

Domestic Homicide Review

Sandra/2014

Overview Report

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Commissioned by:

Kent Community Safety Partnership

Medway Community Safety Partnership

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DOMESTIC HOMICIDE REVIEW

SANDRA DODDS

Purpose

The key purpose of a Domestic Homicide Review (DHR) is to:

- a) establish what lessons are to be learned from the domestic homicide 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 they will be acted on, and what is expected to change as a result;
- c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
- d) Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra- and inter-organisation working.

Scope

This DHR examines the contact and involvement that organisations had with Sandra Dodds between 1 January 2010 and her death on 5 December 2014 at the hands of her partner, David Bryant.

In order to meet its purpose, this DHR also examines the contact and involvement that organisations had with the perpetrator, David Bryant.

Terms of Reference

The terms of reference for the DHR are set out in [Appendix A](#) to this report.

Timescales

This review began on 9 January 2015 following the decision that the case met the criteria for conducting a DHR. David Bryant was arrested on the day of Sandra's death and was charged with her murder. The Crown Prosecution Service did not request that the DHR was suspended pending the criminal trial, however they did ask that members of both Sandra's and David's families were not seen as part of the review until the trial was over. This was because there was a potential for family members to be called as witnesses.

The review was completed on 21 October 2015.

NHS England Mental Health Homicide Investigation

NHS England undertakes an independent investigation when a patient, who has recently received care and treatment for a mental health disorder, commits a homicide. David Bryant fitted this criterion and a Mental Health Homicide Investigation (MHHI) was commissioned. The MHHI Terms of Reference are set out in Appendix B to this report.

Following discussion between the Independent Chairman of the DHR and the Head of the regional NHS England MHHI Team, it was agreed that the terms of reference of the DHR and MHHI could be met by conducting a joint DHR/MHHI. The DHR was the lead process and this Overview Report includes the information and analysis required to meet the MHHI terms of reference. A separate MHHI report will not be published and following the publication of this report, a link on the NHS England website will lead to it.

There will be a link from the MHHI section of the NHS England website to the DHR report. In order to provide a review of the treatment that David received, NHS England has engaged an independent Consultant Old Age Psychiatrist, Dr Hugh Series DM, FRCPsych, LLM, MA, MB, BS. Dr Series is a member of the DHR Review Panel.

Publication

This DHR report is publicly available and can be found on the websites of both Kent and Medway Community Safety Partnerships.

Glossary

A glossary of abbreviations, acronyms and terms used, which may be unfamiliar to those who are not professionals in the agencies concerned, is included in Appendix C.

Anonymisation

This report has been anonymised and all the personal names contained within it, with the exception of members of the review panel, are pseudonyms.

Overview Report

1. Introduction

- 1.1 This Overview Report is an anthology of information gathered from Independent Management Reports (IMRs) prepared by representatives of the organisations that had contact and involvement with Sandra Dodds and/or David Bryant between January 2010 and Sandra's death on 5 December 2014, along with information gleaned from interviews with those representatives. The requirement to complete an IMR does not assume or suggest failings by an organisation.
- 1.2 An IMR is a detailed examination of an organisation's contact and involvement with Sandra and/or David. It is a written document submitted using a template. The IMR is written by a member of staff from the organisation subject to review, who has no involvement with anyone who is a subject of the review. It is signed off by a senior manager of that organisation before being submitted to the DHR Review Panel.
- 1.3 Each of the following organisations completed an IMR for this DHR:
 - Kent and Medway NHS and Social Care Partnership Trust (KMPT)
 - NHS West Kent Clinical Commissioning Group (WKCCG)
 - Kent Police
 - National Probation Service
 - HM Prison Service (HMPS)
- 1.4 Oxleas NHS Trust were commissioned to provide medical services in HMP Elmley prison during the period covered by this review and they have made records of the treatment they provided to David available for the purposes of the review.
- 1.5 Enquiries were made with West Kent Housing Association (WKHA), which provided support to Sandra through its Domestic Abuse Floating Support Service. WKHA made all of its records, relating to Sandra, available for the purposes of the review.

2. The Review Process

2.1 The Review Panel

2.1.1 The Review Panel consisted of an Independent Chairman and senior representatives of the organisations that had relevant contact with Sandra Dodds and/or David Bryant. It also included the Kent and Medway Domestic Abuse Coordinator and a senior member from each of Kent County Council and Medway Council Community Safety Teams. In addition, the manager of Choices, a Kent-based domestic abuse support organisation, sat on the Review Panel.

2.1.2 The members of the panel were:

Tim England	Medway Safer Communities
Christopher Gill	NHS England
Alison Gilmour	Kent & Medway Domestic Violence Coordinator
Tina Hughes	National Probation Service
Carol McKeough	Kent Adult Social Services
Sylvia Murray	Choices Domestic Abuse Support Service
Paul Pearce	Independent Chairman
Shafick Peerbux	Kent Community Safety
Andy Pritchard	Kent Police
Dr Hugh Series	Independent Consultant Old Age Psychiatrist commissioned by NHS England
Tracey Creaton	NHS West Kent Clinical Commissioning Group
Cecelia Wigley	Kent and Medway NHS and Social Care Partnership Trust

2.1.3 The Independent Chairman of the Review Panel is a retired senior police officer who has no association with any of the organisations represented on it. In particular, he did not serve with Kent Police. He has experience and knowledge of domestic abuse issues and legislation, and a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to dealing with domestic abuse. He has a background in conducting reviews, investigations, and inspections, including disciplinary enquiries.

2.2 Review Meetings

2.2.1 The Review Panel met first on 4 February 2015 to discuss the terms of reference, which were then agreed by correspondence. A briefing for IMR writers was held on 27 February 2015 and the Review Panel met on 11 May to consider the IMRs. The next meeting of the Panel was held on 7 September 2015, where the first draft of the Overview Report was considered, and amendments agreed.

2.3 Family Involvement

2.3.1 The Review Panel considered which family members should be consulted and involved in the review process. The Panel was made aware of the following family members:

Name	Relationship to Sandra Dodds	Relationship to David Bryant
Christopher Dodds	Husband*	
Laura Dodds	Daughter	
Elizabeth Dodds	Daughter	
Michael Dodds	Son	
Andrew Mills	Brother	
Lisa Grant		Daughter

*Sandra had separated from her husband before the start of the period covered by this DHR.

2.3.2 The Independent Chairman wrote to family members on 24 July 2015 following the trial of David Bryant. He offered to meet them to discuss the DHR process and listen to any views and concerns they had. The letters were sent by recorded delivery.

2.3.3 As a result the Independent Chairman met with members of Sandra's family. They were able to provide background information about her, including aspects of her relationship with David which were not recorded by agencies. Where relevant to the terms of reference, this information has been included in the report but has not been attributed to an individual.

2.3.4 Following the completion of the draft Overview Report, the Independent Chairman wrote to family members, offering them a further opportunity to meet and to discuss its content, conclusions and recommendations. He again met with members of Sandra's family.

3. The Death of Sandra Dodds

3.1 Events Surrounding the Death of Sandra Dodds

3.1.1 Sandra was found dead by police officers who went to her flat about 3.20pm on Friday 5 December 2014. The sequence of events that led to them going there is considered in more detail in section 5.4 below.

3.1.2 David was present when police officers arrived at Sandra's flat and, after they found her body, he was arrested on suspicion of her murder. He was subsequently charged with this and remanded in custody.

3.1.3 Sandra had suffered obvious blunt and sharp force injuries, but her death was caused by compression of her chest, which led to asphyxiation.

3.2 Trial of David Bryant

3.2.1 On 22 June 2015, a trial of the facts began at Maidstone Crown Court. The jury were asked to decide whether David carried out the acts that led to Sandra's death, not whether he was guilty of a criminal offence.

3.2.2 The jury decided that he had carried out the acts. Following a trial of facts a sentence cannot be passed and David received a hospital order.

4. Summary of Relevant History

4.1 Sandra Dodds

- 4.1.1 At the time of her death, Sandra was married but separated from her husband; the separation happened before the period covered by this DHR. Although she and her husband did not live together at any time after their separation, they remained in contact until her death.
- 4.1.2 Sandra and her husband had three children: two daughters and a son. Each had varying amounts of contact with Sandra during the period covered by the review.
- 4.1.3 Her family said that, following her separation from her husband, Sandra lived for a short period with a man in Maidstone. The relationship did not last and Sandra was then provided with temporary accommodation in a hotel in Town B, East Sussex; a town that they said she had always liked. A short time later, she was provided with permanent accommodation in a flat in Town C, Kent.
- 4.1.4 In 2010, while living in Town C, she was referred to West Kent Housing Association (WKHA), which at the time was commissioned by Kent County Council (KCC) to provide a floating support service to victims of domestic abuse. Sandra stated that she had been a victim of domestic abuse. Family members who have been spoken to during the course of this review were unaware that she had been a victim or that she had made the allegation.
- 4.1.5 Sandra subsequently moved to Town A in a property exchange. She had lived in in a nearby town during her marriage, where her family still live. Sandra was living in Town A at the time of her death.
- 4.1.6 Although Sandra had previously been diagnosed with and treated for depression, her mental health problems became significant in late 2013.
- 4.1.7 Sandra first met David in February 2014 when both were in-patients in Ward A at Priority House, a KMPT inpatient facility in Kent. They were discharged later that month within a few days of each other and shortly afterwards he moved into her flat. On two occasions between then and Sandra's death, David told professionals that they were engaged and Sandra told a member of her family the same. However, she was still married at the time of her death.
- 4.1.8 There was little contact between Sandra and agencies while she was living with David, and there was no evidence that she was a victim of domestic abuse during this period, prior to the event that caused her death.

