safe & sound
Dudley's Community Safety Partnership

Dudley Domestic Homicide Review 2 Local Learning Briefing

Who should read this?

Any practitioner or manager within the Borough who works with adults. It may also be of interest to individuals that work with children, young people and their families due to the impact that childhood experiences had on the case.

Background information

This Domestic Homicide Review, commissioned by Safe & Sound Dudley's Community Safety Partnership, concerns the death of a woman known as Annette, who was 78 years of age at the time of her death in January 2016.
She lived with her son, Phillip who was 38 years of age at the time of Annette's death.
Annette had a significant medical history. She suffered from various ailments including Chronic Obstructive Pulmonary Disease (COPD) and she had been diagnosed with cancer shortly before she died.
On Christmas Eve 2015, Phillip was trying to plan the Christmas dinner the following day for Annette and himself. He describes how Annette picked an argument over the roast potatoes that resulted in Phillip taking hold of Annette to move her out of the way so he could leave the room and escape further argument. As he tried to move Annette, she slipped and fell fracturing her hip.
Annette was taken to hospital by ambulance where she was admitted. Her condition deteriorated in hospital and she died later in January 2016. A Forensic Pathologist determined that Annette had died as a result of pneumonia caused by a combination of lung carcinoma, chronic obstructive airways disease and hospitalisation as a consequence of a fractured hip.
On the direction of Crown Prosecution Service (CPS) Phillip was charged with the offence of manslaughter. He subsequently appeared before the Crown Court where he was acquitted of all charges.
In compliance with the Home Office Guidance[1], the Community Safety Partnership was notified of Annette's death by the Police and a Domestic Homicide Review was authorised following agreement that the circumstances met the criteria of the definition for a review.

Key Areas of Learning Identified

Capacity to make decisions

Annette's medical and mental ill health issues were recognised many years before her death. Phillip described how he repeatedly asked Social Care for assistance for his mother, however it

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

was decided that Annette had capacity to make her decisions, although there was no evidence of a capacity assessment being conducted.

More Timely Assessments and Checks

Annette had significant dealings with the Dudley Disability Service (DDS) and their candid IMR identifies that more timely assessments could have been made which may have led to the family receiving support. It is also noted that allegations of harm to others should be taken seriously and checks should be made with other agencies to inform Safeguarding investigations.

Hoarding

The IMR from Dudley Group NHS Foundation Trust mentions that the state of Annette's and Phillip's home was of concern in that it was obvious that Annette was a hoarder and there were areas of the house that were deemed to be 'trip hazards'. Had a holistic view been taken of the conditions of the house, it may have resulted in positive action being taken to support both Annette and Phillip.

Follow Up on Missed Appointments

There were numerous occasions when Annette failed to attend medical appointments and she is described by the Community Nurse as being 'stubborn' in relation to her health care. With regards to Annette's failing to attend appointments it appears that other than repeat letters no further investigation was made as to why the appointments were not kept.

Recognition of Carers Needs

It also appears that the Community Nurses were unaware that Phillip had had a nervous breakdown and did not appreciate that he was not coping with his mother's needs.

After Annette's diagnoses of cancer both Annette and Phillip saw a MacMillan nurse consultant and at the end of the consultation Phillip specifically mentioned to the consultant that he was unable to cope with his mother any longer and he was unwell himself. He was advised to speak to his GP about his own health and contact Social Services about getting help at home. At this Annette said she did not want anyone in her house and refused help. This was a missed opportunity to explore with Phillip his concerns and more could have been done.

There is no indication that domestic abuse was identified by any of the professionals involved with either Annette or Phillip. The lack of self-care and self-management of Annette's own health was obvious but there is no evidence of any discussion with Phillip about the effect of that was having on his own health.

Dudley Group NHS Foundation Trust (DGNHSFT) was also involved with Annette. Overall their IMR considers that whilst professionals may not have been able to predict the death of Annette, Phillip could have received more support as a carer and that the impact of self-neglect on other members of the family was not recognised. The DGNHSFT IMR states 'potentially if he had received the appropriate support as a carer, he may not have assaulted his mother'.

Professional Curiosity

The Dudley and Walsall Mental Health Partnership concludes that there were no identified risk factors or disclosures made regarding domestic abuse and the main trigger for Phillip's depression was linked to the stress for caring for his mother. Consequently, the emphasis was placed on providing co-ordinating support to reduce his stress level. The IMR identifies a lack of professional curiosity which may have led to opportunities for further enquiries into Annette's problems and a fuller understanding of Phillip's situation at home.

Overview Recommendations for Safe and Sound, Dudley's Community Safety Partnership

Recommendation 1

Dudley's Community Safety Partnership works with Dudley Safeguard Adults Board to ensure that Dudley's Multi-Agency Hoarding Framework and the DSAB Self Neglect Policy are launched and implemented as soon as is possible in 2019 and that further multi-agency Self Neglect and Hoarding Training is commissioned by DSAB.

Recommendation 2

Dudley's Community Safety Partnership should work with Dudley Safeguarding Adult Board and Dudley's Safeguarding Children Board to re-establish multi-agency training in respect of domestic violence and abuse.

Recommendation 3

Dudley's Community Safety Partnership to receive assurances from all agencies that professional curiosity is included within training and the CSP is assured within 6 months from the date of publication of the final report.

More information

To access the full report and Executive Summary, including individual agency recommendations please visit: https://www.dudleysafeandsound.org/ourwork

For more information in respect of Domestic Abuse please visit our helphub: https://www.dudleysafeandsound.org/help-hub