



Cumberland
**Community Safety
Partnership**

**Domestic Abuse Related Death Review
Pamela/Feb 2021
Overview Report**

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Commissioned by: Cumberland Community Safety Partnership

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1. Introduction

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

¹ S.44 Mental Capacity Act.

1.8 Following discussions and research received from the DARDR Core Group panel, it was confirmed in February 2021 that the case met the criteria for conducting a DARDR. That agreement was ratified by the Chair of the Cumbria Community Safety Partnership.²

2. Confidentiality

2.1. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms have been agreed by Pamela’s daughter.

2.2. Details of the deceased and perpetrator:

Name (Pseudonym)	Gender	Age at time of death	Relationship to deceased	Ethnicity
Pamela	Female	72	<i>Deceased</i>	White British
Roy	Male	58	<i>Husband Perpetrator</i>	White British
Frank	Male	50	<i>Son Perpetrator</i>	White British

2.3 The following individuals/family members were known to the Review Panel and have been given the following pseudonyms to protect their identity:

Pseudonym	Relation to deceased:	Relation to perpetrator:
Susan	Older Sister	Frank’s aunt No relation to Roy
Andrea	Daughter	Frank’s sister No relation to Roy
Sandra	Twin sister	Frank’s aunt No relation to Roy

3. Other Reviews/Investigations

3.1. A postmortem found that Pamela had a malignant tumour on her right lung, however this had not played any part in her death. She was severely emaciated, and this along with infected pressure ulcers, played a part in her death.

3.2. Pamela’s husband and son were arrested following her death. On 19th February 2024 both were convicted of gross negligence manslaughter, Pamela’s husband was sentenced to three years, and her son was sentenced to two years and eight months imprisonment.

² From April 2023, the local government in Cumbria changed. The six district councils and Cumbria County Council was replaced by two unitary authorities – Cumberland Council, and Westmoreland and Furness Council.

3.3. At the time of the DARDR report being finalised, the Prison and Probation Ombudsman were conducting a review into the death of Pamela's son, whilst in custody.

4. Timescales

4.1. This review began in February 2021 and completed in February 2025.

4.2. At the commencement of the DARDR, the criminal proceedings were still ongoing and did not conclude until April 2024.

4.3. The Independent Chair therefore set the Terms of Reference and requested initial information from agencies. The review was paused in June 2022, until the completion of the criminal trial. The DARDR restarted in May 2024.

4.4. Following the convictions of Pamela's husband and son, the Independent Chair requested both men's information from health and social care agencies. However, there was no further information gathered from agencies.

5. Methodology

5.1 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.

5.2 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.

5.3 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.

5.4 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.

5.5 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.

6. Terms of Reference

6.1. 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.

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

6.3. The family did not contribute to the terms of reference as they were not involved with the review process at the point where the terms of reference were set. When speaking to the family members, it was clear that they had not spoken to Pamela in decades and were unable to provide any context to her circumstances prior to her death.

6.6. 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 DARDs of a similar nature within Cumbria, and beyond?

7. Involvement of Family Members and Friends

- 7.1. During the Police investigation it became apparent that Pamela had become estranged from members of her family some years before her death. Pamela has a daughter named Andrea, who Pamela had not had contact with since Andrea was in her early twenties – around thirty years before Pamela's death.
- 7.2. The Chair spoke with Andrea, and also spoke to Pamela's twin sister Susan, at the commencement of the review in 2022. Both women were provided with the Home Office DHR Leaflet, and both were happy to provide information about Pamela and indicated that they would like to comment on the final draft report. Both declined the support of AAFDA.
- 7.3. It should be highlighted that neither Andrea or Susan had spoken with Pamela in decades and were unable to provide a pen portrait of her, not were able to provide information regarding Pamela's situation leading up to her death.
- 7.4. The Chair reached back out to Andrea in 2024, following the guilty verdict and sentencing. Andrea told the Chair that she had not heard from her brother in many years. She had hoped he would contact her after being sentenced, however this had not happened. Andrea did not have anything to add to the information she was able to share when the Chair first spoke with her in 2022.
- 7.5. Following the conviction, the Independent Chair wrote to Pamela's husband and son in prison June 2024. There was no response from them.
- 7.6. In September 2024, Pamela's son passed away in prison. The Chair spoke with Andrea again following her brother's death. She had found out about this as a third party, from family members, as she was not recorded on prison or police records as a family member or next of kin. Andrea confirmed that her brother had passed away following an illness but was not sure of the exact details.
- 7.7. This report includes information gathered from Pamela's husband and son's police interviews, as well as information presented to the court by both the prosecution and the defence barristers. The panel are mindful that this information may not provide a full picture, as it presents their version of events and their experiences prior to Pamela's death. The information from Andrea and Susan was not able to counteract the husband and son's versions of events, as the relationship which both women had with Pamela – over thirty years prior – was also reflective of the relationship presented by Pamela's husband and son during the police investigation.
- 7.8. There were no other friends or family identified to the panel, and Pamela's lack of contact with agencies or professionals also negated the opportunity to gain an insight into Pamela via case notes and interviews with staff.

