

KENT & MEDWAY DOMESTIC HOMICIDE REVIEW

Roger/2015

Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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Domestic Homicide Review

Roger Hills

Purpose

The key reasons for conducting a Domestic Homicide Review (DHR) are to:

- a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- b) identify clearly what those lessons are both within and between organisations, how and within what timescales 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, 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 the victim of this domestic homicide, Roger Hills (aged 54 years), prior to his death on 19 May 2015. It also examines the contact and involvement that organisations had with the perpetrator, Roger's younger son, Stephen Hills.

The Terms of Reference also include Roger's elder son, Graham Hills (aged 33 years), who was injured in the same incident in which Roger died.

Timescale

This Review began on 7 July 2015, following the decision by Kent Community Safety Partnership (CSP) that the case met the criteria for conducting a DHR.

Stephen Hills was arrested on the day of Roger's death and was charged with his father's murder. The Crown Prosecution Service (CPS) requested that there was no contact made with members of Roger's family before the conclusion of Stephen's criminal trial.

The trial concluded on 23 February 2016, following which the Chairman of the DHR Panel wrote to relatives of Roger and Stephen. The DHR was completed on 27 June 2016 (see section 2.2 below for DHR panel meeting dates) and then approved by the Kent Community Safety Partnership. It was submitted to the Home Office Quality Assurance Panel on 7 July and considered by the panel on 22 November 2016.

Publication

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

Anonymisation

This report has been anonymised and all the personal names contained within it, except for members of the DHR Panel, are pseudonyms.

Kent Domestic Homicide Review Panel

Domestic Homicide Review - Roger Hills

Overview Report

1. Introduction

- 1.1 This Overview Report contains the findings of the DHR Panel. It is an anthology of information and facts gathered from Independent Management Reports (IMRs) prepared by representatives of the organisations that had contact and involvement with Roger, Stephen or Graham Hills between 1 January 2008 and Roger's death.
- 1.2 The start date of the period covered by the DHR was agreed by the Review Panel for two reasons. First, it allows the inclusion of the significant events leading up to the Roger's death. Second, it is a key purpose of a DHR to consider whether there are lessons to be learned and to make recommendations to improve the support given to domestic abuse victims in future. The policies, procedures and practices that organisations have in place for safeguarding and supporting victims of domestic abuse have changed significantly over the last few years. Conclusions reached and recommendations made about organisations' actions before 2008 are therefore unlikely to be relevant to current practice and procedure.
- 1.3 The detailed information on which this Overview Report is based was provided in the form of Independent Management Reports (IMR) completed by each organisation that had relevant involvement with Roger, Stephen or Graham. An IMR is a written document submitted using a template.
- 1.4 Each IMR was written by a member of staff from the organisation to which it relates. Each IMR was signed off by a senior manager of that organisation before being submitted to the DHR Panel. Neither the IMR author nor the senior manager had any involvement with any person subject to the review. Each of the following organisations completed an IMR for this DHR:
 - Kent Police
 - National Probation Service (NPS)
 - West Kent Clinical Commissioning Group (WKCCG)
 - Kent & Medway NHS and Social Care Partnership Trust (KMPT)

1.5 In addition to IMRs, the Review Panel may request information from other agencies that had contact or involvement with the subject(s) of the DHR if it appears that this would be helpful in providing contextual information.

1.6 In this case written information was provided by:

- Circle Housing Russet (CHR)
- Tonbridge & Malling Borough Council - Housing Department

2. The Review Process

2.1 The Review Panel

2.1.1 The Review Panel was made up of an Independent Chairman and senior representatives of the organisations that had relevant contact with Roger, Stephen or Graham Hills. It also included the Kent & Medway Domestic Abuse Co-ordinator and a senior member of Kent County Council Community Safety Team. In addition, a representative from Oasis Domestic Abuse Service, a Kent-based domestic abuse support organisation, sat on the Review Panel.

2.1.2 The members of the panel were:

Deborah Cartwright	Oasis Domestic Abuse Service
Tracey Creaton	West Kent Clinical Commissioning Group
Alison Gilmour	Kent & Medway Domestic Abuse Co-ordinator
Pam Flight	Kent Police
Tina Hughes	National Probation Service
Carol McKeough	Kent County Council Adult Social Services
Paul Pearce	Independent Chairman
Shafick Peerbux	Kent Community Safety
Cecelia Wigley	Kent and Medway NHS & Social Care Partnership Trust

2.1.3 The Independent Chairman of the panel is a retired senior police officer who has no association with any of the organisations represented on it. He did not serve with Kent Police. He has experience and knowledge of domestic abuse issues and legislation, and an 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 August 2015, to consider draft Terms of Reference, the scope of the DHR and those agencies that would be required to submit an IMR. The Terms of Reference were agreed subsequently by correspondence and form [Appendix A](#) to this report.

2.2.2 The Review Panel met again on 13 November 2015, to consider the IMRs and whether any further information was required.

2.2.3 The next meeting of the Review Panel was held on 23 February 2016, to consider the first draft of this Overview Report. Amendments were made to the Report and a final meeting was held on 11 April 2016 to consider the second draft. Following this meeting, final consultation with panel members was made by correspondence to finalise the report.

2.3 Family Involvement

2.3.1 The Review Panel considered which family members should be consulted and involved in the DHR process. The following have been contacted:

Name	Relationship to:	
	Roger Hills	Stephen Hills
Diane Hills	Wife	Mother
Graham Hills	Son	Brother
Lorna Hills	Daughter	Sister
Theresa Stewart nee Hills	Daughter	Sister
Patricia Townsend	Sister	Aunt

2.3.2 The Review Panel was not made aware of all the family members at the start of the DHR. The Independent Chairman wrote to Diane Hills and Patricia Townsend on 14 September 2015, explaining the purpose of the review and that he would make further contact following the trial of Stephen Hills. A copy of the Home Office DHR leaflet for family members was included with those letters.

2.3.3 The Independent Chairman wrote to family members on 18 March 2016, following the conviction of Stephen Hills and the completion of the draft Overview Report. He offered to meet them to discuss the DHR process and listen to any views and concerns they had. To date, no request to meet the Independent Chairman has been received.

2.4 Other Reviews/Investigations

2.4.1 Apart from the criminal investigation into Roger's death, there are no other reviews or investigations taking place into this homicide.

2.4.2 NHS England were contacted by Kent & Medway NHS Social Care & Partnership Trust (KMPT) to establish whether the circumstances met the requirement for a Mental Health Homicide Investigation. NHS England confirmed that it did not because of the time that had elapsed between Stephen's last contact with secondary mental services and Roger's death.