4.2 David Bryant

- 4.2.1 David was one of nine children. His childhood appears to have been unhappy due to him being a victim of violence at the hands of his father; he was also apparently bullied at school.
- 4.2.2 He was married for 30 years and this marriage ended around 2001, although the exact date is uncertain. David and his wife had two children and he subsequently had two grandchildren.
- 4.2.3 After his marriage ended, David had another relationship that lasted about four years. This ended in 2009, about the time that one of his brothers died suddenly.
- 4.2.4 David worked consistently throughout his life until 2011, when he suffered a medical episode. He was advised not to drive and this meant that he could not continue in his job as a bus driver, a post which he had held for 17 years. There is no record that he worked after this.
- 4.2.5 Throughout the period covered by this DHR, David suffered significant mental health conditions and received treatment for these, both as an inpatient and in the community.

5 The Facts and Analysis of Organisations' Involvement

5.1 Introduction

- 5.1.1 This section considers, in detail, the contact and involvement that Sandra and David had with agencies during the period covered by the terms of reference. The facts are based on IMRs submitted by organisations, the MHHI report and information gathered from discussions with family members.
- 5.1.2 Each IMR included a detailed chronology of contact and involvement with Sandra and David, a consolidated version of which is submitted with this Overview Report.
- 5.1.3 In the absence of information that Sandra and David knew each other before they met in Priority House, their involvement with agencies prior to 8 February 2014 is considered separately. Between that date and Sandra's death in December 2014, it is considered jointly.

5.2 Agency Involvement with Sandra Dodds - 1 January 2010 to 7 February 2014

- 5.2.1 On 21 December 2009, KCC Supporting People Team referred Sandra to the West Kent Housing Association Domestic Abuse Floating Support Service (WKHA). At the time of the referral she was living in a flat in Town C, Kent, having previously been provided with temporary accommodation in Town B, East Sussex, following her separation from her husband and the ending of a short-term relationship.
- 5.2.2 The primary client group for the WKHA floating support team was those at risk of domestic abuse. The referral stated that Sandra '*...has fled [domestic abuse]*' but did not contain further details. Family members who were spoken to during this DHR were unaware that Sandra had been a victim of domestic abuse.
- 5.2.3 The referral to WKHA also stated that Sandra was '*...currently experiencing domestic violence*'. Again, there is no further information about this. She was involved in a dispute with a neighbour in Town C at this time but that would not fall within the definition of domestic abuse.
- 5.2.4 At the time of the referral, Sandra was suffering from physical and mental health conditions and was vulnerable. WKHA supported her in making benefit claims, in particular for Disability Living Allowance (DLA). Her WKHA case manager represented her at an appeal tribunal, where a decision not to award DLA was reviewed; this appeal was successful.

- 5.2.5 The dispute between Sandra and her neighbour was resolved, and she remained in Town C for the period during which she was supported by a WKHA case manager.
- 5.2.6 The Floating Support Team assisted her in establishing her life following a difficult period. The referral to and support given by WKHA was an example of good practice in providing help to a person who they believed was a victim of domestic abuse and vulnerable.
- 5.2.7 Kent Police was involved with Sandra on a number of occasions during a six-month period in 2010; each contact arose from the dispute with her neighbour in Town C. It appears that Sandra was the victim and, on two occasions when criminal offences were committed, the offender was dealt with appropriately. In each case they were given a Fixed Penalty Notice for Disorder, which can be used to deal with a variety of minor crimes.
- 5.2.8 The fact that police involvement was over a short period of time corroborates the record made by Sandra's WKHA case manager, that Sandra took the initiative to resolve the dispute with her neighbour. Her family confirm that Sandra subsequently became close friends with this neighbour, to the extent that she visited her with David.
- 5.2.9 Following the last police involvement regarding the neighbour dispute in August 2010, the next relevant recorded contact that Sandra had with any agency was in November 2013. By this time, she had moved to the flat in Town A where she was living at the time of her death.
- 5.2.10 On 27 November 2013, Sandra contacted the police several times, making allegations against a different neighbour. Police officers attended and identified that Sandra appeared to be suffering from a mental health condition. As a result, they made a referral to the KMPT Duty Team at a local KMPT outpatient facility.
- 5.2.11 The KMPT staff member who received the referral, wrote to Sandra's general practitioner (GP) on the same day, informing him of it, and requesting further information to establish whether there was a requirement for secondary mental health services.
- 5.2.12 The following day, another KMPT staff member tried to contact Sandra by telephone to arrange an appointment for an assessment. Although this attempt was unsuccessful, following further contact from Kent Police she spoke to Sandra, who said that she would not allow a mental health practitioner to enter her home. She said that she was not paranoid but that she suffered from depression. She added that she had an appointment for a mental health review with her GP. The KMPT staff member then contacted

Sandra's GP and confirmed this appointment.

- 5.2.13 Sandra's GP provided KMPT with details of her recent contact with the surgery. On 4 December, the GP surgery confirmed that Sandra had not attended the mental health review and KMPT then sent her a letter offering an appointment for an initial assessment on 17 December at her home.
- 5.2.14 Given that the initial referral to KMPT by Kent Police about Sandra did not suggest that she presented a risk to herself or others, the actions subsequently taken by KMPT were appropriate. KMPT contacted her GP surgery to obtain background information, which provided this within a week. When first contacted by KMPT, Sandra declined help but they persisted and offered her an assessment at home. This was an example of good practice.
- 5.2.15 On 15 December 2013, Kent Police attended an incident involving Sandra, who appeared to be suffering from a mental health condition. The circumstances met the criteria set out in Section 136 of the Mental Health Act 1983 (S.136 MHA) and she was taken to Priority House by ambulance.
- 5.2.16 On many occasions when a person appears to be suffering from a mental health condition, they will be taken to a police station in a police vehicle. The MHA identifies a police station as 'a place of safety' but mental health facilities are usually more appropriate to take such persons. Taking Sandra to Priority House by ambulance was an example of good practice.
- 5.2.17 A formal mental health assessment was undertaken and Sandra was admitted to Ward A at Priority House under S.2 MHA. Three assessors identified that she was paranoid and that she presented a risk of harm to herself. They also identified that she had been self-neglecting. The admission was to enable a more thorough assessment of her mental health to be conducted in a safe environment.
- 5.2.18 Since this time, Kent & Medway Safeguarding Adults Board (KMSAB) have introduced the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect. This provides comprehensive instructions and guidance for organisations on a multi-agency approach to people who are identified as self-neglecting. The aim is to ensure that such people are offered and receive a comprehensive and coordinated service from all the agencies that can assist them.
- 5.2.19 Kent Adult Social Services (KASS) were not notified of Sandra's situation, although she was a vulnerable adult and self-neglect was identified. Had the current self-neglect policy and procedures been in place at the time she might have met the criteria, in which case KASS would have been informed and might have been able to offer her additional support.

- 5.2.20 Although separated from her husband, Sandra nominated him as her next of kin at this time. She was particularly concerned about her pets and he agreed to look after them, providing updates to her about this via Ward A staff.
- 5.2.21 On 17 December, Sandra was discharged because the statutory criteria for detention under S.2 MHA were no longer met. She was assessed as having a low risk to herself and others, and her mental health had improved substantially.
- 5.2.22 A consultant psychiatrist had a lengthy conversation with one of Sandra's daughters, who was concerned that she was being discharged. Her daughter also provided additional information to the psychiatrist, including details of a traumatic incident Sandra suffered while at work that may have resulted in her mental health problems, and that Sandra was a heavy drinker. When her consultant discussed this with Sandra, she disputed the details of the incident and denied that she was a heavy drinker.
- 5.2.23 Sandra initially agreed to remain in Priority House as a voluntary patient but left there of her own accord on 19 December without telling staff. Her daughter later confirmed that Sandra had returned home.
- 5.2.24 Priority House staff remained concerned about Sandra and on 20 December, the day after she left, a health care assistant from Ward A asked Kent Police if they would conduct a welfare check. Kent Police declined to do this because there was no apparent risk to Sandra or others.
- 5.2.25 The KMPT West Kent Crisis Resolution Home Treatment Team (CRHT) agreed to undertake a welfare check if accompanied by a member of staff from Ward A. There was no one available from the ward so the welfare check was not carried out that day.
- 5.2.26 On 21 December, CRHT received a call from Kent Police who had been contacted by Sandra's neighbour to express concern about her behaviour. CRHT contacted Ward A, where it was agreed that a further request should be made of CRHT and Kent Police to undertake a welfare check.
- 5.2.27 Contact was made with Kent Police who stated, as the apparent risk posed by Sandra to herself and others was not high, they would not visit unless a member of mental health staff was present. This was a reasonable decision because the mental health professional would have been the appropriate person to deal with Sandra if she was found to have mental health problems at the time. Police officers only have the power, under S.136 MHA, to take a person to a place of safety if the person is in a public place when the police deal with them.