7.9. The family were provided with the report ahead of finalisation, and submission to the Home Office.

8. Contributing Organisations

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

8.2. 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
Department for Work and Pensions (DWP)	Summary report
Cumberland Council	Summary report

9. Review Panel Members

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

9.2. 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	Detective Constable
	Fae Dilks	Detective Inspector

Cumberland Council, Adult Social Care & Housing	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

9.3. 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.

10. Independent Chair and Author

10.1. The Independent Chair is a SafeLives Accredited Service Manager who has worked within the field of domestic abuse for over ten years; initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. She delivers domestic abuse and coercive control training to a variety of statutory, voluntary and private sector agencies. Her doctoral thesis examines the experiences of abused mothers within the child protection system. She has independently completed specialist review Chair training with Advocacy After Fatal Domestic Abuse and is a full member of the AAFDA DHR Network.

10.2. The Independent Chair has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Abuse Related Death Reviews.

11. Publication and Dissemination

12.1. This overview report will be published on the Cumberland Council Community Safety Partnership website.

11.2. Family members will be provided with the website addresses and offered hard copies of the report. The family have not indicated any dates to be avoided when publishing the review.

11.3. Further dissemination will include:

- Independent chair and members of Cumberland Community Safety Partnership
- The Crime Commissioner for Cumbria

- Chief Constable - Cumbria Constabulary
- Chief Officer – North East and North Integrated Care Board
- Chief Officer – NHS Foundation Trust, Mental Health and Disability Trusts
- Chief Executive - NHS Foundation Trust
- Director – Children’s Services, Cumberland Council
- Chief Executive – Cumberland Council
- Police and Crime Commissioner

11. Background Information

- 12.1. On 21st January 2021, Pamela’s husband called 111 as he had returned home from work and found Pamela blue and unresponsive. Her son was also present at this point. The transcript from the call does not indicate that either recognised the urgency of Pamela’s situation.
- 12.2. They told the hospital, and later the police, that Pamela’s health had been declining for four weeks and that she had not moved from the sofa for two weeks.
- 12.3. Pamela weighed four and a half stone when she was found. She was malnourished and dehydrated. Records indicate that had she wanted to move off the sofa at this point, she would not have had the energy to do so.
- 12.4. The Pathologist report which was presented at the trial of Pamela’s husband and son stated that although Pamela had a malignant tumour on her lung, although it was not considered that this would have contributed to her death. Neither her husband or son were aware of the cancer, neither were they aware of Pamela herself being concerned, or aware of the cancer.
- 12.5. Pamela also had Stercoral Colitis, which is a condition where the presence of impacted faeces in the colonic lumen is associated with inflammation and distention of the affected colon segment. It is often seen in elderly, bedbound patients; however this condition can be treated. Pamela was severely emaciated and had neglected pressure ulcers which were infected. The Pathologist indicated that these ulcers were at least three weeks, but possibly six weeks old, and her levels of dehydration indicated that she had not had adequate fluids for seven to ten days.
- 12.6. At the point where Pamela was taken to hospital, the couch she was sitting on was so drenched in urine, that the wooden framework had been water damaged, however her level of dehydration was such that it was unlikely she had passed urine for seven to ten days.
- 12.7. The level of urine soaking the couch indicated that she would have been confined to the couch with no access to a toilet for around four to six weeks.
- 12.8. Pamela had gangrenous toes which indicated that the level of severity of her dehydration would have caused her delirium for a number of days, and she would have been drowsy for two to three days before she was taken into hospital.