3. The Death of Roger Hills

- 3.1 About 7.30pm on Tuesday, 19 May 2015, Kent Police and South East Coast Ambulance Service went to a house in a residential area of Town A, the home of the Hills family, following a report of man *'swinging a knife around'*. They found the body of Roger Hills in the back garden; his death resulted being stabbed multiple times.
- 3.2 Roger's elder son, Graham, had been taken to hospital having also been stabbed several times. The injuries that Graham suffered were not life threatening and he subsequently recovered.
- 3.3 Roger's younger son, Stephen, was found in the street nearby and he was arrested on suspicion of his father's murder.
- 3.4 On 23 February 2016, following a Crown Court trial, Stephen Hill was found not guilty of the murder but guilty of the manslaughter of Roger. In respect of the stabbing of Graham, Stephen was found guilty of grievous bodily harm with intent.
- 3.5 On Wednesday 2 March 2016, Stephen was sentenced to 18 years imprisonment for the manslaughter of Roger and nine years imprisonment for stabbing Graham, the sentences to run concurrently.
- 3.6 In his summing up before sentence, His Honour Judge Statman referred to Stephen's relationship with his father saying *'In your mind, you felt humiliated by him. Your father was physically an extremely large man...it is to be noted he sadly had mental health difficulties of his own, as did your mother. He [Roger] had sought in the past to take his own life. There is a recorded act of violence in 2008 perpetrated against when you ended up in hospital. Your father introduced you as a child to alcohol. He expected that the rules of his house were to be obeyed. In school parlance, he ran a tight ship at home.'*
- 3.7 Referring to the incident in which Stephen killed his father, Judge Statman said *'You stabbed him through the arm and then inflicted a further, but substantially less serious wound to his chest. Whatever Roger Hills' failings were, by your actions your mother has been left without her beloved husband and your brother and sisters have been deprived of their father.'*
- 3.8 Judge Statman added *'I am satisfied this is a slow burn of loss of control, following accumulative abuse over the years, which steadily built up against the background of mental health frailties I have heard about. I deal with it as manslaughter with a loss of control. The tragedy of this case is that by your*

acts you have lost contact with those who are nearest and dearest to you. I am mindful of the fact that you have an IQ of 74. I am mindful of what you said to him [Roger] after the attack "I should have done that years ago." '

4. Family History

- 4.1 Roger Hills had been married to Diane for many years and they had lived in the same house throughout the period covered by this DHR (1/1/08 to 19/05/15). References in this report to 'the family home' relate to this house, which the family had lived in for many years.
- 4.2 Roger and Diane had four children together during their marriage. In addition to their sons, Stephen and Graham, they had two daughters: Lorna (31 years) and Theresa (28 years). They had two granddaughters, one by each of their daughters.
- 4.3 From the start of the relevant period until 2009, Stephen was living at the family home. In a housing application made in November 2014, he describes where he had lived in the previous five years: from 2009 to 2012 'sofa surfing' with family and friends; from April 2012 to May 2013 in rented flat (social housing sector) in Town D, Kent and from May 2013 to October 2014 sofa surfing with family and friends.
- 4.4 In a letter from Roger, in support of the housing application submitted by Stephen, he states that Stephen had then been living at the family home since 31 October 2014. He lived there for over seven months, until Roger's death.
- 4.5 Stephen's brother, Graham, was also living in the family home at the time of Roger's death; his two sisters were living elsewhere.
- 4.6 At the time of Roger's death, Stephen was unemployed and claiming Jobseeker's Allowance.

5 The Facts and Analysis of Organisations' Involvement

5.1 Introduction

- 5.1.1 This section sets out in detail the facts and analysis of the contact and involvement that Roger and Stephen Hills had with organisations during the relevant period. The facts are based on IMRs and information submitted by organisations.
- 5.1.2 Each IMR included a detailed chronology of contact and involvement with Roger and Stephen.
- 5.1.3 The analysis is based on the facts, and from it come conclusions and lessons learned.
- 5.1.4 The facts and analysis make references to terms that will be familiar to professionals in the relevant organisations, but which may need further explanation for other readers. Where such references are made, the reader is referred to the glossary in [Appendix B](#), where more detail is provided.

5.2 Kent Police

- 5.2.1 The Hills family were known to Kent Police for many years prior to Roger's death. Most of their involvement was related to family disputes at their home in Town A. These involved Roger and either his wife or their two sons. The first record of Kent Police dealing with Roger was in 1979 when he was investigated and subsequently convicted of assault occasioning actual bodily harm.
- 5.2.2 Prior to the start of the relevant period (1 January 2008), when police officers attended incidents involving Roger he had usually been drinking heavily. On two occasions in 2006, he had self-harmed by using a knife to cause minor injuries.
- 5.2.3 Stephen first came to the notice of Kent Police when he was the victim of a minor assault in 1998. Although he was present on a number of occasions when police officers attended the family home prior to the start of the relevant period, no significant events relating to him were recorded by Kent Police.
- 5.2.4 On 20 July 2008, Roger called Kent Police and stated that Stephen had been drinking heavily and had assaulted him. As a consequence, Stephen had been '*thrown out of the house*'. Police officers went to the family home and spoke to Roger and Stephen. Roger withdrew his complaint of assault

and Stephen was allowed back into the house. There is no record that this incident was treated as domestic abuse, although the fact that there was an allegation of assault (violence) by Stephen meant that it should have been.

- 5.2.5 On 8 August 2008, Stephen was arrested for being drunk and disorderly. He was subsequently given a Penalty Notice.
- 5.2.6 On 6 February 2009, Stephen was seen by police officers after he reported that his brother, Graham, had assaulted him during an argument. His speech was slurred and he said that he and his brother had been drinking. Kent Police records show that he had 'sore elbows'. When he was spoken to the following day by a police officer, he said he could not remember anything as he had been drunk. He did not wish to report an assault and the matter was not investigated further.
- 5.2.7 When he was talking to the officers about this incident, Stephen said that he wished to be taken to 'Ward A' (an inpatient ward at Hospital A, a KMPT mental health hospital in Town B) to '*brainwash his memories*'. As a result, the police officers called an ambulance and Stephen was taken to the A&E department of Hospital B in Town C. Stephen was drunk and the officers might have ignored his comments for that reason. It was positive that the police officers took him seriously and prioritised his medical needs.
- 5.2.8 This incident involved domestic abuse but was not recorded as such. This was an omission but, given the circumstances, the police response was otherwise pragmatic and reasonable. They followed up the assault allegation next day, when a police officer saw Stephen (although not Graham, who could also have suffered injuries) and decided that there could be no certainty about the facts of the incident.
- 5.2.9 The next Kent Police involvement with Stephen was on 3 January 2010, when he flagged down a patrol car outside Town A police station. He said he wanted a lift to the '*tranquilliser centre*' because '*of all the things going on in his head*'. He added that he had had a verbal altercation at home, that his family were wearing him down and his head was being affected. The police officers he spoke to described him as being under the influence of alcohol. He was detained under [Section 136, Mental Health Act 1983](#) (S.136) and the officers took him to the A&E department of Hospital B.
- 5.2.10 Taking Stephen to hospital was a positive action by the police officers. A police station is classed as a 'place of safety' for a person detained under S.136. However, in this case the officers recognised that a hospital is a more appropriate place for a person who might be suffering from mental health issues.