- 5.2.28 On 22 December, two members of CRHT visited Sandra's flat. She opened the door but refused to let them in, stating that she was '*mentally fine*' but felt ill physically. CRHT staff recorded that there was no obvious thought disorder in her speech nor was there any obvious response to unseen stimuli. As she was unwilling to engage with them, they were unable to evaluate her mental state or the risks she posed to herself and others. They informed Ward A of the outcome of the visit and concluded that there was no current role for CRHT.
- 5.2.29 Staff at Priority House were concerned about Sandra's welfare after she left Ward A on 19 December. They should have contacted CRHT, who in turn should have visited Sandra. There was no information to suggest that Sandra might pose a risk to KMPT staff or herself if they visited her, so there was no need for either Priority House staff, or subsequently CRHT staff, to contact Kent Police. In addition, there was no reason for CRHT staff to request that a member of Priority House staff accompany them on the visit. Doing so built in an unnecessary delay.
- 5.2.30 KMPT should review existing policies relating to inpatient discharge in order to ensure that in every case, whether by self-discharge or not, the responsibility for further care is decided within 24 hours of the unexpected absence of a patient from a ward. This should apply whether a patient is unexpectedly absent without leave or has self-discharged.

(Recommendation 1)

- 5.2.31 It is doubtful that a policy under which responsibility is shared between teams would be robust enough to ensure safe practice in all circumstances, because of the risk that in urgent circumstances responsibility will fall between teams.
- 5.2.32 There are circumstances in which it is appropriate for police to accompany KMPT professionals on a visit to a patient, such as where there is reason to believe that the visit might result in the person attempting to harm KMPT staff or themselves. The policy relating to inpatient discharge should include the criteria for asking for police attendance and detail how such requests will be made.
- 5.2.33 In order to support inter-agency working, KMPT must include a section in their inpatient discharge policy that sets out the criteria for requesting Kent Police attendance when visiting patients after discharge. KMPT must consult Kent Police when drafting this section. **(Recommendation 2)**
- 5.2.34 On 23 December, following CRHT informing Ward A of their visit to Sandra, a staff nurse from Ward A contacted a senior practitioner at the local Community Mental Health Team (CMHT) to discuss concerns about her. It

was agreed that Sandra would be seen in the community by CMHT rather than at a mental health facility.

- 5.2.35 On 24 December, a number of unsuccessful attempts were made by a CMHT community psychiatric nurse to contact Sandra by telephone.
- 5.2.36 On 25 December, Kent Police attended a disturbance between Sandra and her neighbour. When they attended a further call of a similar nature on 6 January 2014, they attempted to speak to Sandra but did not get a coherent response from her. She was described by the police officer attending as having 'clear mental health problems'.
- 5.2.37 During that Christmas and New Year period, CMHT staff continued to try to contact Sandra by telephone without success and on 30 December it was agreed that a home visit would be arranged. In addition, a care coordinator was appointed for her.
- 5.2.38 On 16 January 2014, the care coordinator undertook a home visit but when she explained her role, Sandra shut the door. On the same day, Kent Police again attended her address, intending to talk to Sandra about problems between her and her neighbour. She was again described by the police officer attending as suffering from 'mental health problems'.
- 5.2.39 The following day, 17 January, Kent Police attended a disturbance between Sandra and her neighbour. Sandra was described as being agitated and would not engage with the officer who attended. It was stated that there were '*...concerns that she had not been taking her medication*'.
- 5.2.40 Following her leaving Priority House on 19 December, Sandra's mental health was of concern to KMPT and Kent Police but there does not appear to have been any contact between the two organisations.
- 5.2.41 One of the main benefits of multi-agency working is that when an agency does not have the expertise to manage a person's issues it can contact the agency that does. This should ensure that the person gets the appropriate form of help. In this case Kent Police were not the agency with the skills to manage Sandra's mental health condition and they should have contacted KMPT.
- 5.2.42 In Sandra's case, during December 2013 and January 2014, Kent Police was dealing with a person correctly identified as suffering from a mental health condition. They did not make a referral to KMPT and this was a missed opportunity to share information that may have altered the way in which KMPT supported her.

5.2.43 In order to support joint agency working with KMPT, Kent Police must ensure that officers and staff understand the circumstances in which they should make referrals of people they believe are suffering from mental health conditions to KMPT and that the emphasis is on ensuring that the person gets the support they need from the appropriate agency.

(Recommendation 3)

5.2.44 At a KMPT meeting on 20 January 2014, it was agreed that a senior practitioner would contact the Kent Police Community Liaison Officer to arrange a joint visit to Sandra. This contact was made and a visit arranged for 29 January.

5.2.45 On 29 January, before the home visit, Sandra was arrested for affray and possessing an offensive weapon - a baseball bat. She was taken to a police station in a town close to where she lived and underwent a full mental health assessment. As a result, she was again admitted to Ward A under S.2 MHA.

5.2.46 Sandra was not charged or cautioned for the offences for which she was arrested; following her arrest it was realised that she was suffering from a mental health condition and she was treated accordingly. This was appropriate in the circumstances and an example of good practice by Kent Police.

5.2.47 Sandra's behaviour during the first few days of the stay at Ward A was variously described as restless, irritated, hostile, angry and aggressive. However, she was prescribed medication and subsequently seemed to settle in the ward. On 6 February, she had responded to treatment sufficiently for discussions to take place with her about her discharge back home.

5.2.48 It was on 8 February, while she was a patient in Ward A, that there is the first record of Sandra meeting David. Agency involvement with Sandra from that date is considered in 5.3 below.

5.2.49 During the period covered by this subsection, Sandra visited the various GP practices that she was registered with on a number of occasions, suffering from physical health conditions. Some of the GP practices also received information about her mental health, following her involvement with KMPT. She changed GP practices several times and there would have been delays in each having up to date information about her because her records would have needed to be transferred.

5.2.50 On 12 December 2013, a GP made an unannounced ad hoc visit to Sandra while he was in the area of her home address. He did this following receipt of information from mental health services. She was reluctant to engage with the GP but he felt that she was not expressing any mental health issues

that required escalation. This visit was an example of good practice.

5.2.51 Sandra did not report that she was the current victim of domestic abuse during the period covered by this DHR and she did not present in a way that would have given any professional reason to believe that she was.

5.3 Agency Involvement with David Bryant between 1 January 2010 and 7 February 2014

5.3.1 During this period, David was diagnosed with a number of physical conditions, some of which were actually or potentially serious. He received treatment for these but he was hard to engage and missed some appointments. There is no information to suggest that his physical conditions had any bearing on Sandra's death and they are not considered any further in this DHR.

5.3.2 In November 2010, David was assessed by a CMHT professional after he complained of feeling depressed for about a year. He disclosed that he was having strong thoughts of suicide. As a result of the assessment he was admitted to Ward A as a voluntary patient.

5.3.3 This stay in Ward A lasted until 17 January 2011 when David was discharged home. During this stay he had a number of nights of home leave. There were occasions when David was spoken to by Ward A staff about how his behaviour was impacting adversely on other patients. On one occasion he was seen kissing a female patient and apologised when challenged about this.

5.3.4 On 21 January 2011, a family member brought David back to Priority House because she had become concerned about him when she visited his home. He was assessed and readmitted. After spending a few days in Ward B, he was transferred to Ward A on 26 January.

5.3.5 On 2 February, David failed to return to Ward A having been on leave. He was discharged and it was noted that his case would be '*...followed up the Community Mental Health Team.*'

5.3.6 On 7 April, David was admitted to Ward C, another ward at Priority House, after he attempted to hang himself. He was transferred to Ward A on 20 April.

5.3.7 David then remained in Ward A until 13 June when he was discharged home. In the weeks following his release, contact was maintained with him by South West Kent CRHT by way of home visits and telephone calls.

