Domestic Homicide Review
Ruth Fisher/2018
Executive Summary
Cumberland Community Safety Partnership

Author: Dr Liza Thompson

Commissioned by:
Cumberland Community Safety Partnership

Review completed: May 2023

EXECUTIVE SUMMARY

1. The Review Process

1.1. This summary outlines the process undertaken by the Domestic Homicide Review panel in reviewing the death of Ruth Fisher, who was a resident of Town A, Cumbria, prior to her death on 11th September 2018.

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

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

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

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

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

1.7. Following feedback from the Home Office, a new DHR Author was required to re-write the report. There was a delay in identifying an appropriate Author to re-write the review, and the new Author was commissioned in October 2022.

2. Contributors to the Review

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

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

3. Review Panel Members

3.1. The panel for the re-write process consisted of:

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

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

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 in Cumbria.

5. Terms of reference for the review

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

5.2. <u>The Purpose of the DHR</u>

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

5.3. <u>The Focus of the DHR</u>

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

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

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

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

5.4. <u>Specific Issues to be Addressed.</u>

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

i. Were practitioners sensitive to the needs of the Ruth? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Ruth? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency forums?
iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?
iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?
viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?
ix. Was this information recorded and shared, where appropriate?
x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
xi. Were senior managers or other agencies and professionals involved at the appropriate points?
xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?
xiv. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be

improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

xvi. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to Ruth?

6. DHR Methodology

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

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

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

7. Summary Chronology

7.1. From historic police records Ruth and Bill were in a relationship from 2003 – and from then until 2012 Cumbria Constabulary dealt with Bill for twelve offences against Ruth. These ranged from Actual Bodily Harm (ABH) to criminal damage. Prior to 2009, the DASH[1] was not in use, and instead a matrix was used to estimate frequency and potential risk faced, based upon the level of offences.

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

7.3. As a result of this visit, a safeguarding concern was raised, this did not lead to a Adult Social Care involvement.

7.4. Ruth was allocated a support worker who helped Ruth until May 2017.

[1] Dash Risk Checklist | Saving lives through early risk identification, intervention and prevention

7.5. Bill was always present at the home; he was rude to professionals and always intoxicated.

7.6. Ruth's mobility deteriorated, she did not leave the house unless she was supported to do so, and Bill was using her money for his own purposes.

7.7. Property inspections found the home to be in a neglected state, neighbours complained about noise, and it was generally accepted that Bill was violent and controlling towards Ruth.

7.8. In May 2018 to the condition of the property, gas engineers refused to undertake the annual gas safety inspection, and the landlords organised a deep clean to assist Ruth.

7.9. In September 2018, an ambulance was called to the flat, as Ruth was in cardiac arrest, she was found deceased at the scene. Attending officers did not identify anything suspicious, Bill told officers he was a friend who did not live there and had found her in cardiac arrest.

7.10. The following say, after reviewing the photos taken at the scene, the coroner Officer raised a concern with the police – Bill was arrested for gross negligence manslaughter, on 11th January 2019, the Home Office pathologist found that Ruth had multiple rib fractures, however Bill had passed away six days before so could not be arrested.

8. Conclusion

8.1. Coercive Control

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

8.1.2. The elements of the offence are:

a) A person (A) commits an offence if they repeatedly, or continuously, engage in behaviour towards another person (B)
b) At the time A and B are personally connected
c) The behaviour has a serious effect on B
d) A knows, or ought to know, that the behaviour will have a serious effect on B.[2]

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

a) A and B are in an intimate relationship

[2] S.76 (1)

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

8.1.4. From 5th April 2023, the definition of 'personally connected' in section 76 of the Serious Crime Act will be replaced with the definition in Part 1 of the Act, so that the offence may apply to former partners and family members.[3]

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

8.1.6. Ruth told the LAC on one occasion that she wished Bill would move to his own property. In April 2016 LAC did support Bill to secure his own independent tenancy which was set up ready for him to live in. However, information suggests that he did not spend much time at the property despite efforts from the LAC to look at the reasons for this.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.2. Homicide Timeline

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

18.2.2. The Eight Stages of Homicide[4] framework has been developed from Professor Monckton-Smith's ground-breaking research which has spanned many years. The homicide timeline lays out identifiable stages in which intimate relationships where one partner is coercive, can escalate to murder. The timeline aims to support a better understanding of coercive control and domestic homicide amongst professionals responding to domestic abuse.