- 5.2.11 There was no evidence that Stephen was a victim of domestic abuse in this incident. A verbal altercation within a family may simply be conflict that does not constitute domestic abuse. It was reasonable that the officers did not pursue the matter by visiting the family because that might have made the situation worse.
- 5.2.12 KMPT records show that Stephen was taken to the A&E department at the Hospital B on 3 March 2010. Kent Police have no record of this. If the officer(s) involved found or were approached by Stephen and did not tell the police control room what they were doing, there would be no record, other than perhaps a pocket notebook entry. It is unusual for officers not to notify the control room that they are engaged in a task, but it was not one for which they required any assistance.
- 5.2.13 On 29 August 2010, police officers attended the Hills family home following the report of argument between Stephen and Roger. This also involved Roger's son-in-law (Stephen's brother-in-law). Because of the argument, Roger suffered a medical collapse (there was no allegation of assault), which resulted in an ambulance being called.
- 5.2.14 Stephen and his brother-in-law had left the family home by the time the police arrived. There was no record of Stephen returning while the police officers were present. There was no violence reported but the officer completed a [Domestic Abuse Stalking and Harassment \(DASH\)](#) risk assessment with Roger and completed a [Secondary Incident Report \(SIR\)](#). The actions the police officers took were appropriate, given that no criminal offences were disclosed.
- 5.2.15 On 8 May 2011, police officers attended a report of a man damaging a car at the Hills family home. They found Stephen at the scene carrying a baseball bat. He subsequently admitted using this to damage Roger's car because Roger had told him that he could not go to the family home for dinner. Stephen had also cut his arms by running them over the broken glass in the car's windows. He was taken to hospital for treatment.
- 5.2.16 Stephen was subsequently cautioned for damaging his father's car. A DASH risk assessment was not completed at the time police first attended because the family did not wish to answer any questions.
- 5.2.17 Three days later, on 11 May 2011, Roger and his wife reported to Kent Police that Stephen had come to the family home while drunk. He had banged on the door, stating that he wished to apologise for damaging his father's car. His parents asked him to leave, which he did, but his mother

suffered an angina attack, apparently because of stress caused by the incident.

- 5.2.18 The officer who attended this incident completed a DASH risk assessment, which was classified as Standard. The officer then visited Stephen, who was living at another house in Town A, to warn him about his behaviour, but he was not at home. This was because, after leaving his parents' house, he went to Town A police station where he told other police officers that he needed to be sectioned because he was going to kill himself. He was described as being very drunk. The officers took Stephen to the A&E department of the Hospital B so that that he could be seen by the mental health team.
- 5.2.19 Later that day, hospital staff reported Stephen missing because he had left before being seen. Police officers went to his home and spoke to him; he stated that he had got fed up with waiting at the hospital and had left.
- 5.2.20 This series of incidents, which began with Stephen damaging his father's car, were dealt with appropriately by Kent Police. They decided to treat them as domestic abuse and having been unable to complete a DASH risk assessment on the first occasion, persisted and completed one on the second. Although Stephen was drunk, the officers took his threat of suicide seriously and took him to hospital for assessment.
- 5.2.21 When the officers submitted the DASH risk assessment, a Detective Inspector considered a specialist Domestic Abuse Officer attending the family home. It was decided that this was not necessary, which was appropriate given the nature of the incidents and the demands on this specialist resource.
- 5.2.22 A few days later, on 16 May 2011, Roger reported to Kent Police that Stephen was outside the family home. There were no altercations and no offences, but Roger was concerned because of the recent incidents.
- 5.2.23 A short time later, Stephen called Kent Police using the public telephone outside Town A police station and said that he was having suicidal thoughts. The result was that he was taken to Hospital A. Kent Police dealt with this incident appropriately.
- 5.2.24 On 18 August 2012, Stephen reported to Kent Police that he had been assaulted at a friend's flat in Town D, the town to which he had moved to from his parents' home. He had been drinking heavily when police attended but there is no record of any concerns about his mental health.

He had no visible injuries and declined to support a prosecution; because of these factors the police took no further action.

- 5.2.25 On 31 December 2012, Kent Police attended a report of Stephen lying in a road in Town D being kicked by three men. The assailants had left when police arrived. They found Stephen to be extremely intoxicated and incoherent. He was taken to hospital. The assailants remain unidentified and the motive for the attack unknown. Again, there were no recorded concerns about Stephen's mental health. This incident has no direct relevance to the DHR but shows that Stephen was drinking heavily during this period.
- 5.2.26 On 12 April 2013, Stephen called Kent Police to his flat in Town D because graffiti had been scratched on his front door. Who did this and the motive for it remain unknown.
- 5.2.27 Later the same day, one of Stephen's neighbours called Kent Police and said that Stephen was playing music very loudly. A police officer went to Stephen's flat and asked him to turn the music down because a complaint had been received. He did so, but turned up again later and went out onto his balcony, where he began screaming.
- 5.2.28 The neighbour who had called the police earlier told Stephen to '*shut up*', following which Stephen went to neighbour's flat and an argument ensued. The neighbour described Stephen as drunk and appearing to have mental health problems. He also noticed that Stephen had a knife in his pocket, which Stephen said was '*for whoever had damaged his door*'. He then accused the neighbour of doing this, pointed the knife at him and said '*If I see you again I am going to gut [or cut] you.*'
- 5.2.29 A short time later, early on 13 April, Stephen went to another neighbour's flat and damaged his door by scratching it with a knife. When he was confronted by the neighbour he admitted doing the damage, saying he thought this neighbour was responsible for the graffiti on his door earlier. The neighbour then punched Stephen.
- 5.2.30 Kent Police were called and Stephen was arrested for criminal damage to his neighbour's door and for threatening the first neighbour. He admitted both offences and said that he had been very drunk.
- 5.2.31 Stephen was charged with criminal damage. He was convicted at Town E Magistrates Court on 9 July 2013 and sentenced to a Community Order. It was following the incidents which ultimately led to this conviction, that Stephen was evicted from his flat. His eviction was a significant event

because it resulted in him going back to the family home and into an environment of conflict. However, he was evicted from private rented property on justifiable grounds and there would have been no requirement or obligation on the landlord to research his background or to change the decision had the history been known. Stephen's subsequent housing application to the local authority led to him being placed on their waiting list - they did not exclude him because of his eviction, so there are no housing lessons identified for statutory agencies.

- 5.2.32 Kent Police dealt with these incidents appropriately. Although a neighbour expressed the view that Stephen had mental health problems, there is no record that police officers felt this was a factor. When arrested and taken to the police custody centre, Stephen would have been asked about his mental health and had there been any concerns, he would have been assessed further.
- 5.2.33 The neighbour who punched Stephen was also arrested. The assault was recorded and investigated, but there was insufficient evidence to prosecute.
- 5.2.34 This was the first occasion where there was a record of Stephen using a knife, with which he threatened his neighbour.
- 5.2.35 On 28 April 2013, while he was on bail for criminal damage and two weeks after the knife threat, Stephen used a knife to cut the arm of a man who he had been drinking with in his (Stephen's) flat. He was arrested and admitted doing this but denied the man's allegation that Stephen had held a knife to his neck. The victim refused to support a prosecution and Stephen received a caution, which indicates that he admitted the offence.
- 5.2.36 The information about the previous threat that Stephen had made with a knife less than three weeks previously should have been available on the Kent Police [Genesis](#) intelligence system to officers investigating the knife assault. Whether it was, and if so whether they read it, is unclear. In the case of the assault they may have had sufficient evidence to prosecute Stephen without the victim's support. The Crown Prosecution Service should have been consulted about whether there was sufficient evidence to prosecute. It is not recorded whether this was done.
- 5.2.37 The next involvement that Kent Police had with any member of the Hills family came almost two years later. On 3 March 2015, Stephen's brother-in-law called Kent Police to say that Stephen had left the family home, having had a row with Roger. The call was made as an expression of concern for Stephen rather than Roger. His brother-in-law said that Stephen had '*purchased a great deal of alcohol*' after having not been

drinking for a number of years. He also said that Stephen had attempted suicide in the past.

