (NCIC)	Sam Finn	Specialist Safeguarding Practitioner
Victim Support	Sarah Place	Operations Manager

3.3. Panel members hold senior positions in their organisations and have not had contact or involvement with Pamela, Roy or Frank. The panel met on three occasions during the DARDR.

4. Author of the Overview Report

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

4.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent

Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHR's, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs). She lectures at Christchurch University Canterbury, delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system.

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

5. Terms of reference for the review

5.1. The scoping period of the review was from 1st January 2016, until February 2021 when Pamela died. A five year scoping period was agreed, in the absence of any other event occurring to inform a start date for the scoping. IMR authors were also asked to provide information about anything pertaining to domestic abuse prior to this date.

5.2. The full subjects of this review were Pamela, Roy and Frank.

5.3. Specific issues which were considered within the IMRs and short reports were;

i. Were practitioners aware of, and sensitive to, Pamela's needs?
ii. How accessible were the services to Pamela?
iii. How effective were agencies in identifying and responding to the needs and risks faced by the victim and her family?
iv. Did the agency have policies and procedures for domestic abuse risk assessment and management, and were those assessments correctly used in the case of Pamela?
v. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
vi. Were appropriate services offered or provided, or relevant enquiries made in the light of any assessments, given what was known or what should have been known at the time?
vii. When, and in what way, were the Pamela's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the Pamela should have been known? Was she informed of options/choices to make informed decisions? Was she, or her carers signposted to other agencies?
viii. How did the Global Covid-19 Pandemic effect Pamela and the care she received from her family, and also from professionals?
ix. Had Pamela, or her family/carers disclosed any concerns to any practitioners or professionals and, if so, was the response appropriate?
x. What opportunities can be identified to create appropriate interventions for people who are resistant to health and/or social care involvement?

xi. Was consideration given to Pamela's vulnerability and/or age? Were any of the other protected characteristics relevant in this case?
xii. Are there ways of working effectively that could be passed on to other organisations or individuals?
xiii. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
xiv. Can themes be identified, and lessons learnt from other DARDRs of a similar nature within Cumbria, and beyond?

6. DHR Methodology

6.1 The Review Panel first met in February 2022 to consider draft Terms of Reference, the scope of the DARDR and those organisations whose involvement would be examined.

6.2 The information on which this report is based was provided in Individual Management Reviews (IMRs) and where more appropriate, summary reports, which were completed by each organisation that had involvement with Pamela prior to her death. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

6.3 Each IMR and short report was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DARDR Panel. Neither the IMR/short report Authors nor the Senior Managers had any involvement with Pamela during the period covered by the review.

6.4 Most of the agencies held very little information about Pamela. There is no evidence that she had engaged with any services, including her GP, since 2017. There is no evidence of any contact with the legacy District Copeland Council Housing Team or any other departments, beyond standard Council Tax communications – presumably this is because the house she lived in was owned outright. Therefore, the majority of agencies provided a summary report, which detailed a chronology of contact between professionals and Pamela along with a short analysis of the contact where appropriate.

6.5 Following Pamela's son and husband being found guilty of gross negligence manslaughter, the Chair requested any information held about both parties. All of the agencies confirmed they had no contact with either, aside from the information already provided in the original short reports.

7. Summary Chronology

7.1. Pamela was estranged from her wider family, and at the time of her death she was living in the home she had shared with her father until his death in 1994. Her husband and her adult son loved with her.

7.2. Pamela died in February 2021. She had been sitting on her sofa for a number of weeks and had not eaten or had sufficient fluids during this time. She was emaciated, weighing less then four and a half stone, and the sofa she was sitting on was soaked in urine. Pamela had pressure sores, which had become infected.

7.3. Following her death, her husband and son were both arrested, and subsequently found guilty of gross negligence manslaughter. Pamela's son died whilst serving his sentence.

7.4. During the criminal investigation it was identified that Pamela had not been seen by any health services or professionals since 2017. Pamela's husband and son both stated that Pamela was adamant that she would never request help from the GP, as she was fearful of being admitted to the local hospital.

7.5. Pamela had taken to her bed around eighteen months before she died, and she had asked her husband to carry her downstairs to the sofa a few months before she died, where she had remained util her death.

8. Conclusions

<u>Effects of Covid Pandemic</u>

8.1. The police interviews with Pamela's husband and son are the only insights available into what may have been happening in the household prior to Pamela passing away. She was not known to any services at this time, and therefore there is no learning for agencies which is specific to this review.

8.2. Pamela's husband and son both spoke about Pamela taking to her bed some eight months before her death. This would have been during the height of the Covid-19 restrictions, and widespread fear of the virus spreading. They did not mention in their interviews that Covid itself had caused Pamela to take to her bed; however taking into account Pamela's apparent choice to increase her isolation – she was said to have not been outside or spoken to anyone outside the household for about eighteen months – it can be easy to see how the unfolding societal anxieties about Covid may have further impacted her mood and motivation.