18.2.3. Professor Jane Monckton-Smith clarifies further that, although people outside of a relationship may find it difficult to identify coercive control, there is always a trail left by victims and abusers, often in the form of "repeating patterns".[5] To facilitate the identification of this trail, she has created the "eight stages of homicide". This theoretical tool can be applied practically by practitioners who want to identify the risk of homicide in a relationship.

18.2.4. Stage one occurs before the relationship even begins; this stage refers to a "type" of person who may be predisposed to domestic homicide rather than the dynamics between two people. Monckton-Smith talks about the "predictive strength of someone's past behaviour."[6] The most significant red flag being that they are controlling and have been controlling before.[7] They will often tell their friends, or new partners, about their "crazy-ex" who knew how to "push their buttons".[8] We do not have any information about Bill's past relationships, as he had been with Ruth for many years.

18.2.5. Stage two is the "commitment whirlwind". Monckton-Smith explains that when a controlling person finds someone they want to be in a relationship with, they move things on very quickly. They demand commitment, which in their minds can never be withdrawn.

---

[4] Monckton-Smith J *In Control: Dangerous Relationships and How They End in Murder* (2021)
[5] Monckton-Smith, J *In Control: Dangerous Relationships and How they End in Murder* (2021) p.45
[6] *Ibid p.49*
[7] *Ibid* p.23
[8] *Ibid p.35*

They display jealousy and possessiveness.[9] We know from Ruth's sister that Bill moved into Ruth's flat very quickly after they met.

18.2.6. Stage three is where the victim is "living with control", and Monckton-Smith describes two pillars of this control. One being "patterns of jealousy", which leads to the victim behaving in a way which aims to stop the jealousy, which in turn "manoeuvres them into living isolated lives to stop the jealousy."[10] The abuser will use emotional blackmail during this time. The second pillar of control is "the loyal code", which is a series of hidden tests designed to make the non-abusive partner prove their devotion, and at the same time removes or controls any influence that others may have over them. We know from the chronology, agency analysis and also from Ruth's sister that her life was confined mostly to the flat. Bill was always present, and we do not get a sense of Ruth having very much of a life outside of the relationship with Bill. We also know that Ruth alcohol intake became problematic. This could have been a coping mechanism for her, or it could have been encouraged by Bill to increase his control of her.

18.2.7. During stage three the abuser maintains routine and ritual, and the victim complies with this as to change anything that will cause trouble for them.[11]

18.2.8. It is important at this stage that those responding to domestic abuse are aware that when a victim is managing their safety, this may look to the outside world as choosing to maintain their relationship. The victim knows by now that the only way to stop the abuse is to comply with the demands, as once the victim stops complying, the perpetrator will become dangerous.[12] To the untrained eye, "compliance doesn't look like fear, it looks like consent."[13]

18.2.9. Monkton-Smith tells us that stage three is all about making sure the non-abusive partner is compliant and trapped within the relationship. If there is no challenge to the control, or any challenges are effectively overcome, this stage can last a lifetime.[14]

18.2.10. Stage four introduces the "trigger"; this could be something within the relationship or external to the relationship, which indicates to the abuser that they are losing control of the victim. For example, actual or perceived separation from the victim.[15] In Bill's case, this trigger could have been Ruth's engagement with support services, but it also could have been his own deteriorating physical health which triggered an increase in violence which led to Ruth's death.