Pamela

- 12.9. At the beginning of the review process, the Independent Chair met virtually with Pamela's daughter Andrea, and sister Susan, who were able to give some background to Pamela's life.
- 12.10. Pamela's mother had passed away when her and her twin sister were four months old. The twins were therefore adopted by their uncle and aunt. Pamela's twin was very poorly as child and spent a lot of time in hospital. Susan told the Chair that this meant Pamela grew up as an only child, and when her sister came out of hospital it caused her distress to share her parents. Susan believes that the trauma of Pamela's childhood had made her very controlling, and Andrea believes that Pamela was able to twist the truth and managed to manipulate people into believing her side of any situation.
- 12.11. Andrea explained that when she had reached eighteen years old, her mother left the family home. Andrea and Frank were therefore raised by their father. Despite attempting to reconcile with her mother following the birth of her first child, Pamela did not wish to speak to Andrea, and they did not have contact again.
- 12.12. Pamela had given birth to Andrea when she was 15 years old and was married to Andrea's father – who was the same age - at 15. The reason she gave for leaving the family home 18 years later was that Andrea's birth had ruined her life. Susan explained that Pamela had been at grammar school and had hoped to go onto university – following the pregnancy she had been forced to marry Andrea's father due to societal expectations at the time.
- 12.13. Andrea believes that when Pamela had reached thirty years old, she had wanted to enrol in an Open University course and her father had not been supportive of this. Andrea's memory is that her father worked long hours to give them a good life and that her mother was often in the pub with other men.
- 12.14. The family had moved to County B, however following the separation Pamela returned to Town A and moved in with her father. Her mother had passed away, and when her father also passed away Pamela took over the property which was owner occupied. This was the property where Pamela remained living until her death.
- 12.15. Andrea told the Chair that both her and Frank stayed with their father in County B, until Frank had given up university, and had eventually moved in with Pamela. Andrea believes that her mother dominated Frank and refused to allow him contact with her or their father.
- 12.16. Andrea did not know anything about Pamela's husband Roy and had only found out about her mother's death when her aunty Susan had seen Frank in town, and he mentioned that his mother had passed away.
- 12.17. Pamela's sister, Susan has lived in Town A all her life. She was also estranged from Pamela, although she would sometimes see Frank in Town and have a catch up with him – if he wasn't with his mother. The bus she took into town went past Pamela's house, which

she told the Chair had progressively become run down over the past two years, which had led her to believe that something was not right with Pamela and Frank.

- 12.18. Both Andrea and Susan told the Chair about Pamela's father, who had found that he had developed Cancer and had taken to his bed, refusing any medical assistance. This was whilst Pamela was living with him, and it is believed that Pamela had left him in bed and did not insist on accessing medical assistance for him.
- 12.19. One day, Susan was concerned that she had not seen Pamela's father in town for a long while and let herself into the house with a spare key. She found him collapsed on the floor in a very poor condition, and with help from Pamela's twin sister Sandra (also estranged from Pamela), managed to get him into hospital where he passed away after a short period.
- 12.20. Andrea and Susan both believe that prior to her death, Pamela may have realised that she had cancer, and had also decided not to access medical treatment; and that Frank and her husband would not go against her wishes. They base this belief on the fact that she did not challenge her father's wish not to access medical assistance even when he was in the very late stages of cancer, and on their understanding of Pamela's control over Frank since he returned to live with her twenty years ago.
- 12.21. Andrea stated that she didn't believe her mother would have ever asked for help if she was ill. She emphasised to the Chair that Pamela was very strong minded and needed to be in control at all times. Susan agreed with both of these sentiments and told the Chair that "stubbornness runs in the family."
- 12.22. Pamela's husband and son both told police during interview that Pamela was in charge in their relationships. Her son said he would never go against her, and her husband said, "she is the strong one in this relationship." Both stated that Pamela said on many occasions that she would take her own life, before she would go to hospital.
- 12.23. Pamela was a heavy smoker, her husband and her son would provide her cigarettes – her son bought these in lieu of paying her rent. Neither men smoked, and her husband described this as a bone of contention between them, and also that the heavy smoke surrounding Pamela at all times, was one of the reasons he did not check on her very much.
- 12.24. Pamela was said to have been a keen reader, gardener and knitter – there were many books, including a whole box room full of books, throughout the house. Her husband said that when she had been well, she had knitted many items for local charity shops, and that the blankets which were covering her on the sofa had been hand made by her.
- 12.25. Both men stated that Pamela had stopped going out of the house around eighteen months, to two years, before her death and had stopped doing anything and had taken to her bed eight months before. Neither could work out why. Her husband had asked her, but she had not given him an answer.