- 5.3.8 He was assessed on 5 July at a local KMPT outpatient facility, and as a result of his mental health condition, he was readmitted to Ward A.
- 5.3.9 On 30 July, David left Ward A about 9.30am to visit a local shop but did not return. Enquiries with his family revealed that his behaviour was erratic. One of his brothers returned him to Ward A on the afternoon of 31 July and he settled back in.
- 5.3.10 He then remained in Ward A until his discharge on 14 November 2011. He was provided with temporary accommodation in North Kent, and his after-care was taken over by Dartford, Gravesham and Swale (DGS) CRHT.
- 5.3.11 DGS CRHT continued to work with David but it became more difficult to engage with him. They discharged him on 23 November for follow up by the South West Kent Access Team (the previous term for a CMHT). At the time of the transfer, David had moved into a flat in Town D, Kent. He was spoken to three times during the next month by staff from the Access Team but he failed to keep an appointment with them.
- 5.3.12 On 28 December, he was arrested for arson having set several fires in his flat in Town D by lighting crumpled up paper. Having done so, he alerted neighbours to the danger. When interviewed by Kent Police he said that he felt compelled to set fires and also referred to attempts to take his own life by hanging and overdose. He was remanded in custody and appeared before Maidstone Magistrates Court the following day.
- 5.3.13 On 23 April 2012, David was sentenced to 2 years imprisonment for arson. While on remand and while serving his sentence he was imprisoned in HMP Elmley, Kent. In terms of David's behaviour while in prison, there were no events that are relevant to this DHR.
- 5.3.14 At the time David was in HMP Elmley, Oxleas NHS Foundation Trust provided mental health services in the prison. David's medical notes from his time in HMP Elmley have been made available to the review. These are very comprehensive and cover his physical and mental health assessments, the treatment he received, and the medication he was prescribed.
- 5.3.15 It is usual for a person sentenced to 2 years imprisonment to be released on conditional licence after 1 year, subject to their behaviour while in prison. Time spent on remand before conviction is deducted from the sentence. After David's conviction, a probation officer (PO) was assigned to him. On the approach to his licence release date, she made numerous referrals to various accommodation providers, all of whom refused to accommodate David following his release. His conviction for arson and his mental health were significant factors in accommodation providers refusing to consider

him.

- 5.3.16 Prior to David's release from HMP Elmley, a senior Kent Probation Service manager authorised the funding of emergency bed-and- breakfast accommodation. It was agreed that he would attend Town D District Council on the day of his release with the letter from his PO outlining his circumstances and vulnerability. There was good work done by the Probation Service, who recognised how vulnerable David was and made efforts to support him.
- 5.3.17 An officer at Town D District Council, which was the social housing authority for the area in which David had lived before his conviction, stated that David had made himself intentionally homeless by committing arson. The officer told David's PO that the Council did not have a duty of care towards him, despite being told about his mental and physical health conditions. The officer challenged David's PO as to whether other housing referrals had been made and the PO was able to list these.
- 5.3.18 Efforts were also made by David's PO to get him registered with a GP, which was essential because his mental health condition required him to take prescription medication. One GP practice refused to register him following his release because he no longer lived in Town D. Three other GP practices were contacted: one was unable to provide an appointment, and a second refused to register David because offenders known to the Probation Service '*...always end up being violent and abusive to my staff.*' A third GP practice agreed to give David an appointment.
- 5.3.19 The comment made by one GP practice about patients known to the Probation Service was a generalisation, which is concerning and potentially discriminatory.
- 5.3.20 David's release address, supplied to Kent Police by HMP Elmley through the Prison Intelligence System, was given as the flat that he had set fire to. He was no longer a tenant at that address and it was no longer available to him.
- 5.3.21 In the week following his release, David initially stayed with friends and family, before moving into a hotel in Town D, where he funded his accommodation from his own savings. This was not sustainable in the long-term.
- 5.3.22 Porchlight, an organisation that specialises in offering help to homeless people, were very supportive in assisting David and his PO when trying to secure suitable accommodation for him in the period following his release. They were able to offer a one-bedroom flat in mid-April in Town E, Kent but David refused it, stating that its condition was '*awful*'.

- 5.3.23 After living in the hotel in Town D for over three months, David viewed and subsequently moved into a mobile home on a site in Town F, Kent. It is unclear whether he rented this or bought it, although it was probably the latter. He also registered with a GP in Town F.
- 5.3.24 It might have appeared that things were improving for David but on 23 April he was admitted to Littlebrook Hospital, Kent, having been detained under S.136 MHA. He had attempted to take his own life by hanging. He self-discharged against medical advice the following day but was then readmitted to Littlebrook Hospital on 25 April having again been detained under S.136 MHA. On this occasion, he had gone to the bridge at the Dartford Crossing and indicated an intention to jump.
- 5.3.25 By 29 April, David had been discharged from Littlebrook and returned to living in his mobile home. From then on his attendance at meetings with his PO became more erratic and he missed a number of appointments. His PO made consistent efforts to try to trace him, including contacting family.
- 5.3.26 On 1 May, David was admitted to the Intensive Care Unit at Maidstone Hospital, having taken an overdose of prescribed medication. He remained in the hospital until 9 May, when he was transferred to Ward C, at Priority House. While he was there, he had a lengthy conversation with a staff member who had previously nursed him in Ward A. David said that he had the support of his daughter and son. He also said that the overdose had been a serious attempt to end his life and added *'You really can't get any lower than me can you?'*
- 5.3.27 During his time in Ward C, David spent a few days at a rehabilitation unit before being discharged about 10 June, following which he went back to live in his mobile home. During the next three weeks he consistently failed to keep appointments with or to contact his PO. He next saw her on 3 July when he became agitated and emotional saying *'I shouldn't be alive' and that he would be 'better off in prison'*.
- 5.3.28 Following his failure to keep another appointment with his PO, David was sent a Final Warning letter on 11 July. He did not keep his next appointment and on 17 July a decision was made by a senior Kent Probation service manager that he would be recalled to prison.
- 5.3.29 On 23 July, David was arrested at his mobile home for breaching his licence and was returned to HMP Elmley. Although he was there on that day, he was in dispute with the owner of the mobile home park about unpaid rent and it was clear that he would not be able to return there after this period in prison.

- 5.3.30 Throughout his period of release on licence, David had self-funded his accommodation. He left the hotel in Town D because his savings were running out and he subsequently defaulted on the rent for a mobile home. On three occasions he considered taking his own life and came very close to doing so on the third occasion.
- 5.3.31 David's comment to his PO that he would be better off in prison was understandable given his situation. His failure to find suitable affordable accommodation, despite the efforts of his PO and of Porchlight, was a most significant issue during this period, although his attempts on his own life were after he had moved into the mobile home.
- 5.3.32 There are accommodation providers who are willing to give housing to ex-offenders recently released from prison. However, those who have committed arson, particularly to their own accommodation, are likely to be seen as an exceptional risk even to those providers. In addition, when the person seeking accommodation has a mental health condition which might further increase the likelihood of unpredictable behaviour, the provider is likely to need reassurance that the person is supported by mental health services and is taking their prescribed medication.
- 5.3.33 Much is made of the need for prison to rehabilitate inmates. David's case illustrates that, regardless of what good work is done by HMPS and the Probation Service while a person is in prison, lack of support by other agencies when the person is released makes rehabilitation much more difficult. It may also have a detrimental effect on their health.
- 5.3.34 During his second period in HMP Elmley, David was initially assessed as a standard risk prisoner but this was increased to high risk shortly after his return when information about his mental health and suicide attempts was known.
- 5.3.35 As with his first period in HMP Elmley, David's mental health notes were made available to this DHR by Oxleas NHS Foundation Trust, which provided mental health services to prisoners there. Again, these notes were very comprehensive.
- 5.3.36 During this period at HMP Elmley, he was assessed as being stable enough to support an elderly prisoner, which was an indication that he did not present a risk to others. He was prescribed medication in prison for his mental and physical health conditions and reported being bullied by other prisoners who wanted him to give the medication to them.
- 5.3.37 There were no notable events during his stay. On his release from prison on 31 December he went straight to the Accident & Emergency Department of

Medway Maritime Hospital, accompanied by a prison officer, because he had suicidal ideation. He was assessed by Medway & Swale CRHT and admitted to Littlebrook Hospital, Kent.

- 5.3.38 During the period that David was treated by the prison psychiatric service throughout his second stay in HMP Elmley, there is evidence of good liaison between Oxleas NHS Trust, who were treating him in prison and KMPT who provided secondary mental health services in Kent and Medway.
- 5.3.39 In addition, Oxleas NHS Trust were making efforts to find accommodation for David through Ashdown Medway Accommodation Trust (AMAT), a housing provider that is willing to accept people with mental health issues and those with a history of offending.
- 5.3.40 This liaison was taking place up to and including the day of David's release, and Medway CMHT were made aware that David was being taken to an A&E hospital following release.
- 5.3.41 The liaison between Oxleas NHS Trust and KMPT was driven by the former and is a strong example of good practice when prisoners are being released who have ongoing health – in David's case physical and mental health – needs.
- 5.3.42 Kent Police records show that they were again told that David's release address was the flat in which he had committed arson. David did not have a history of giving incorrect information to professionals about where he living so it appears that HMP Elmley had not asked him what his release address would be. His PO would have known that this was not his address and she was also not consulted.
- 5.3.43 In order to ensure that the Prison Intelligence database is accurate, HMP Elmey must make appropriate enquiries to ensure that the release address they record for prisoners is accurate. **(Recommendation 4)**
- 5.3.44 On 11 January 2014, David was transferred to Ward A at Priority House where he settled in well and mixed with other patients. It was there that he met Sandra.
- 5.4 Agency Involvement with Sandra Dodds and David Bryant Between 8 February 2014 and 5 December 2014
- 5.4.1 At the start of this period both Sandra and David were inpatients in Ward A at Priority House. This was mixed sex accommodation. Sandra had been in Ward A since 29 January and David since 11 January, although he had been a patient at Priority House on another ward since 1 January.