- 5.2.38 Police officers went to the family home and were told that Roger and his wife had had a verbal argument, in which Stephen became involved. His father had told him to leave, which he did. Officers recorded that Stephen was living at the family home then. The officers completed a DASH risk assessment, which they classified as Standard.
- 5.2.39 This was the first incident recorded by Kent Police that involved Stephen and his father for almost four years. During that period, Stephen had moved out of and then back into the family home. There was nothing recorded about this incident that would have alerted Kent Police to the potential for what was to happen two and a half months later.
- 5.2.40 Later that day, Stephen's brother-in-law called Kent Police again to say that he had spoken to Stephen, who was in an unspecified public house and intoxicated. He said that Stephen was aware that the police were looking for him, although it is not clear that they were because he had not committed any offences during the argument at his parents' home. Stephen had said to his brother-in-law that people should not come looking for him because he had just acquired a baseball bat.
- 5.2.41 Later that day, Stephen was arrested by British Transport Police officers at a railway station in East Sussex for being in possession of a baseball bat. He had made no threats, but as a baseball bat is not an offensive weapon per se, the fact that he received a formal caution means that he must have admitted having it with some illicit intent.
- 5.2.42 The next and final involvement that Kent Police had with the Hills family during the period covered by this DHR was on 19 May 2015. They attended the family home and found Roger dead in the back garden, having suffered multiple stab wounds. Graham had been injured, also from stab wounds. Stephen had left the house but was quickly found in the same street and arrested for the murder of his father.
- 5.2.43 Given the nature of their work, the proportion of people that the police become involved with who have alcohol abuse, substance abuse and/or mental health issues is greater than in the general population. In addition, they will see many of those people time and time again. In this context, during the relevant period, Kent Police had relatively few interactions with members of the Hills family. They would not have been considered frequent users of police services.

- 5.2.44 There is no evidence of Roger or Stephen having had drug misuse problems. There was some history of Roger drinking heavily in his younger years but not during the relevant period, perhaps because by this time he had been diagnosed as suffering from diabetes. He also reported suffering from depression when younger, but there is no evidence that he had mental health issues during the relevant period.
- 5.2.45 Stephen had been drinking heavily on most occasions when he had contact with Kent Police. When he told police officers he had mental health problems, they took positive and appropriate action.
- 5.2.46 An issue identified regularly in reviews is that, because police work is a 24/7 activity and incidents involving the same people are attended by different officers, the history of previous police involvement that could inform the response on each occasion is not identified. In short, each incident is dealt with in isolation, rather than as part of a pattern of behaviour that may indicate an escalating risk or threat.
- 5.2.47 There is no evidence that this was a significant issue in this case. Had Stephen's propensity to use knives to threaten and assault people developed beyond two incidents within three weeks, this DHR would have been able to establish whether Kent Police identified a pattern. However, it did not develop and following the second incident they were not involved with him at all for almost two years.
- 5.2.48 On two occasions, once in July 2008 and once in February 2009, incidents that fitted the definition of domestic abuse that was current then (see [Appendix C](#)), were not recorded as such. All three subsequent incidents that fitted the definition were dealt with as such, suggesting Kent Police's policies and procedures for identifying domestic abuse and recording became more effective.
- 5.2.49 Kent Police had no indication that Stephen was likely to kill his father. They recorded one incident where Roger alleged that Stephen had assaulted him, in July 2008. The incidents that suggested Stephen might have a propensity use a knife happened less than three weeks apart and two years before he killed Roger. It did not take place in the family home or during a period when he was living there and the victim was not a family member.
- 5.3 National Probation Service (NPS)
- 5.3.1 NPS was established on 1 June 2014. Prior to this, probation services in Kent were provided by Kent Probation Trust. This DHR acknowledges this

but refers to NPS throughout because it is to the current organisation that any recommendations and learning would be directed.

- 5.3.2 NPS were never involved with Roger or Graham. They had dealings with Stephen following his conviction on 9 July 2013 for an offence of criminal damage (paragraph 5.2.30). He was sentenced to a 6-month Community Order with a standalone [Reducing Reoffending Specified Activity Requirement](#) (RR SAR) of up to 10 days.
- 5.3.3 Stephen was allocated an NPS Probation Service Officer and attended nine appointments between 16 July and 19 September 2013. Seven of these were RR SAR sessions and two were before the RR SAR began.
- 5.3.4 During a meeting with a Probation Service Officer held on 25 July 2013, Stephen said he was living with his sister but that he was intending to move to his parents' home the following week. He said that he had not been drinking alcohol during the previous three months and that he had never used *'illicit'* drugs. He added that he had been prescribed an anti-depressant by his GP.
- 5.3.5 In NPS computer records (on a system called nDelius) completed by NPS staff who dealt with him, Stephen is described as attending the RR SAR *'promptly'* and always appearing *'interested and engaged'*. Some concern was recorded about his level of understanding of the intervention material.
- 5.3.6 During one of the RR SAR sessions, Stephen described himself as a *'quiet person'* who could *'get irritated by others'* and who *'tried to keep himself to himself'*. He said that he was benefiting from attending group sessions and talking openly without *'feeling judged'*. In another session, he said that he had *'good family support'*.
- 5.3.7 During the last RR SAR group session, Stephen reported that he had set himself some personal goals, including securing independent accommodation, getting personal ID and a bank account, reducing his alcohol intake, not carrying a knife in future and maintaining the support of his family.
- 5.3.8 At the end of the RR SAR, a Probation Service Officer wrote to a colleague asking if a one to one meeting could be arranged with Stephen to help him get personal identity documentation and a bank account. The author stated that she and another colleague thought that Stephen had *'learning difficulties'*. The NPS computer record suggests that a one to one meeting was to be arranged but does not confirm whether it took place and if so, what the result was.

- 5.3.9 Evidence given at Stephen's criminal trial for the killing of his father stated that his IQ was 74: lower than average and indicative that he might have learning difficulties. The nature of the work that NPS were doing with Stephen meant it was more likely that his learning difficulties would have become evident to them. That it was identified by two professionals and as a result it was recommended that he receive one to one help was good practice.
- 5.3.10 Following the end of the RR SAR in September 2013, NPS had no further contact with Stephen. His Community Order expired in January 2014.
- 5.3.11 NPS facilitated and supervised Stephen's RR SAR, which was a requirement on him to attend several themed sessions. These explored issues such as Victim Awareness, Consequential Thinking and Substance Misuse. He attended all and records show that, although he was quiet, he cooperated and contributed.
- 5.3.12 It is unclear whether he received the support suggested by a member of NPS staff to a colleague because the records do not show whether the one to one meeting took place. Whether it did or not, it would not have been related to domestic abuse.
- 5.3.13 There are no concerns recorded about Stephen that would have given NPS staff reason to think his offending behaviour might escalate, or which required any further action or sharing with other organisations.
- 5.3.14 There is nothing recorded by NPS that suggests Stephen conflicted with his family, to the contrary he mentioned having *'good family support'*. NPS could not have anticipated Stephen harming or killing his father.

5.4 West Kent Clinical Commissioning Group (GP Practice)

- 5.4.1 This sub-section considers the involvement that Roger, Stephen and Graham had with their GPs at the Medical Centre in Town A, where they were registered as patients. This is a multi-doctor surgery where Roger and Stephen were seen by various GPs during the relevant period. The practice used a computerised patient records system (EMIS) throughout this period.
- 5.4.2 Roger had very little involvement with the GP surgery. Two visits were made for routine diabetic screening and on the first occasion he was also screened for depression; the Practice Nurse thought he was looking *'very down'*. On both visits he told the Nurse that he was drinking alcohol but the quantities he disclosed were not excessive.