Roy

- 12.26. Pamela's husband was twenty years younger than her, and told police in interview that he had met her when he had "picked her up off the floor in the pub".
- 12.27. He worked night shifts, as a security guard and had worked in retail and also in hospitals. He told officers he would be out of the house from around 4pm until 9am and then would sleep all day and get up in time to get ready and return to work. This was five or six days a week.
- 12.28. Roy did mention having some friends, and it seems that he had some life outside of the home.
- 12.29. There is very little else known about Roy.

Frank

- 12.30. Frank's defence team stated that Pamela had dominated her son all of his life, and due to his personality, he did not question her orders, even when it may have been clear that she did not have the capacity to give these orders.
- 12.31. When speaking to the Independent Chair or this review, Pamela's daughter Andrea and sister Susan reiterated Pamela's control over Frank, who they said was not permitted to speak to any family members who Pamela had become estranged from. Andrea believed that Frank led a very isolated life, which was controlled by their mother.
- 12.32. The psychological report presented to the court stated that Frank had average cognitive functioning, severe levels of depression and high levels of anxiety. He was found to be a non-assertive, overly accommodating and socially inhibited man. He lived an isolated existence which may have stemmed from being bullied as a child.
- 12.33. They defence summarised that Frank was a vulnerable man, with personality traits which rendered him suggestible, he had low self-esteem, and he did little to nothing to push against his mother's wishes not to seek medical care.
- 12.34. Frank himself told the police during interview that he did not enjoy talking to people, he rarely spoke to his mother or Roy and spent most of his time in his room reading or playing on his computer.
- 12.35. Frank told police that he had not cared properly for his mother, and that he had neglected her medical care, because that is what he thought her choice was. He reflected that *"until the last few days I would have said yes mum was capable of making her own decisions, what she wants, and she is quite strong in her opinions, obviously not now though"*.

12. Equality and Diversity

- 13.1. The panel considered Pamela's protected characteristics, as provided within The Equality Act 2010 – and discounted gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion/belief, and sexual orientation.

- 13.2. Although there was very little personal information gathered about Pamela, the panel determined that Pamela's experiences may have been shaped by her age and sex. Furthermore, these characteristics would have intersected at times, exacerbating one another in terms of how she may have been perceived by society and how she may have accessed services.
- 13.3. Pamela was an older woman, which may have rendered her invisible to society and services. Research has highlighted the invisibility of elderly people,³ and more specifically the invisibility within the community of elderly women.⁴
- 13.4. It is also of interest how, in police interview both Pamela's husband and son equated the poor state of the house with the fact that Pamela had stopped cleaning or tending to the garden some eighteen months before her death. Possibly highlighting the fact that although all three adults had worked fulltime, including long hours and shift work, it was Pamela – as the female in the home – who had kept the house habitable.⁵
- 13.5. It is not known whether Pamela had experienced poor mental health during her life. There are no GP records to indicate that she sought assistance for mental health issues, and there is no indication that professionals or services ever had reason to doubt her mental capacity during the minimal contact they had with her. However, during the trial of Pamela's husband and son, the court heard how Pamela's mental capacity to make decisions about her care - namely whether she would have wanted her family to call for medical assistance – would have been affected at the point of her death, and possible for a few days before she had died. This was due to her dehydrated and malnourished state leading up to her death. Although Pamela's husband and son stated that she refused to move off the sofa, and the courts heard that towards the end of her life, Pamela could not have consented to being left on the sofa.
- 13.6. Pamela's husband and son had a duty of care to her. In the criminal case of *R v Evans*⁶ the court emphasised that once a person becomes aware of a life-threatening risk, they have a duty to take reasonable steps to help. Pamela may have consented to being left without medical care for a period time, however when it became apparent that she was no long capacitous – for example when she became incoherent, or unconscious – her husband and son had a duty to intervene and call for help. Although they eventually did do this, the court found that at the point of calling for help, Pamela's capacity to accept or decline care had been lacking for some time.
- 13.7. Pamela's socio-economic status may have affected her visibility to service. The house where she lived was owned outright, as she had inherited this from her father – see below. The House of Lords' Adult Social Care Committee described adult social care as "largely