- 5.4.2 The first recorded contact between them was on 8 February when a health care assistant (HCA1) noted in Sandra's record that *'[She] had a Chinese takeaway offered by fellow patient DB'*.
- 5.4.3 The same day a staff nurse (SN1) noted in David's record that he *'...purchased a Chinese takeaway that he shared with other patients.'* It was also noted that David was *'pleased by the offer of accommodation that he had from other [unspecified] patients.'* The following morning, SN1 recorded in Sandra's record that she had shared a takeaway with an unnamed male patient.
- 5.4.4 On 9 February, a health care assistant (HCA2) recorded in David's record that he had approached staff and *'...stated that peer SD has been drink [sic] when off the ward.'* A staff nurse (SN2) recorded in Sandra's record that *'Another ward patient DB reported to staff that Sandra had been drinking.'*
- 5.4.5 These are the only entries in either Sandra's or David's records of contact between them in Priority House. The ward manager of Ward A at the time has said that there was no evidence of a relationship between them. She added that David was known to like the company of other clients and his case notes suggest he was sociable.
- 5.4.6 At time Sandra and David met, Ward A was mixed sex accommodation. The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. NHS Trusts are required to report breaches of this expectation to NHS England, who publish the data on a monthly basis. Between April and August 2015 KMPT reported that there had been no breaches.
- 5.4.7 David was discharged from Priority House on 10 February. A risk assessment carried out by a psychiatrist on that day identified that he did not pose a risk to others and that the risk he posed to himself was low.
- 5.4.8 It was clear that David was going to be homeless on his discharge. When he was told that his care coordinator was not going to accompany him to Maidstone Borough Council (MBC) offices to discuss his housing needs following his discharge, David became angry and said that he would refuse to leave hospital and would have to be removed by the police. However, he left the hospital of his own accord later that afternoon.
- 5.4.9 The following day, David went back to Priority House where he received a letter from a doctor to give to the Housing Department, confirming that he had been an inpatient.

- 5.4.10 David was initially given temporary accommodation by MBC at a hotel in the town. However, MBC found out almost immediately that he had failed to disclose his conviction for arson and they told Maidstone Community Mental Health Team (CMHT) that as a result of this they had ended his temporary accommodation.
- 5.4.11 On 11 February, David self-funded his room at the hotel but the following day staff there reported to South West Kent Crisis Resolution Home Treatment Team (CRHT) that he was behaving erratically and being aggressive and abusive towards them. Later that day, the hotel telephoned Priority House to say that they had discovered a pickaxe in David's room. Priority House informed CRHT of this and the hotel was advised to report any concerns to the police.
- 5.4.12 On 12 February, David visited his GP who recorded that he was of no fixed abode and was staying in a hotel in Kent.
- 5.4.13 Sandra was discharged on 12 February. The discharge summary sent to her GP practice recorded that she had been treated for alcohol withdrawal, hostility and delusional disorder. It also stated that she posed a risk to her neighbour and the neighbour's two-year-old son. It was recorded that the neighbour would be rehoused although it is not clear how or from where this information originated.
- 5.4.14 The day after her discharge, police officers visited Sandra at home to discuss issues arising out of the dispute with her neighbours. The officers knew that she had just been discharged from a mental health facility. They warned her that any further incidents would result in her being liable for arrest and prosecution, and recorded that she understood this.
- 5.4.15 From 14 February onwards, numerous attempts were made to contact David, primarily by a community psychiatric nurse from Maidstone CMHT (CPN1). This included contact with a family member, who provided a telephone number for him. However, all attempts to contact David were unsuccessful.
- 5.4.16 On 17 February, Sandra was visited at home by a social worker from South West Kent CMHT, who was her care coordinator. He found her to be friendly and communicative and she had settled in well. She was happy with her medication. The assessment outcome was that she presented no risk to herself or others, and that her mental state appeared normal.
- 5.4.17 This was the last recorded contact between Sandra and KMPT before her death. Following it, the care coordinator and his line manager agreed to discharge Sandra. However, her case was never closed and Sandra was not told of the decision to discharge her. These were significant omissions;

anyone looking at Sandra's notes would have believed that she was still a KMPT patient. In addition, she would have been under the impression that she still was, as would her GP.

- 5.4.18 Members of Sandra's family say that her mental health condition was much better following her discharge from Priority House while she was taking her prescribed medication.
- 5.4.19 On 17 March, Sandra's mental health care plan was reviewed by her GP, who recorded that her mood was stable, she was taking her medication regularly and was being supported by a local KMPT mental health facility in her home town. The latter comment was not correct, because KMPT had decided to discharge her. Had the discharge process been completed correctly, a letter would have been sent to her GP and he would have known that she was not receiving any support from secondary mental health services.
- 5.4.20 On 7 May, David was discharged by KMPT after efforts to contact him since February had failed. This decision was taken by senior practitioners at a risk forum held by Maidstone CMHT. Consideration of the discharge at that forum was good practice. It was not recorded whether David and/or his GP were informed of the decision.
- 5.4.21 On 23 May, David contacted Kent Police to report damage to and theft from his car while it was parked outside the bed and breakfast accommodation that he had stayed at between his discharge from Ward A and moving in with Sandra. He made a number of calls about this during the following three weeks.
- 5.4.22 On 3 June, David's GP notes record that he attended his GP practice with Sandra. He said that he had been living with her for the past four months and that they met in Priority House. This was the first record of Sandra and David living together. The GP recorded that Sandra appeared committed to caring for David and she agreed to '*...look after his medication*', which he had stopped taking.
- 5.4.23 Part IV of the Mental Health Act 1983 (MHA) states that treatment for mental disorders can be given without consent if a person is detained under any of the following sections: 2, 3, 36, 37, 38, 45A, 47 or 48. The definition of 'treatment' is broad and includes medication. This means that during detention under any of the relevant sections, a patient can be compelled to take medication. There is no record that David refused to take medication during his periods of detention under the MHA and therefore no record of him being compelled to take it.

- 5.4.24 A patient detained under Section 3 (and only under section 3) can be discharged on a Community Treatment Order (CTO). CTOs are covered by Sections 17A to 17G of the MHA and Chapter 29 of the MHA Code of Practice published by the Department of Health. The version of the Code of Practice current at the time of writing this report can be found at: <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>
- 5.4.25 The purpose of a CTO is to allow suitable patients to be treated safely in the community rather than in hospital. There is no requirement that a patient detained under Section 3 must be discharged on a CTO. On the contrary, a CTO imposes conditions on a person and treating them using the least restrictive options and maximising their independence must be considered when deciding whether a discharge on a CTO is appropriate.
- 5.4.26 A CTO allows the recall to hospital of a person who fails to comply with its conditions, which will be linked to a patient receiving medical treatment (which may include medication) in the community. The conditions will vary from patient to patient dependent on the needs of each.
- 5.4.27 David was detained under Section 3 on more than one occasion, including the last time he stayed in Ward A when he met Sandra. He was never discharged on a CTO and consideration of this option was not specifically in his notes. However, his behaviour while detailed do not appear to meet one of the criterion for discharge on a CTO: it is necessary for his health or safety or for the protection of other persons that he should receive such treatment.
- 5.4.28 When David visited his GP, accompanied by Sandra, one of them disclosed that he was not taking his medication. Although not explicit, the GP record suggests that this was discussed and Sandra agreed to help in this regard. There is no record that David was exhibiting symptoms that would have caused the GP to seek a mental health assessment that might have led to David's detention and in turn to him being compelled to take his medication. In the light of this, the GP's actions were pragmatic and proportionate.
- 5.4.29 The timing of his reports to Kent Police about the incident involving his car seems to contradict what he told the GP about how long he had been living with Sandra. It may have been that the crimes were historical when David reported them.
- 5.4.30 On 6 June, David's GP faxed and wrote a referral to Maidstone CMHT, which included the information that David had been living with Sandra for the past four months and that they had met at Priority House. This referral followed a discussion that the GP had with CPN3, who had tried unsuccessfully for some months to contact David.