- 5.4.3 A letter dated 2 September 2008 was sent to the GP surgery from the A&E department of Hospital B. This described an attendance by Roger that day when he was suffering from an injury to the fingers of his right hand, which he said had happened at home. An X-ray revealed a closed fracture of his right middle finger. There was no record of the cause of the injury, nor whether Roger was asked but declined to disclose it.
- 5.4.4 On 5 September 2008, Roger's son-in-law attended the surgery and said that Roger had a lacerated hand and had been seen at A&E three days previously. His son-in-law said the laceration was throbbing and was red; Roger could not attend the surgery as he was not able to drive. The GP prescribed Cefalexin (a commonly prescribed antibiotic). Again, there is no record of how the injury happened or whether Roger's son-in-law was asked about this.
- 5.4.5 Prescribing medication to a patient based on the account of a third party about the patient's condition was and is an unusual practice, but it is not recorded why the GP did this. The injury described by Roger's son-in-law differs from that described in the letter from the hospital to the GP practice dated 2 September. However, this letter was not entered onto EMIS until 11 September, so it is unlikely that the GP would have been aware of the conflicting description of the injury when he saw Roger's son-in-law.
- 5.4.6 The only other record of Roger visiting the surgery was in January 2012, when he reported chest pains, which were not related to exertion and always experienced when sitting. He stated that '*...there is lots of stress at home, which was worse recently.*' The diagnosis was that his condition was gastric in nature and there is no record that his comment about stress at home was explored.
- 5.4.7 Stephen was not a frequent visitor to the surgery, attending about a dozen times in just over seven years. Only occasions when the visit might have been relevant to the DHR are described in this report. There are also entries in Stephen's patient notes about secondary health treatment, for both physical and mental health conditions, which were sent to the GP surgery for information. Those related to his mental health are described in section 5.5.
- 5.4.8 On 18 August 2008, Stephen visited his GP surgery complaining of low mood. He disclosed that he had some difficulty with writing but could read. He said he was embarrassed by a speech impediment that he suffered, that he was sleeping poorly and had a low appetite. He had self-harmed (scratches to arm) when his father '*had a go at him*'. He felt that his anger needed to be treated. He declined counselling and requested anti-

depressants. He was prescribed fluoxetine (better known by one of its trade names as Prozac), which he subsequently stopped taking because he suffered side effects.

- 5.4.9 On 28 October 2008, Stephen was seen at the surgery by a GP. This followed him attending the A&E department at Hospital B after taking an overdose of quinine sulphate. He told the GP that he had ongoing suicidal ideation, no definite life plans and he was feeling depressed. The latter affected his ability to function at work. The GP recognised the need for secondary mental health input and telephoned the KMPT [Community Mental Health Team](#) (CMHT). An appointment was made for Stephen to attend the CMHT later the same day. This was an example of good practice by the GP in securing immediate mental health support for Stephen. It was the first time that he was seen by KMPT.
- 5.4.10 On 3 November 2008, Stephen saw another GP at the surgery. He was back at work and was requesting a repeat prescription of quinine sulphate, which he had previously been prescribed for leg cramps. The GP declined to issue a further prescription because of the risk of a further overdose and advised Stephen to drink tonic water (which contains quinine).
- 5.4.11 The next time Stephen visited a GP was on 10 March 2010, when he presented with a low mood and pharyngitis (an inflammation causing a sore throat). In relation to the former, he said that he lived with his parents, who did not want him to claim benefits *'as it will affect their income'*.
- 5.4.12 On 21 July 2010, on another visit to the GP surgery with pharyngitis, Stephen said that because of stress at the family home, he had moved out and was living with his sister and brother in law, at their suggestion. He was working, his mood was good and he was hoping for *'council accommodation'*. There is no record that GPs explored the issues Stephen raised about stress at home in this and his previous visit.
- 5.4.13 On 11 May 2011, Stephen visited the GP surgery twice, seeing a different GP on each occasion. On the first he recounted the incident where he damaged his father's car (paragraph 5.2.15). He was advised to stop drinking alcohol and to stay at his aunt's, where he was currently living.
- 5.4.14 On his second visit, he said he had been involved in another family altercation that day. He was reported as being drunk and feeling suicidal. He stated that he wanted to be sectioned because he felt he would harm himself or others, and added that he would keep drinking until he died. The GP then telephoned KMPT [Crisis Resolution and Home Treatment Team](#) (CRHT) and discussed Stephen's case with them. It was agreed that

Stephen should go to Hospital B A&E department and remain there until he was sober, following which a mental health assessment would be carried out. This was another example of a GP recognising the importance of immediate secondary health support for Stephen and was good practice.

- 5.4.15 KMPT records show that Stephen was taken to A&E by the police that day, having approached a patrol and expressed concerns about his mental health. It may be that, as his attendance had been already agreed with his GP, he was simply seeking a lift.
- 5.4.16 On 10 June 2011, Stephen visited the GP surgery. He said that he had stopped drinking but was feeling isolated and had thoughts of self-harm. The GP recorded that his issues appeared alcohol related and decided to see him again in two weeks to ensure that he was still not drinking. He was also given a medical certificate for a week.
- 5.4.17 On 28 June 2011, Stephen was seen again by a GP and it appears that he was not drinking. He was given a further medical certificate; the reason for this is not recorded.
- 5.4.18 On 4 November 2011, he went to the GP surgery and complained of depression. He said he was temporarily living in Town B with his sister and was awaiting a placement by an organisation that specialises in providing support for homeless people who are suffering from mental health conditions. He described symptoms of depression, although his main purpose in visiting the GP seems to have been to get a medical certificate allowing him to claim Education Support Allowance.
- 5.4.19 On 20 January 2012, Stephen again visited the GP surgery complaining of depression. As on his previous visit, he said he had thoughts about cutting himself, although he did not feel suicidal. He was prescribed citalopram, an anti-depressant.
- 5.4.20 On 9 May 2013, Stephen went to the GP surgery complaining of depression. He was awaiting a court case (paragraph 5.2.32) and was being evicted. He continued to take citalopram.
- 5.4.21 Stephen next went to his GP surgery 19 months later, on 11 February 2015, suffering from depression. He was feeling low and said he was liable to become '*irritable and snappy*'. Significant recent events had been the death of an uncle and of his dog. He reported '*occasional thoughts of self-harm but no plans*'. He said he felt better when taking citalopram and that he would be able to reduce his alcohol intake '*with the help of his family*'. There is no record of a diagnosis after this visit or whether he was

prescribed medication. This was his last recorded visit, and entry in Stephen's GP notes, before he killed his father.