³ Arber, S and Ginn, J "The Invisibility of Age, Gender and Class in Later Life" *Sociological Review* (1991)

⁴ Feldman, S and Poole, M *A Certain Age: Women Getting Older* (1999)

⁵ Seedat S, and Rondon, M "Women's Wellbeing and the Burden on Unpaid Work" *The British Medical Journal* (2021)

⁶ *R v Evans* (Gemma) [2009] EWCA Crim 650

invisible” within society, with many people not understanding or engaging with it until crisis point, and this invisibility extends to those who need support but are not in the system.⁷

13.8. Pamela’s invisibility from services due to her age and socio-economic status would have intersected to render her unseen; and in turn any issues she was living with, which led her to decline services, were invisible - and therefore untreatable - by agencies and services.

13. Chronology

14.1. Pamela’s father passed away in 1994. Pamela was already living in the family home, and after he passed away, she remained in the house.

14.2. In August 2012, Pamela phoned GP Practice A to request that Do Not Resuscitate be added to her notes. She was advised to put this request in writing. There is no record that she followed this up with a written request.

14.3. In January 2016, Pamela attended her GP regarding a loss of appetite. It is recorded at this time that she consumed large amounts of alcohol and was a heavy smoker. She was given a blood test and returned the following week for a consultation. There are no results, or any follow up with Pamela recorded in the papers gathered for the review.

14.4. Pamela’s wish to be cared for at home are recorded in her GP notes at this time, she indicated that she did not want to die in hospital. There was no further discussion or contact with Pamela regarding this.

14.5. In August 2016, Pamela attended Practice A for an ear irrigation procedure. This was the last time Pamela was seen by her GP

14.6. In January 2017, Pamela did not attend a routine breast screening appointment.

14.7. In December 2017 and January 2018, Pamela declined a flu jab invitation and a bowel screening invitation, respectively.

14.8. In August 2018, Practice A closed, and Pamela was registered at Practice B, although up until her death she never attended Practice B.

14.9. In January 2019, Pamela did not take up a smoking cessation appointment invitation.

14.10. In February 2020, Pamela did not take up a bowel screening invitation. Also in February 2020, Pamela sent a letter to Practice B declining all future health checks. Letters for appointments did continue to be sent to Pamela, as many of the health screenings and

⁷House of Lords Adult Social Care Committee “A Gloriously Ordinary Life”: spotlight on adult social care *Report of Session 2022-23* (2022)
committees.parliament.uk/publications/31917/documents/193737/default/

routine appointments were not managed directly by the GP Practice, it was only the GP Practice who had been asked to no longer send invites.

- 14.11. During February and March 2020, Pamela did not take up a smoking cessation invitation, and an invitation for breast screening.
- 14.12. On 25th January 2021, Pamela's husband returned from a night shift and found her blue and unresponsive. He called 111, who advised him to start CPR and called her an ambulance.
- 14.13. Pamela was conveyed to hospital, upon admittance it is recorded that she had multiple areas of broken skin and pressure ulcers, she was excessively unkempt and dehydrated.
- 14.14. Pamela was admitted to a ward and a safeguarding alert was raised the same day. This resulted in a Multi-Disciplinary Team meeting being on 26th January 2021 – and police were alerted.
- 14.15. On 26th January 2021 Pamela's husband and son were arrested for ill treatment and neglect, as they had not contacted health providers with concerns about Pamela.
- 14.16. On 27th January 2021, a Safeguarding Adults strategy meeting was held. At this meeting it was agreed that as Pamela 's prognosis was poor, supervised visits could be facilitated for her husband and son.
- 14.17. Between 28th January 2021 and 3rd February 2021, there were daily Multi-Disciplinary Team briefings held. Adult Social Care⁸ and Police worked together with the hospital to support supervised visits for Pamela's husband and son.
- 14.18. On 3rd February 2021, Pamela died.
- 14.19. The postmortem revealed that Pamela had developed cancer, although there are no medical records indicating that this was identified or diagnosed officially when she was alive.
- 14.20. The pathologist's report stated: *"The autopsy identified a malignant tumour within the upper lobe of the right lung. This tumour is known as a combined small cell carcinoma. No bronchopneumonia was associated with this mass and a single enlarged lymph node was identified which contained metastasis of this tumour. Examination of all other major organs identified no evidence of metastatic spread and in particular there was no evidence of metastatic spread to the brain which may have been proposed as a differential diagnosis in this lady's confusion at presentation. It is therefore, my opinion that this malignant tumour to the right lung played no part in the fatal outcome and was incidental in nature."*