- 5.4.31 On 23 June, David had a telephone assessment made by another CPN (CPN2). It was agreed that David would attend a routine mental health assessment at a local Community Mental Health Centre on 8 July. He said that he was living with a woman who he had met while at Priority House. He added that he had proposed to her and that she had accepted.
- 5.4.32 KMPT were now aware that David was living with Sandra. When David was discharged from Ward A, his risk assessment identified that he did not pose a risk to others. There was no information or evidence that he had ever deliberately attempted to harm anyone; when he set fire to his flat, he immediately told other residents to leave the building. There was no reason why the fact that he was living with Sandra would have raised concerns with KMPT.
- 5.4.33 David did not attend the assessment on 8 July and another CPN (CPN3) attempted to contact him by telephone. This was unsuccessful. CPN3 then contacted David's GP practice, who provided an alternative telephone number. When CPN3 rang this number it was not answered.
- 5.4.34 A letter was then sent to David offering him an appointment on 22 July. He failed to attend this and a KMPT social worker (SW1) tried contacting him by telephone. A woman answered and no message was left. A further letter was sent to David asking him to contact Maidstone CMHT within seven days. He did not make contact.
- 5.4.35 On 7 August, following a number of attempts to contact David by letter and telephone, Maidstone CMHT wrote to his GP stating that they had discharged him.
- 5.4.36 On 11 September, David registered with a GP practice in Town A. This was close to where he lived with Sandra and was the GP practice she attended. When he registered at the surgery, he disclosed his physical and mental health history.
- 5.4.37 On 20 September, he saw a GP to request repeat medication. He was accompanied by Sandra and he said that they had got engaged the previous week.
- 5.4.38 On 3 November, Sandra visited her GP suffering from low mood, anxiety and depression. She had stopped taking her medication in March because she had been feeling better but in view of her current feelings she asked to start it again, which was agreed. Her notes record that she was not sleeping well and had poor motivation. She was not keen on counselling 'but agreed to self-refer'. There was no record that she did this and she was not seen again by a GP before her death.

- 5.4.39 Given that it is recorded that Sandra had poor motivation, it is unclear why the GP left her to self-refer – it is not clear whether this self-referral was to be for counselling or other services. Whatever it was, if he felt there was a need, it would have been better for the GP to make the referral.
- 5.4.40 On 28 November, David presented at a local KMPT CMHT facility, asking to speak to someone. Although he did not have an appointment, he was seen by two members of the duty team and during the meeting with them David said that he was not having thoughts about harming himself, but he had thoughts about burning down a building that was being built in the place where his old mobile home had been.
- 5.4.41 The practitioners knew that David had a conviction for arson because, before assessing him, they checked the current and previous KMPT computerised records systems (RiO and EPEX respectively). As part of their assessment of him they explored the nature of the threat he was currently making and told him that if they thought that he was serious they would report it to the police. David then rapidly ‘backed down’ and said that he had no intention of carrying out the threat.
- 5.4.42 The practitioners felt that at that time there was little evidence that David was a risk to others, and that use of the MHA (to admit him to hospital) or a referral to the CRHT was not warranted on the basis of his presentation that day. He was advised to see his GP because he reported having hallucinations, which is a common symptom of the medication he was taking.
- 5.4.43 On 2 December, South West Kent CRHT received a call from Kent Police stating that Sandra had reported David missing. Kent Police were told about his assessment on 28 November, when he had talked about burning down a building at the mobile home site where he had lived. They were advised to contact the local KMPT CMHT facility where the assessment had been made.
- 5.4.44 Having gone to Sandra’s address when she reported him missing, a police officer called David’s mobile phone and he answered. He said that he was staying at a hotel in Essex. Kent Police requested that Essex Police attend the hotel and speak to David. When he was seen he was found to be safe and well. He said that he was visiting the town to ‘see different sights.’ The fact that Kent Police asked their colleagues in Essex to visit David, rather than take what they were told in the telephone call at face value, was good practice.
- 5.4.45 At 12.13pm on 5 December, a BT operator contacted Kent Police Force Control Room (FCR) following a 999 call made from a mobile telephone. BT initially receives all 999 calls and the operators route the calls to the

emergency service the caller requests. This call was made by a man who had asked for the police but who cleared the line before he could be connected to Kent Police. An FCR operator (FCR1) called the number back but there was no reply.

- 5.4.46 FCR1 also researched the number and within three minutes had found the subscriber to be Sandra, whose address was also known. Further research on the Kent Police Genesis computer system, which records details of crimes and intelligence, gave Sandra's age and highlighted warnings of '*suicide*' and '*mental health*'.
- 5.4.47 Kent Police established the address the call was made from and that they had knowledge of Sandra. At 12.23pm they called the number again but there was no reply. A text message was sent to the number giving advice about how to make contact by text message if the person could not speak. The action was then for further calls to be made and, if there was no reply, a '*welfare check*' was to be made.
- 5.4.48 The call from BT and all subsequent actions were recorded on a uniquely identifiable log created on the Computer Aided Dispatch (CAD) system.
- 5.4.49 All 999 emergency calls made to Kent Police are received in its FCR. The force receives between 700 and 800 emergency calls on an average day. Taking the lower figure, over 250,000 will be received any year. Of these, about 30,000 (almost 1 in 8) will be 'abandoned' calls – those where the caller ends the call before there is any speech or conversation. There are many causes of abandoned 999 calls including deliberate hoaxes, children playing with telephones and genuine emergencies where the caller is unable to speak. On average, 95% of abandoned 999 calls result in no further police action.
- 5.4.50 When a 999 call is made from a mobile telephone, the police have no sure way of knowing who the owner of the phone is or where the call is being made from. In this case, the reason the FCR operator knew that the mobile phone was Sandra's was because Genesis showed that it was linked to previous incidents involving her. This was intelligence; it did not confirm that the call was made from her address.
- 5.4.51 In the case of an abandoned 999 call from a mobile phone, the initial course of action taken by Kent Police will be to ring the number back. This was done within a minute of the first notification by BT and again nine minutes later. As well as establishing through research that the phone was linked to Sandra, the FCR operator sent a text message to it.
- 5.4.52 The only thing that might have raised the priority of the call were the

warnings on Genesis about Sandra relating to suicide and mental health. Such warnings are put onto the intelligence system to inform anyone looking at the record about the potential risks both to the person themselves and to others.

- 5.4.53 Overall, the way in which this abandoned call was handled was in line with Kent Police policy. Given that the call was from a mobile phone, it was reasonable not to dispatch a police officer to Sandra's address, as there was nothing to confirm that the call was made from there.
- 5.4.54 At 1.28pm a second 999 call was received by BT from the same number and this was put through to Kent Police. A man told the FCR operator (FCR2) that he needed her help and requested police at Sandra's address. He cleared the line without giving any information about the nature of the emergency.
- 5.4.55 At 1.32pm, FCR2 called the number back. A man answered and kept repeating what the FCR2 was saying to him. He then told her to 'Go and give yourself up, darling' and cleared the line. FCR2 then recorded on the CAD that she was not going to call the number again as she did not think there was an emergency.
- 5.4.56 The second 999 call and subsequent actions were recorded on a separate, uniquely identifiable CAD log. However, the log created in relation to the first call was linked at 1.30pm to that created for the second. This enabled anybody looking at either log after that time to see the existence of the other.
- 5.4.57 The second 999 call was put through to FCR2 who spoke to a man; it was not an abandoned 999 call. There was a clear request for help at a specific address.
- 5.4.58 The operator called the number back but the man who answered kept repeating what she was saying before making a strange comment and clearing the line. The fact that the call was made by a man on a mobile phone owned by a woman is no more unusual than a caller from a landline telephone being a different gender to the subscriber and would not, in itself, raise concerns.
- 5.4.59 As well as abandoned calls, the emergency services receive many misguided, unintentional or nuisance 999 calls. These may come from people who are drunk, under the influence of substances, suffering from mental health problems or who simply do not understand that the number should only be used for genuine emergency calls.
- 5.4.60 Based on the policy and practice of Kent Police in dealing with 999 callers who are not genuine, there is no cause to criticise the operator or the force

for the way in which this call was dealt with.

- 5.4.61 At 1.58pm BT received a third 999 call from the same number. The call was initially silent and when the BT operator challenged the caller to make a sound, she said that she may have heard a noise. As the call was being transferred to Kent Police, the BT operator heard a man shout 'No' and the line then cleared.
- 5.4.62 At 2.03pm, the CAD log created for the third call was linked to that created for the second call. An FCR dispatcher, who was viewing the second log, could see that there were now three calls from the address. At 2.06pm a police officer was assigned to attend Sandra's address.
- 5.4.63 The CAD log records that the police officer was currently committed and unable to attend. He remained assigned to the incident and at 3.14pm when he became free he went to Sandra's address, arriving at 3.19pm.
- 5.4.64 The third 999 call, which was abandoned, did not contain any more information that would have required an emergency response than the first two. Given the nature of the calls, the decision to deploy a police officer following his current commitment was appropriate.
- 5.4.65 When the officers arrived at Sandra's flat, they were met by David. When police officers went into the flat they found Sandra, who was dead. David was arrested on suspicion of her murder.
- 5.4.66 It was over two hours between the time of the first call and police arriving at Sandra's flat. During that period, three 999 calls had been received. The inevitable question is whether, if officers had attended sooner, Sandra's life may have been saved. That question cannot be answered by this DHR.
- 5.4.67 With the benefit of hindsight, it can now be said that it is likely that Sandra was in the flat at the time of the three 999 calls, and that she may have been alive for some of that time. This is corroborated because of a call that was made to the mobile phone of David's daughter, which went to voicemail. This was not heard until after Sandra was found dead. The police were unaware of that call and their response to the calls, based on what they did know, was appropriate. No recommendation is made to change the way such calls are handled.
- 5.4.68 Kent Police referred the case to the Independent Police Complaints Commission (IPCC) as the circumstances required them to do. The decision of the IPCC was that the matter could be investigated by Kent Polices Professional Standards Department. The result of that investigation was that no police officers or staff should be subject to misconduct proceedings.