- 5.4.22 As with physical health, most people suffering from mental health conditions will, in the first instance, visit their GP. They will know who their GP is and the surgery is likely to be based close to where they live. GPs are the universally accessible entry point for mental health care.
- 5.4.23 Stephen's case shows how GPs, as primary healthcare providers, provide mental healthcare that is complementary to that available from secondary mental health providers, in this case KMPT. He was prescribed anti-depressant by GPs. On two occasions, over two years apart, two different GPs recognised that Stephen was presenting with symptoms which required a more detailed assessment of his mental health and immediately referred him to KMPT services.
- 5.4.24 In terms of managing Stephen's mental health, the GPs at the Medical Centre provided appropriate treatment, which was proportionate to the symptoms that he presented with.
- 5.4.25 There were two cross Government definitions of domestic abuse during the period covered by this DHR: one from the start of that period until 2013 and one from 2013, which is current at the time of writing. These are set out in [Appendix C](#).
- 5.4.26 Neither Roger nor Stephen personally disclosed any incidents to GPs that fitted the definition of domestic abuse in place at the time. Stephen reported conflict within his family, and particularly between him and his father, to GPs on several occasions. Conflict in a domestic environment is not necessarily an indication or precursor of domestic abuse. Professionals who misinterpret domestic conflict as domestic abuse, and act on it, may cause problems to escalate, particularly if a decision is made that one party is the victim and the other the perpetrator without clear reasons.
- 5.4.27 A letter was sent to the GP surgery from the A&E department at Hospital B describing briefly Stephen's attendance there on 27 September 2008. He said that he had been assaulted at home. He was diagnosed with a minor head injury for which no treatment was required. This would have been a domestic abuse incident if the injury had been caused by a member of his family, but the assailant is not recorded. It is not clear if the latter was the case because Stephen was not asked who the assailant was or if he was asked but declined to answer.

- 5.4.28 A similar letter was received in relation to Graham Hills, who attended A&E on 14 October 2008 suffering a fractured nose and a minor head injury, following an assault at home. He received treatment for his nose injury; there is no record of his assailant.
- 5.4.29 The letters were sent to the GP surgery for information. They would have been added to the EMIS system but would not necessarily have been viewed by a GP at the time. Neither Stephen nor Graham attended the surgery in relation to these assaults.
- 5.4.30 GPs at the Medical Centre at which Roger, Stephen and Graham were registered recorded occasions when tensions within the family were mentioned. These were recorded in each of their records and would not have been collated to provide an overall picture of what was happening in the family.
- 5.4.31 GPs at the Medical Centre could not, individually or collectively, have foreseen that Stephen might seriously harm any member of his family.

5.5 Kent & Medway NHS and Social Care Partnership Trust (KMPT)

- 5.5.1 Throughout the relevant period and at the time of writing, KMPT provide a variety of mental health services to people over the age of 14 years who live in Kent and Medway. These services are generally delivered through community based teams, crisis services, inpatient units and specialist services.
- 5.5.2 There was some restructuring and relocation of service delivery during the relevant period but this does not seem to have affected the service provided in this case.
- 5.5.3 From 1 January 2008, KMPT has no record of dealing with Roger as a patient.
- 5.5.4 Records relating to Stephen begin in October 2008 and end in May 2011, the latter being four years before Roger's death.
- 5.5.5 KMPT's first involvement with Stephen was on 23 October 2008, when his GP faxed a referral (following a telephone call) to the local Community Mental Health Team (CMHT) stating that Stephen had taken an overdose of quinine sulphate tablets the previous day. He had been taken to the A&E Department of Hospital B, where he was pronounced medically fit. He denied any thoughts of suicide. He discharged himself from the hospital before he was seen by the Psychiatric Team.

- 5.5.6 Because of this referral, he was seen by a psychiatrist and a social worker at the CMHT on 28 October. Stephen said that before taking the overdose, he had drunk two beers and had then had an argument with his father. He became upset and took the tablets as a '*cry for help*'. He said he had no suicidal ideation or intent. He complained of low mood for the past year but this had improved in the last month due to '*his father making more of an effort*' – this contradicted the reason he had given for taking the overdose. He said he felt anxious and worried all the time, and had felt this way for most of his life. He added that his relationship with his father was '*turbulent*'.
- 5.5.7 The diagnosis following this assessment was a '*possible generalised anxiety disorder*'. It was recorded that he posed no risk to himself, although his risk to others was not mentioned. No medication was prescribed but a follow up outpatient appointment to review whether a psychology assessment would be beneficial was arranged for 13 January 2009. Stephen failed to attend the appointment and his GP was advised of this.
- 5.5.8 On 7 February 2009, following the incident where Stephen reported being assaulted by Graham (paragraph 5.2.6), Stephen was seen in the A&E department of the Hospital B by an [Approved Mental Health Practitioner](#) (AMHP) from the [Crisis Resolution and Home Treatment Team](#) (CRHT).
- 5.5.9 Stephen again reported low mood and described '*cobwebs in his head*'. He said he was drinking six cans of beer a day and feeling anxious about family dynamics. He said that he dwelt on childhood experiences of Roger (who he described as a disciplinarian) hitting him as a child. He added his father was having health problems, including depression, which he (Stephen) was worried about.
- 5.5.10 The result of this assessment was recorded as '*to see GP and discuss re referral to CMHT*'. The subsequent records suggest that this meant that Stephen was to see his GP and that Crisis and Home Resolution Team would contact the CMHT.
- 5.5.11 Stephen's GP received a detailed report of the CRHT assessment but there is no record that he saw Stephen following it. This is an indication that Stephen did not consult his GP as advised by the CRHT; it is not a criticism of the GP.
- 5.5.12 During the next two months, Stephen failed to attend an appointment with the CMHT and did not reply to letters sent to him. On 28 April 2009, a letter

was sent to his GP surgery by a psychiatrist, discharging Stephen back to his GP.

- 5.5.13 In the early hours of 4 January 2010, following the involvement described in paragraph 5.2.9, police officers took Stephen to the A&E department at the Hospital B, where he was seen by a trainee doctor. On this occasion he said he was contemplating suicide. He reported '*verbal aggression*' from one of his sisters (not Graham as he had told the police), who was also living at his parents' home. He said that his sister was '*not protecting him*'.
- 5.5.14 Stephen told the A&E doctor that he was having dreams about '*violence from his father and also violence to his father*'. He reported '*childhood abuse*' from his father and that the last incident of abuse from him was in 2009, when Stephen was 24 years old. This expanded on his previous disclosure that his father was a disciplinarian who had hit him when he was a child.
- 5.5.15 There is no record that his disclosure about violent dreams was explored. It would not have been routine for Stephen to have been seen by the A&E Approved Mental Health Practitioner; this would apply only if the person was detained under S.136 of the MHA.
- 5.5.16 It is not recorded whether Stephen was questioned about the nature of the abuse he had suffered at the hands of his father. He was either not asked or if he was asked, his answers were not recorded. If it is the former, it seems to show a lack of professional curiosity because childhood abuse is recognised as a potential cause of mental health issues later in life.
- 5.5.17 If Stephen was asked about the abuse and it was felt that his answers were not relevant to his presentation, it is a question of professional judgement whether to record them. On balance, it would have been best to have done so because the information might have been helpful in providing the fullest possible history for any other professional dealing with Stephen in future.
- 5.5.18 As a result of this assessment, Stephen was admitted to Ward A as an inpatient for observation. Later that day his parents telephoned the ward and Stephen said he did not want any information to be given to them. His mother said he had been getting drunk, and that he had recently fallen and injured his head while intoxicated. Roger asked the staff to find Stephen accommodation and said that following an incident the previous weekend, his parents could not cope (with Stephen) anymore. Roger said that Stephen '*thought he was Superman [unclear whether meant literally] when he has had a drink and becomes violent*'.