14. Overview

⁸ This department is now called Adult Social Care and Housing

- 15.1. For the majority of the agencies involved in this review, the first contact they had with Pamela was on 25th January 2021.
- 15.2. Pamela last attended her GP practice in August 2016, and the GP practice which she was registered with at the time of her death had never seen her in person.
- 15.3. There is no agency information to indicate that any services knew that Pamela' mental or physical health was in decline, that she was possibly self-neglecting from around mid 2020 by refusing to get out of bed, that around two months before her death she was unable to care for herself – and vitally that neither her husband or her son were prepared to go against her wishes to get help for her.

15. Analysis

Primary Care

- 16.1. As far as Pamela's GP Practice is concerned, she was an adult with mental capacity who was able to make informed decisions about her health care. For example, whether to attend for vaccinations or health checks. There is no evidence of any concerns about domestic abuse and no routine enquiry questions were asked at face-to-face appointments prior to 2016.
- 16.2. There was also nothing in the Pamela's GP notes to indicate that her husband or her son were caring for her. Without any information to the contrary, it was presumed that Pamela was able to care for herself.
- 16.3. Following GP Practice A closing, Pamela registered at GP Practice B, although she was never seen by anyone at this Practice. NHS England's contract with GP Practices requires Practices to register new patients, collect core health information, and ensure continuity of care and safe prescribing. There is no contractual obligation to offer routine GP appointments, a universal new-patient health check, or a face to face review for all new registrants. Practices are permitted to decide where they offer checks to all new registrants, offer checks to those with long-term conditions, or offer no routine checks and rely on the information provided in the patients' registration forms. In Pamela's case, she was not known to have a long term condition, and she was not in receipt of any repeat prescriptions. It is therefore reasonable that the GP Practice had no reason to see or speak to Pamela, during the period of her registration.

Cumbria Constabulary

- 16.4. Cumbria Police were not involved with Pamela prior to her death.
- 16.5. They became involved due to a safeguarding alert raised by NCIC following Pamela's admission into hospital on 25th January 2021.
- 16.6. At this time, the Police incident log was reviewed in a timely manner by a Detective Sergeant, and an investigative plan was initiated in a timely manner.

- 16.7. There was an early recognition of the gravity of the incident. Subsequently, the correct appointment of Senior Investigation Officer to direct the investigation from the outset was made, and specialist safeguarding investigators were deployed to the incident, rather than a uniformed officer. This is correct practice.
- 16.8. There was an early arrest of Pamela's son and husband, in order to secure their evidential accounts – this also facilitated the scene of the incident to be secured and forensically examined.
- 16.9. There was good practice when accompanied visits were facilitated by Police, to allow Frank and Roy to see Pamela before she passed away, even though they were on bail for offences for which she was the victim. The humanitarian aspect of investigations of this kind can be easy to overlook, and the rights of all involved need to be taken into consideration.

NCIC

- 16.10. There had been no contact between Pamela or NCIC staff until the point of Pamela attendance at the Emergency Department on 25th January 2021.
- 16.11. As Pamela had no contact with NCIC prior to this incident, there was no opportunity for routine safeguarding questions or professional curiosity to be triggered.
- 16.12. There were no contacts with Pamela's husband or son prior to 25th January 2021, which made any reference to there being any concerns with family relationships.
- 16.13. NCIC and NHS services nationally were greatly affected by the COVID-19 Pandemic, however there is nothing to suggest that any of the services from NCIC involved with Pamela, Roy or Frank had any specific or detrimental effect to this specific case.