- 5.4.69 During the period that Sandra and David were living together, she had contact with members of her family, including her husband from whom she was separated. Sandra's younger daughter had a child shortly after Sandra was discharged from Priority House in February 2014 and Sandra regularly visited her granddaughter. Family members believe that, following her discharge, her mental health was much improved and say that she was able to live independently.
- 5.4.70 Members of the family knew that Sandra was living with David but she did not discuss their relationship, nor did she attempt to impose David on them. They know that he bought her presents and that the couple holidayed on the Isle of Wight when they were living together. Her estranged husband visited Sandra's flat after she died, having not been there for some months. He said that it was clear that the couple had done a lot to improve the décor and had made improvements to the bathroom.
- 5.4.71 Sandra did not give her family reason to believe that she was a victim of domestic abuse while she was living with David. They are aware that Sandra and David had a disagreement in late 2014 when David discovered that she had bought her husband (from whom she was separated) a birthday present, but this would not be unusual in a relationship where one or both parties were in contact with previous partners.

6. Conclusions

- 6.1 Sandra and David met while they were inpatients in Ward A at Priority House. Within four months of their discharge they were living together at Sandra's flat. There is nothing to suggest that they were more than social acquaintances while they were at Priority House. There are no grounds for criticising KMPT's policies and procedures or the actions of any of its staff in relation to the two meetings and subsequently forming a relationship.
- 6.2 There is no evidence or information available to the Review Panel that Sandra was a victim of domestic abuse at the hands of David, prior to the event that led to her death. Similarly, there is no evidence or information to suggest that David had been a domestic abuse perpetrator prior to the actions which caused Sandra's death.
- 6.3 The Review Panel considered but discounted the likelihood that David formed a relationship with Sandra simply because he faced the prospect of being homeless after his discharge from Priority House. He bought her presents, went on holiday with her and helped her improve her flat, which indicated that his feelings for her went beyond regarding her as a means of keeping a roof over his head.
- 6.4 David, who had a conviction for arson, found it very difficult to get social accommodation once providers became aware of it; this was the case despite his vulnerability, which was due to his mental health condition. There is no evidence of multi-agency discussion about David's accommodation issues, beyond positive attempts by his probation officers to engage with housing providers.
- 6.5 There are also statements from accommodation providers that indicate David's mental health was a factor in not being willing to house him. This demonstrates how mental health conditions are still stigmatised in a way that physical health conditions are not.
- 6.6 A prison officer accompanying David to an Accident & Emergency Department, on his release from HMP Elmley, was an example of good practice. There was no duty placed on HMP Elmley to do this and, although David was free to do as he chose, it probably resulted in him getting immediate secondary mental health treatment after his release.
- 6.7 In addition Oxleas NHS Trust liaised regularly with KMPT prior to David's release, so the latter would have known of his mental health history and treatment while in prison. This was a strong example of good practice.

- 6.9 Historically, it is possible that David's mental health condition and his homelessness could have resulted in his remaining in an institution indefinitely, particularly following the arson. Had this been the case he may not have met Sandra.
- 6.10 Mental health treatment is now focused on providing services in the community; when a patient is admitted to hospital every effort is made to return them to the community as soon as possible, having regard to the patient's health and safety and that of others. The treatment that David received was appropriate to his condition but it relied on him taking his prescribed medication, which can be difficult to manage when patients live in the community.
- 6.11 The use of Community Treatment Orders (CTO) is a way of attempting to ensure that patients with mental health conditions continue with treatment (including taking medication where appropriate) when they have been discharged into the community. This should be considered prior to every discharge from detention under Section 3 of the Mental Health Act 1983. although in this case it is not clear that David's condition would have met the criteria for a CTO.
- 6.12 There are no significant acts or omissions by agencies with whom either Sandra or David had contact during the period covered by this DHR that if they had not been made would have prevented her death. No one could have predicted that David would kill Sandra.

7. Lessons Learned

- 7.1 This DHR does not identify any lessons that relate specifically to domestic abuse or the prevention of domestic homicides. This is primarily because Sandra was not a victim of domestic abuse during the period covered by the review, nor was David a perpetrator. The only incidence of domestic abuse was the act that led to Sandra's death.
- 7.2 The two lessons learned in relation to mental healthcare each cover post patient-discharge actions: the need to decide the responsibility for further care in a timely manner and establishing a protocol for requesting police to visit patients who have been discharged.
- 7.3 Four recommendations have been made arising out of the information that has been provided by agencies that had involvement with Sandra and/or David, but these are not directly related to the circumstances of Sandra's death.

8. Recommendations

8.1 The Review Panel makes the following recommendations from this DHR:

	Paragraph	Recommendation	Organisation
1.	5.2.30	KMPT should review existing policies relating to inpatient discharge in order to ensure that in every case, whether by self-discharge or not, the responsibility for further care is decided within 24 hours of the unexpected absence of a patient from a ward. This should apply whether a patient is unexpectedly absent without leave or has discharged him or herself.	KMPT
2.	5.2.33	In order to support inter-agency working, KMPT must include a section in their inpatient discharge policy that sets out the criteria for requesting Kent Police attendance when visiting patients after discharge. KMPT must consult Kent Police when drafting this section.	KMPT
3.	5.2.43	In order to support joint agency working with KMPT, Kent Police must ensure that officers and staff understand the circumstances in which they should make referrals of people they believe are suffering from mental health conditions to KMPT and that the emphasis is on ensuring that the person gets the support they need from the appropriate agency.	Kent Police
4.	5.3.43	In order to ensure that the Prison Intelligence database is accurate, HMP Elmley must make appropriate enquiries to ensure that the release address they record for prisoners is accurate.	HMP Elmley

DHR Terms of Reference

1 Background

- 1.1 On 5 December 2014, police officers went to a flat in Town A, Kent, which was the home address of the victim, Sandra Dodds. They were responding to a 999 call made by the alleged perpetrator, David Bryant. When the officers arrived, David was there but refused them entry. They forced their way in and found the body of Sandra.
- 1.2 David was arrested for Sandra's murder, with which he was subsequently charged and remanded in custody.
- 1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004 it was agreed by the Kent and Medway Domestic Homicide Review (DHR) Core Panel at a meeting held on 9 January 2015 that the criteria for a DHR had been met.
- 1.4 That agreement was ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed.

2 The Purpose of the DHR

- 2.1 The purpose of this review is to:
 - i. Establish what lessons are to be learned from the death of Sandra Dodds in terms of the way in which professionals and organisations work individually and together to safeguard victims.
 - ii. Identify what those lessons are, both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result.
 - iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra- and inter-agency working.
 - iv. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra- and inter-agency working.

3. The Focus of DHR

- 3.1 This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Sandra Dodds.
- 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.
- 3.3 If domestic abuse was identified, this review 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. In particular, 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 take into account 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.
- 3.4 The initial research does not suggest that Sandra was a victim of domestic abuse at the hands of David prior to the incident resulting in her death. However, it is clear that both suffered from significant mental health conditions and that the events and involvement with agencies that each experienced in the years leading up to the homicide are likely to have had a bearing on it. For that reason, this DHR will have a particular focus on how both of them were treated and supported.
- 3.5 The review will examine in detail:
 - The quality and scope of the health care treatment, care planning and risk assessments for both Sandra and David.
 - The appropriateness of Sandra's and David's treatment, care and supervision in respect of the following aspects:
 - His assessed health needs.
 - His assessed risk of potential to harm himself and or others.
 - Any previous mental health history including drug and alcohol use.
 - Any previous forensic history including convictions.
 - The appropriateness on the intervention following self-referral to the West Kent Community Mental Health Team on the 28 November 2014.
 - The circumstances of Sandra and David meeting while in-patients on an acute ward, exploring any safeguarding issues that may have arisen.

- The learning from this incident and any recommendations to prevent such future incidents

4 DHR Methodology

- 4.1 Independent Management Reviews (IMRs) must be submitted using the templates current at the time of completion.
- 4.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Sandra and/or David in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Sandra or David, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.
- 4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.
- 4.4 Each agency required to complete an IMR must include all information held about Sandra and/or David from 1 January 2010 to 5 December 2014. If any information relating to Sandra being a victim, or David being a perpetrator, of domestic abuse before 1 January 2010 comes to light, that should also be included in the IMR.
- 4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Sandra and/or David. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. in 2010, X was cautioned for an offence of shoplifting).
- 4.6 Any issues relevant to equality, such as disability, cultural and faith matters, should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.
- 4.7 When each agency that has been required to submit an IMR has done so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further

meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

5 Specific Issues to be Addressed

5.1 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 Sandra and David, knowledgeable about potential indicators of domestic 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 the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Sandra and/or David (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Sandra Dodds subject to a MARAC?
- iii. Did the agency comply with 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. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Sandra and David (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?
- vii. Were senior managers or other agencies and professionals involved at the appropriate points?
- viii. Are there ways of working effectively that could be passed on to other organisations or individuals?
- ix. Are there lessons to be learned from this case relating to the way in

which an agency or agencies worked to safeguard Sandra and promote her welfare, or the way it identified, assessed and managed the risks posed by David Bryant? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

- x. How accessible were the services to Sandra and David (as applicable)?