- 5.5.19 Stephen remained as an inpatient at Ward A until 11 January 2010, when he was discharged. His discharge summary states that there was no indication of mental illness while there and his mood was consistently euthymic (positive, not showing signs of depression). It was noted that there was a difficulty with *'family dynamics'* and that Stephen had a problem with excessive alcohol consumption.
- 5.5.20 Stephen did not attend an appointment at the Hospital Discharge Clinic or two subsequent appointments at a CMHT outpatient clinic. His case was discussed at a CMHT meeting on 19 February 2010, at which there was an appropriate consideration of the risks he posed to himself and others (classified as moderate). The decision of the meeting was that he would be discharged back to his GP.
- 5.5.21 A letter was sent to Stephen's GP on 3 March 2010, but in the meantime, on 26 February, KMPT records show that he had again been brought to the A&E department at Hospital B by police officers, who had found him walking along a road. He had told them he wanted to be admitted to Ward A and they took him to the A&E. Kent Police have no record of this involvement with him.
- 5.5.22 On this occasion, Stephen said that things had initially been *'OK'* following his discharge from Ward A but he was now finding life stressful. It seems he was living at the family home again because he said that he was *'feeling under pressure from his father to find a job and move out.'* He asked to be re-admitted to Ward A to have a break from the stress and so that he could get help to sort out his housing and financial situation.
- 5.5.23 Stephen was given the contact number for Citizens Advice Bureau and KCA (an alcohol support service based locally). The notes record *'Refer back to GP/CMHT'*: it is not clear from whether this was done.
- 5.5.24 It was 15 months later, on 12 May 2011, that KMPT had their next involvement with Stephen. This was the day after he was brought to the A&E department at Hospital B by police officers (paragraph 5.2.17). KMPT records suggest that he was brought there under S.136 but Kent Police records do not.
- 5.5.25 Stephen was assessed by an [Approved Mental Health Practitioner](#) and a [Section 12 Doctor](#). During this, he disclosed that he had been bullied as a child and was a victim of violence perpetrated by his father. He added that he had *'head scars'* from his relationship with his father, which the assessors took to mean psychological difficulties. He also described in detail the incident that led to him damaging Roger's car. When it was put to

him that his self-harming was an angry gesture and that his anger appeared primarily to be directed towards his father, he agreed with this summary.

- 5.5.26 This was the second time that Stephen had disclosed being a victim of childhood abuse at the hands of his father and again there is no record that he was asked any details about this. The damage to Roger's car resulted from an argument following what, taken alone, was a relatively trivial incident at the family home: it was disclosed at Stephen's trial that he killed Roger after a similarly minor incident.
- 5.5.27 The conclusion of the mental health assessment was that there was a degree of ambiguity in relation to Stephen's presentation and that this was primarily because of his use of alcohol and his level of intoxication at the time. However, he was threatening to self-harm and described some paranoia and other possible psychotic symptoms. He was informally admitted to Hospital A.
- 5.5.28 This was the second occasion when Stephen was admitted to Hospital A as an inpatient following assessment by KMPT professionals. On neither occasion was it based on the diagnosis of a specific mental health condition. There was recognition that observing Stephen in a hospital environment would assist in reaching a conclusion about his mental health. This was good practice on both occasions.
- 5.5.29 The disclosure by Stephen that he had suffered violence during his childhood was not shared with any other organisation, although the assessment report in which it is described was sent to his GP surgery.
- 5.5.30 On 16 May, Stephen requested a self-discharge from Hospital A. He was unwilling to wait for the doctor to see him and review his condition and he signed a '*discharge against medical advice form*'. He said that he was going to stay with his aunt in Town A. He was offered an outpatient appointment at the hospital discharge clinic.
- 5.5.31 The following day, 17 May, Stephen presented at Hospital B A&E department having drunk '*eight pints*' and requested admission. He was re-admitted to Hospital A so that a discharge plan could be formalised.
- 5.5.32 On 18 May he was discharged from Hospital A. There was no diagnosis of a mental health condition and he was not prescribed medication. It was agreed that the outpatient appointment previously arranged should be maintained. He was given information about local Alcoholics Anonymous meetings.

- 5.5.33 Stephen was last seen by KMPT on 20 May 2011 at the outpatient meeting arranged when he was discharged from Ward A. At this meeting, he said that he had not been drinking and he did not have low mood or thoughts of suicide. It was decided that continued involvement of mental health services was not required. He was not prescribed any medication.
- 5.5.34 KMPT's involvement with Stephen was over a period of about two and a half years, ending four years before he killed Roger. During this involvement, he was not diagnosed with a specific mental health condition and following both periods as an inpatient, when he would have been under almost constant observation, his discharge summary states that there was no diagnosis of a mental health condition.
- 5.5.35 As with his GP, Stephen disclosed issues to KMPT professionals, on several occasions, that could be classed as domestic conflict, rather than domestic abuse. However, on two occasions, he specifically said that his father had abused him as a child and this had continued into adulthood. There is no record that this was explored further. If so this was a missed opportunity: first to establish whether the abuse might have contributed to a mental health condition and second to the extent of the abuse and whether he was a current domestic abuse victim.
- 5.5.36 Stephen might have been asked about the abuse but if he was, his answers were not recorded. If so, this was a missed opportunity to ensure that the fullest possible history was recorded for the benefit of professionals who might assess him in future.
- 5.5.37 KMPT must ensure that if patients disclose child abuse to professionals, the nature of this should be explored. Any further detail should be recorded and consideration given to sharing this information if serious criminal offences are disclosed because the patient may not have been the only victim. **(Recommendation 1)**
- 5.5.38 KMPT sought to establish whether Stephen was suffering from a mental health condition and he was admitted as an in-patient on two occasions. He was not diagnosed as suffering from a mental health condition and no medication was prescribed by KMPT. Overall, Stephen received a very thorough service from KMPT.
- 5.5.39 KMPT professionals could not, either individually or collectively, have foreseen that Stephen might seriously harm any member of his family.

5.6 Housing Providers

- 5.6.1 The Hills family home was a three-bedroom terraced house in Town A, Kent. It was a social housing sector property owned by Circle Housing Russet (CHR), part of the Circle Housing Group.
- 5.6.2 The Council Housing Register covering Town A is managed by the local council.
- 5.6.3 CHR have no record of contact with Roger and Diane, other than general correspondence about their rent account. There were no concerns about the family as tenants nor were any complaints received about them from neighbours.
- 5.6.4 CHR held Job Club and Learn My Way meetings in Town A, run by the Employment and Skills Coordinator from their Sustainable Communities Team (SCT). The overall aim of the SCT is to improve the life chances of residents by involving them in activities that can help to shape services to meet their needs.
- 5.6.5 Stephen registered for both meetings and attended the Job Club twice in November 2014. When he did not attend subsequent meetings, he was sent a letter in January 2015 by the Coordinator. He did not reply or make further contact.
- 5.6.6 CHR's Financial Inclusion Officer helped Stephen complete a housing application to the Bridge Trust, a charity supporting single homeless people. It seems that moving back to the family home in October 2014 initially prompted Stephen to look for housing and employment, and CHR provided help with this.
- 5.6.7 On 25 November 2014, Stephen applied to the local council to be included on their Housing Register. This included a letter jointly sent by his father and mother, confirming that Stephen was living at the family home. They wrote that although Stephen was '*...buying his own food and stuff*', he was not paying rent.
- 5.6.8 It is unclear whether Stephen completed the application himself but it was very honest: it disclosed that he had been evicted from his flat in Town D for anti-social behaviour (the events described in 5.2.28 onwards) and that he had rent arrears from that tenancy. The only reason that he gave for his application was '*Needing Smaller Accommodation (a place of my own)*'.
- 5.6.9 In the paragraph provided on the application form for additional information, Stephen wrote '*I keep falling out with my parents and arguing all the time*'.