8.3. Pamela's husband and son both spoke about how passionately Pamela refused to attend the local hospital, and to a lesser extent how she was reluctant to access other types of health care support. They both explained that she said she would rather throw herself off a local cliff, than to go into hospital. This fear of the hospital, which neither man could explain

or rationalise, may have been exacerbated by the lockdown. Benbow et al, argue that during the National Lockdown adults who faced new – or worsening – physical health, found it difficult to access health care, or were reluctant to access health care settings in the belief that this would increase their risk of contracting COVID.[2]

8.4. It was well documented during the pandemic that increasing age was associated with greater mortality linked to COVID.[3] The public were also discouraged from accessing services in person and were encouraged to seek help online or by phone. This enforced isolation led older adults to be at a higher risk of abuse or neglect,[4] and further exacerbated their invisibility.[5] Access to physical and mental health services became restricted.[6]

8.5. Pamela may have had an idea that she had cancer, she smoked heavily, she had lost family members to cancer, and she may have decided that she did not want to access health care for this. Instead, she may have decided to pass away at home, by not telling anyone about her possible illness. This would have been made much easier by the fact that for around two years – on and off – from March 2020, it was very normal for people to remain at home, and in fact was the law for a significant period of that time.

Family Members' Duty of Care

8.6. Although informal care, from family members, can work well and is indeed vital to the economy,[7] on occasions when left unassessed and unsupported informal care can be inadequate.[8] Neither Pamela's husband, or her son, considered themselves as her carers, however from their police interviews they also did not seem to consider that Pamela needed formal care.

8.7. In Safeguarding Adult Review (SAR) of Adult O[9] it was found that Adult O's mother was not fully able to meet her daughter's needs, however this had not been identified prior to Adult O's hospitalisation and subsequent death.

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[2] Benbow, S et al "Invisible and at Risk: Older Adults During the COVID-19 Pandemic£ *Journal of Elder Abuse and Neglect* vol. 34 Issue 1 pp.70-76 (2022)

[3] Verity at al "Estimates of the Severity of Coronavirus Disease: a Model Based Analysis" *The Lancet Infectious Diseases* 20 (6) (2020) pp.669-677

[4] Casper, A "Safeguarding Adults and COVID-19: A Sector Led Improvement Response" *Journal of Adult Protection* 22 (6) (2020) pp.401-413

[5] Ayalon, L et al "Ageism and the State of Older People with Mental Conditions During the Pandemic and Beyond: Manifestations, Etiology, Consequences and Future Directions" *United Nations* (2021)

[6] Ayalon, L and Avidor, S "We have become prisoners of our own age: From a continuing care retirement community to a total institution in the midst of the Covid-19 outbreak" *Age and Ageism I 50 (3) (2021) pp. 664-667*

[7] Van Houtven, C at al *The Economics of Informal Care* The Oxford Research Encyclopaedia of Economics and Finance (2019) Available: https://doi.org/10.1093/acrefore/9780190625979.013.265

[8] Reinhard, S et al "Supporting Family Caregivers in Providing Care" in *Patient Safety and Quality: An Evidence Based Handbook for Nurses* (2019)

[9] Safeguarding Adult Review - Adult O (nationalnetwork.org.uk)

8.8. In the SAR regarding "Robyn"[10] it was identified that the 81-year old's son, who was taking care of his mother, was struggling in his caring role.

8.9. As with Pamela's case, the Cumberland non-statutory learning review Sarah (2023) found that Sarah's nephew was not a formal carer, he did not claim Carers Allowance, and Sarah did not claim Attendance Allowance to fund a carer. Just as with Pamela's case, Sarah's nephew and great-nephew provided some shopping for Sarah – however nothing was formalised.

8.10. However, Pamela's case differs from Sarah's in some ways. Firstly, that Pamela lived with her son and husband, in a small house, where they had access to her every day. Sarah did not live with her nephew and great-nephew and this may have created some barriers to being able to recognise her deteriorating health.

8.11. Sarah's case did not result in a criminal trial, and the inquest did not find any evidence of neglect. This was the reason why the review was not published as a DARDR. The coroner in Sarah's case stated that as Sarah's nephew was not medically trained, and was not recognised as her carer, he did not have a duty of care to Sarah. When Sarah declined care and support, and told her nephew not to call for assistance, she had a right to do this. Sarah's mental capacity was presumed as she was ordering in supplies and purchasing items from shopping channels. In Pamela's case, the pathologist could evidence from their postmortem that Pamela would have been delirious some days before the ambulance was called and was therefore not assumed to have capacity during that time.

8.12. The similarities between the two cases do raise lessons to be learnt, namely the need for family members to be feel empowered to go against the wishes of their loved ones in order to support their welfare, along with the need for the general public to understand the concept of self-neglect and how services are able – and increasingly expected to – respond to cases of self-neglect.

9. Lessons to be Learnt

9.1. Information should be made available to the general public around self-neglect, and how this can be responded to by statutory services, alongside provision of information for patients who indicate that they do not wish to be taken to hospital if they become incapacitated. This information would provide a balanced argument about the benefits of accessing health care when faced with serious illness.

9.2. Information and support should be made available around understanding mental capacity, and how this links to self-neglect, the right for individuals with capacity to made poor choices, and where to get help and advice if a family member has care and support needs.

9.3. Following the review, Cumberland Council have developed a briefing to be shared with healthcare settings which includes reference to GP Practices considering the implementation of face-to-face reviews for new patients.

[10] Robyn SAR Final Report

10. Recommendations

10.1. Pamela's review, along with other similar DARDRs and SARs, to be developed into a comparative thematic study, to used within training, to highlight self-neglect, mental capacity, and isolation, in the support of multiagency practitioners' learning. Cumberland CSP will have oversight of the development of this resource.

10.2. Awareness will be raised of the Charity Hourglass, and their dedicated 24 hour helpline, along with learning from this review, to encourage family, friends and members of the local community to ask for help and advice around possible self-neglect, and concerns about neglect from others.