- xi. To what degree could the death of Sandra have been accurately predicted and prevented?

NHS England Independent Investigation of the Care and Treatment of David Bryant and Sandra Dodds by Kent and Medway NHS & Social Care Partnership Trust

1. Purpose of the investigation

- 1.1 This is a joint Domestic Homicide Review and Mental Health Homicide Investigation which involves the death of a woman in December 2014. The perpetrator and victim were both former patients of the Trust and this review will analyse their care and treatment.
- 1.2 Any health recommendations or outcomes of this investigation will be managed through corporate governance structures of NHS England, the lead clinical commissioning group and the provider's formal Board sub-committees.
- 1.3 The purpose of the review is to identify whether there were any gaps or deficiencies in the care and treatment that David Bryant and Sandra Dodds received, which if addressed, could have resulted in the incident being predicted or prevented. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring.

2. Terms of Reference

- 2.1 Review the engagement, assessment, treatment and care that David Bryant and Sandra Dodds received from Kent and Medway NHS Social Care and Partnership Trust: to include David Bryant's first contact with services from November 2010 until his discharge and Sandra Dodds' contact from November 2013 until her discharge.
- 2.2 Review the contact, information sharing and communication between the GP, Probation Services and prison in-reach and Trust services in June 2014 and thereafter.
- 2.3 Review the family's specific questions and ensure these have been fully addressed.
- 2.4 Assess if David Bryant's and Sandra Dodds' risks (to self and others) were fully understood and addressed particularly the safeguarding concerns (vulnerable women and alleged child abduction).

- 2.5 Review if both David Bryant's and Sandra Dodds' care and treatment, including medication, was in line with best practice and national standards.
- 2.6 Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations, and implementation of the action plan and identify:
- If the investigation satisfied its own terms of reference. If all key issues and lessons have been identified and shared:
 - Identify whether recommendations are appropriate, comprehensive and flow from the lessons learned.
 - Review progress made against the action plan.
 - Review processes in place to embed any lessons learned.
- 2.7 Consider, having assessed the above, if this incident was predictable or preventable and comment on relevant issues that may warrant further investigation.
- 2.8 Assess and review any contact and disclosures made to the family measured against the contractual and legal duty of candour.
- 2.9 Review and test the Trust governance and clinical commissioning group's governance, assurance and oversight of incidents against the new NHS England serious untoward incident framework.
3. Level of investigation
- 3.1 Type C: an investigation by a single investigator examining a single case (with peer reviewer).
4. Timescale
- 4.1 Individual Management Reviews from health are expected to be delivered within six weeks and the final report should be completed in line with the timescales of the Domestic Homicide Review.
5. Outputs
- 5.1 To offer independent input, and review the Trust and primary care's Individual Management Reviews (IMR).
- 5.2 To contribute and offer expert advice and support to the Domestic Homicide Review panel.
- 5.3 To help produce a final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

- 5.4 To jointly make contact and engage with the family, initially sharing the terms of reference, ensuring their specific questions are included and examined, and to provide ongoing input to the family.
- 5.5 To share the report, at the end of the investigation, with the Trust and meet the families to explain the findings of the investigation and to engage the clinical commissioning group and Domestic Homicide Review Panel with these meetings where appropriate.
- 5.6 To present the investigation to NHS England, lead clinical commissioning group, provider Board, and to staff involved in the incident as required.
- 5.7 NHS England will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public.

KEY:

Type A: a wide-ranging investigation by a panel examining a single case.

Type B: an investigation by a team examining a single case.

Type C: an investigation by a single investigator examining a single case (with peer reviewer).

GLOSSARY

Abbreviation/Acronym	Expansion
AMAT	Ashdown Medway Accommodation Trust
CAD	Computer Aided Dispatch (see below)
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution Home Treatment Team
DGS	Dartford, Gravesham and Swale
DHR	Domestic Homicide Review
FCR	Force Control Room (see below)
GP	General Practitioner
HMP	Her Majesty's Prison
HMPS	Her Majesty's Prison Service
IMR	Independent Management Report
IPCC	Independent Police Complaints Commission
KMPT	Kent & Medway NHS & Social Care Partnership Trust
KCC	Kent County Council
MBC	Maidstone Borough Council
MHA	Mental Health Act 1983
MHHI	Mental Health Homicide Investigation
NHS	National Health Service
PO	Probation Officer
WKCCG	West Kent Clinical Commissioning Group
WKHA	West Kent Housing Association

The following is an explanation of terms that are used in the main body of the Overview Report. The terms are listed in the order that they first appear in the report.

Kent County Council Supporting People Team

Supporting People is the government's long-term policy to enable local authorities to plan, commission and provide housing-related support services such as homeless hostels, women's refuges and sheltered housing, with a view to helping vulnerable people live independently. The programme began in 2003 and brought together funding streams from a wide variety of sources including health, probation, housing benefit and social services into one central pot. KCC is responsible, on behalf of a partnership of agencies in Kent, for administering the Supporting People funding provided by Government.

The Supporting People Team commissions organisations to provide services including floating services that meet people's short term needs before 'floating away'.

Section 136, Mental Health Act 1983

Section 136, Mental Health Act 1983 gives a police officer the power to remove a person, who appears to be suffering from mental disorder and to be in immediate need of care and control, from a public place to a place of safety where the person may be detained for up to 72 hours.

The purpose is to enable the person to be examined by a doctor and an approved mental health professional in order to make any necessary arrangements for treatment or care. The section does not provide any authority to give treatment.

The full wording of the power given to police officers under this section can be viewed by clicking [here](#).

Section 2, Mental Health Act 1983

Section 2, Mental Health Act 1983 allows a person, who is suffering from mental disorder of a nature or degree which warrants detention, to be detained in hospital for assessment or assessment followed by treatment for up to 28 days. Detention must be necessary in the interests of the person's own health or safety, or for the protection of others.

The section requires an application to be made to the hospital managers by an approved mental health professional, and this must be supported by medical recommendations by two doctors. At least one of the doctors must be approved under the MHA (usually a psychiatrist) and, where possible, the other should have previous knowledge of the patient.

Crisis Resolution and Home Treatment Team (CRHT)

The Crisis Resolution Home Treatment Team (CRHT) is a service set up to respond to and support adults who are experiencing a severe mental health problem which could otherwise lead to an inpatient admission to a psychiatric hospital.

As the names implies, the aim of the team is to resolve the immediate crisis and put in place treatment at a person's home. There are a number of CRHTs in Kent & Medway, each of which covers a geographical area.

More information about CRHTs can be found by clicking [here](#) or at:

<http://www.liveitwell.org.uk/support-help/community-mental-health-teams-cmhts/help-in-a-crisis/>

Community Mental Health Team (CMHT)

CMHTs deliver mental health services to people with long term mental in the community health conditions, rather than at inpatient facilities. As with CRHTs, CMHTs in Kent and Medway cover geographical areas.

More information about CMHTs can be found by clicking [here](#) or at:

<http://www.liveitwell.org.uk/support-help/community-mental-health-teams-cmhts/#Referral>

Force Control Room (FCR)

The FCR is a call centre where Kent Police receives emergency (999) and non-emergency telephone calls from the public and other organisations. It is also a dispatch centre from which police officers and staff are deployed, usually by radio, in response to those calls. All telephone calls made to or from the FCR, including those made on Kent Police's internal telephone system, are recorded. Radio messages both to and from the FCR are also recorded.

The members of staff who receive telephone calls are referred to as call handlers. Those who deploy police officers and staff, and who otherwise manage the calls received, are referred to as dispatchers.

Genesis

This is the proprietary name for the computer system that Kent Police uses to create and store crime reports, secondary incident reports, and criminal intelligence. There is a comprehensive search facility on Genesis; entering a person's name will retrieve all the information held about them. In the case of domestic abuse, it will show the whole history of police involvement including attendance, safety plans, and arrests. Genesis has the facility to store documents such as non-molestation and restraining orders, which will also be retrieved when a person's name is entered. Using a name is only one way to search Genesis; many other search parameters can be entered.

Computer Aided Dispatch System (CAD)

When a telephone call from a member of the public requesting police assistance is received in the FCR, an incident log will be created on computer software by the call handler. That log is used to record all information received and actions taken in response to the call. The log is also used to assist FCR staff in dispatching the appropriate type and volume of resource to an incident. The computer software automatically records the time and date an entry is made and the identity of the person making it.

The computer system on which is used to record calls and dispatch resources is known as a Computer Aided Dispatch (CAD) system. There are a number of proprietary CAD systems; the one used by Kent Police is STORM.