18.2.11. Stage five moves into "escalation", where the abuser "ramps up the control to frighten or coerce the victim back into line."[16] At this point, the escalation tactic may work, the relationship may resume, and the timeline will circle back to stage three. Monckton-

[9] *Ibid pp.63-69*
[10] *Ibid p.77*
[11] *Ibid p.111-114*
[12] *Ibid* p.99
[13] *ibid*
[14] *Ibid* p.127
[15] *Ibid* p130
[16] *Ibid* p.158

Smith tells us that this is very common, and relationships may constantly circle between stage three and five, with the victim never being able to leave. On rare occasions, the relationship may stay broken, the abuser accepts the breakup and circles back to stage one with a new partner – telling the new partner about the crazy-ex and messy breakup from before. However, on some occasions the abuser moves onto stage six.

18.2.12. Stage six is "a change in thinking", which Monckton-Smith describes as "a move on from attempting to keep the partner in the relationship to destroying them for leaving it."[17] Often victims and family members describe this stage as the calm before the storm.

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

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

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

8.3. Financial abuse

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

8.3.2. It can include money being stolen or misused, fraud or putting someone under pressure in regards their money or property. As a form of abuse, it can often be missed due to gendered dynamics of money management within relationships.[18]

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

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

8.3.5. When interviewed for the review, the HAWK reflected that "when I picked up the referral money it was a mess. Ruth was not on the correct benefits and so money was tight

---

[17] *Ibid* p.164

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

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

8.3.6. Research shows that financial abuse is rarely employed in isolation and is often linked with other forms of abuse.[19] It would appear that professionals did not identify financial abuse as a current issue for Ruth and did not link this to other forms of abuse she may have disclosed, or that police had records of.

8.3.7. The financial abuse led to Ruth having a lack of funds to spend on the upkeep of the flat, and social activities which would have allowed a more independent lifestyle for Ruth. In this way, Bill was able to further control Ruth.

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

8.3.9. As with coercive control, financial abuse was less understood during the scoping period for this review. However, the building society were concerned for Ruth's welfare and identified the issues with Bill withdrawing money from Ruth's account. Their response was limited; however, banks and financial institutions are becoming more able to spot and respond to issues of financial abuse.[20]

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

8.4. Self-Neglect

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

8.4.2. Further factors which may indicate self-neglect are social isolation, inadequate housing, the threat of eviction from a rented property, environmental hazards such as living in squalor, thei involvement with an individual which cases them harm, from which they are

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

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

unable to withdraw, lack of insight or will to undertake essential daily tasks.[21] Ruth's circumstances are relevant to all of these factors.

8.4.3. Research has found a close correlation between animal neglect and self-neglect.[22] There were observations made by Home Group and the LAC regarding the strong smell of animal urine, within the context of the property's unkept state.

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

8.4.5. The Cumbria Safeguarding Adult Board (CSAB) Self-Neglect Guidance details risk level threshold of self-neglect. When applying Ruth's situation to the document, she is identified as high risk which would require an Adult Social care referral for a care needs assessment.[23]

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

8.5. Professional Curiosity

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

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

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

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

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

---

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

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

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

8.5.6. Rather than the lack of police involvement since 2014 being due to violent incidents ceasing, there is a possibility that Ruth's experiences of the criminal justice system may have led her to distrust the system. Bill had been arrested for a range of high-risk offences against Ruth between 2002 and 2014 – yet he had only been prosecuted once. Ruth may have decided that the police could not protect her and chosen to no longer report incidents to them. This is not uncommon, as victims may choose to manage the risks themselves if they do not believe professionals – including police – are able to manage it for them.[24]

8.6. Multi-Agency Procedures

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

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

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

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

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

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

9 Lessons to be Learnt

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

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

9.2. Home Group

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

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

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

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

9.3. Cumbria County Council – Adult Social Care

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

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

10. Recommendations

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

9. Recommendations

The Review Panel makes the following recommendations from this DHR:

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