Adult Social Care& Housing

- 16.14. There was no previous Adult Social Care or Housing involvement with Pamela prior to her death. The first ASC&H contact received was a Safeguarding Adults referral on 25th January 2021, from Town A Hospital. Pamela was not known to ASC&H prior to this date and following the first referral, the safeguarding team were unable to ascertain her views and wishes due to her declining physical health.
- 16.15. The referral from Town A Hospital was triaged by the safeguarding team as 'potential severe neglect', from Pamela's husband and son, with a high priority decision to undertake an urgent strategy meeting with the police.
- 16.16. A partnership safeguarding strategy meeting took place two days later 27th January 2021. Attendees from ASC&H, NCIC and Police were all present. The strategy meeting agreed further enquiries under S42 would be police led, due to the potential of a crime having been committed.
- 16.17. A referral was also received by ASC&H on 26th January 2021 from Police, which highlighted the same concerns around neglect.

- 16.18. Following the safeguarding strategy meeting on 27th January, the allocated safeguarding social worker liaised with the ward and consultant around an assessment of Pamela's capacity. At that time, it was concluded that it would be inappropriate for Pamela's capacity to be assessed, due to her decline in physical health and delirium.
- 16.19. On 28th January a request was received by ASC&H Out of Hours team from the NCIC legal team, requesting support to facilitate a supervised family visit on the ward: as it was believed Pamela was nearing the end of her life. This visit was facilitated
- 16.20. From this time until Pamela's death, daily Multi-Disciplinary Team briefs were held between ASC&H, Police and NCIC safeguarding leads. Pamela's condition in hospital was discussed, and further supervised visits were facilitated.
- 16.21. The decisions reached to take forward a S42 safeguarding enquiry in respect of Pamela were appropriately taken, as the concerns received from the hospital indicated the potential of abuse and neglect of an Adult with Care and Support needs. Unfortunately, Pamela views and wishes could not be ascertained throughout the enquiry, as her physical health presentation was too poor.
- 16.22. The needs of family, who were also at the time the alleged perpetrators, were given the same consideration to visitation rights as all families of patients who are end of life. Whilst this direction in procedure was taken from the Ward and NCIC, partnership risk assessment across agencies; police, ASC&H and Health was at the core of this practice.
- 16.23. Safeguarding practice requires the 'duty of co-operation' by all partnership agencies. Positive information sharing and essential sharing of resources within this limited safeguarding enquiry work, demonstrated embedded good practice between partnership agencies.

16. Conclusions

Effects of Covid Pandemic

- 17.1. 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.
- 17.2. 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.

- 17.3. 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.⁹
- 17.4. It was well documented during the pandemic that increasing age was associated with greater mortality linked to COVID.¹⁰ 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,¹¹ and further exacerbated their invisibility.¹² Access to physical and mental health services became restricted.¹³
- 17.5. 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

- 17.6. Although informal care, from family members, can work well and is indeed vital to the economy,¹⁴ on occasions when left unassessed and unsupported informal care can be inadequate.¹⁵ 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.

⁹ 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)

¹⁰ Verity et al "Estimates of the Severity of Coronavirus Disease: a Model Based Analysis" *The Lancet Infectious Diseases* 20 (6) (2020) pp.669-677

¹¹ Casper, A "Safeguarding Adults and COVID-19: A Sector Led Improvement Response" *Journal of Adult Protection* 22 (6) (2020) pp.401-413

¹² 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)

¹³ 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* 150 (3) (2021) pp. 664-667

¹⁴ Van Houtven, C et 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>

¹⁵ Reinhard, S et al "Supporting Family Caregivers in Providing Care" in *Patient Safety and Quality: An Evidence Based Handbook for Nurses* (2019)

- 17.7. In the Safeguarding Adult Review (SAR) of Adult O¹⁶ 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.
- 17.8. In the SAR regarding "Robyn"¹⁷ it was identified that the 81-year old's son, who was taking care of his mother, was struggling in his caring role.
- 17.9. 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.
- 17.10. 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.
- 17.11. 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.
- 17.12. 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.

17. Lessons to be Learnt

- 18.1. 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.
- 18.2. 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.

¹⁶ [Safeguarding Adult Review - Adult O \(nationalnetwork.org.uk\)](https://www.nationalnetwork.org.uk/safeguarding-adult-review-adult-o)

¹⁷ [Robyn SAR Final Report](#)

18.3. 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.

19. Recommendations

a) Pamela's review, along with other similar DARDRs and SARs, to be developed into a comparative thematic study, to be 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.

b) 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.