They both have their own health problems. I don't want to be here and make matters worse for them'. He adds 'I want to stay in [Town A] though to be close to my family'. If these were his own words (there is no evidence that they were not), Stephen does not show animosity towards his family, and his father in particular. He cites his reason for wishing to move out of the family home as not wanting to make matters worse for his parents but he adds that he wants to remain close to them.

- 5.6.10 Stephen was successful in his application to be put onto the local council Housing Register. A person's position on the Housing Register is prioritised objectively according to need and graded A-D, with A being highest priority. Stephen was graded D, which was in line with the criteria in place at the time. Applicants are also restricted in the type of property they can apply for, again based on objective criteria. Stephen could apply for one-bedroom properties.
- 5.6.11 He applied for ten properties between 16 January 2015 and 19 May 2015, using the local council housing department website on each occasion. Each had multiple applicants and the highest priority ranking that Stephen achieved was 44th, although he would not have known this. It is unlikely that Stephen would have been successful in his applications for properties if he was graded D. The number of applicants exceeds the amount of accommodation available for allocation.
- 5.6.12 On 4 March 2015, Stephen telephoned the local council and spoke to a member of the Housing Options Team staff. He said that he had left his parents' house the previous day. When asked why, he said that he '*...felt disrespected and they had been arguing*'. He confirmed that he had not been asked to leave and that his parents had said that he could return. Having established that there was no reason to believe that Stephen was in Priority Need, the member of staff encouraged him to return to his parents' home and to plan a move if he did not intend to stay there. Options, including private rental and hostel accommodation, were discussed with him.
- 5.6.13 The local council dealt with Stephen's application promptly, in accordance with the procedures in place at the time and the information that he had provided.
- 5.6.14 A question on the application form asks '*Does any member of your household have any medical problems that are affected by your current housing?*' Stephen ticked the answer as 'No', so the local council were unaware of his ongoing depression. The question may be a little ambiguous and an applicant may feel it refers only to others, not them.

Following consideration of the draft Overview Report, the question has been amended on the application form to remove this potential ambiguity.

- 5.6.15 The advice given to Stephen in the telephone call, to return to parents' house, was pragmatic, given that there were no other apparent options. The member of staff speaking to Stephen could not possibly have anticipated that he would subsequently kill his father.
- 5.6.16 Neither CHR nor the local council would have had reason to be concerned that Stephen posed a risk to any member of his family.

6. Conclusions

- 6.1 The Hills family, in particular Roger and Stephen, were known to organisations, but it is unlikely that they would have been viewed by any as a 'problem family' because the level and frequency of contact was not exceptional in the context of families that professional organisations deal with.
- 6.2 Graham had very few recorded contacts with organisations, none of which are relevant to this DHR.
- 6.3 Roger had no relevant contact with health organisations during the period covered by this DHR; the contact he had related to physical health conditions unconnected with domestic abuse.
- 6.4 On four occasions Roger was involved in incidents with Stephen at the family home; each of which fitted the definition of domestic abuse that was in place at the time. On the first occasion, he alleged that Stephen has assaulted him. Kent Police did not record this incident as domestic abuse but correctly recorded the later three incidents as such. The Review Panel is satisfied that, had this incident happened today, Kent Police would have recorded it correctly because of the increased level of domestic abuse training that police officers now receive.
- 6.5 Stephen had more involvement with organisations, but not to an extent that would have been considered frequent in the context of families that organisations deal with. In addition to the occasions referred to involving Roger, one incident involving Stephen fitted the definition of domestic abuse. This was when he alleged that his brother had assaulted him. Kent Police dealt with this in a pragmatic and proportionate way but did not record it as domestic abuse. The Review Panel is again satisfied that had this happened more recently, Kent Police would have recorded it correctly.
- 6.6 With hindsight, the most significant incidents involving Stephen were when he threatened a neighbour with a knife and when he cut a man with a knife less than three weeks later. These incidents happened two years before he killed Roger and while he was living some miles away from the family home. If there was any concern that these incidents demonstrated a rapid escalation in violence by Stephen, or a propensity to use knives, this would have been allayed because he had no further contact with Kent Police involving violence for two years, until the day he killed Roger.
- 6.7 Stephen engaged fully with the National Probation Service (NPS). He attended all his appointments and appeared to be interested and involved in

the Reducing Reoffending Specified Activity Requirement sessions. Unlike almost all his involvements with Kent Police before he was sentenced, NPS staff never saw him drunk. Although he referred to family issues, he did not suggest that he had a violent relationship with his other family members. During the period that Stephen was subject to the Community Order managed by NPS, he did not have contact with Kent Police or health services.

- 6.8 On most of the occasions when Stephen visited his GP, he presented suffering from depression, although this was never formally diagnosed following mental health assessments carried out by KMPT staff.
- 6.9 As with physical health conditions, mental health problems including depression, can range from minor through to life threatening. Most people suffering from depression access care and receive treatment through their GP. In most cases the GP will manage their condition and they will not receive treatment from secondary mental health providers.
- 6.10 Stephen was prescribed anti-depressants by GPs as the first step in managing his presentation. However, on two occasions he was immediately referred to KMPT, by different GPs on each occasion. This suggests that the GP practice that Stephen was registered with had a clear understanding of the complementary nature of the relationship between primary and secondary mental health providers.
- 6.11 At his trial it was quoted that Stephen's IQ was 74, which is below average and indicative that a person is likely to suffer learning difficulties – a term that is commonly used and for which there are several definitions. Only a National Probation Service (NPS) professional used this term to describe Stephen's condition. This was based on a professional judgement, rather than a diagnosis or a knowledge of his low IQ.
- 6.12 Unlike mental health conditions, such as bi-polar disorder, psychosis or schizophrenia, 'learning difficulties' cannot be 'treated' with medication. Neither can a person with learning difficulties be 'cured'. What they are likely to require is additional support with day to day activities.
- 6.13 Professionals from agencies subject of this report (apart from NPS), who would be expected to provide additional support to service users with learning difficulties did not record identifying that Stephen might be such a person. It is not possible to judge whether this was because it was not evident, that they lacked the ability to identify it or because they lacked empathy. If learning difficulties are not identified, appropriate support is unlikely to be given.

- 6.14 The GPs who saw Stephen were aware of the tensions in his family because he told them. Depression caused by family tensions is a condition that GPs see on a frequent basis and in most cases it is not an indication that the patient will use violence. Stephen did not disclose anything to a GP that would have given rise to concern that he would become violent.
- 6.15 Stephen had contact with KMPT staff from the Community Mental Health Team, Crisis Resolution and Home Treatment Team, and Hospital A during the period covered by this Domestic Homicide Review. On two occasions, he was referred by his GP and on others he accessed KMPT services based in Hospital A, after initially attending his local A&E department.
- 6.16 Stephen had two periods as an inpatient at Hospital A and on both occasions the conclusion on his discharge was that he was not suffering from a mental health condition.
- 6.17 He disclosed three times that he had been a victim of violence at the hands of his father during his childhood. The first disclosure was to an Approved Mental Health Practitioner, when he said his father was a disciplinarian who had hit him as a child.
- 6.18 The second occasion was a year later (January 2010) when he told a trainee doctor at Hospital B A&E department of '*past childhood abuse*' by his father. He said that the last incident had been in 2009. There was either a missed opportunity to explore this further or a failure to record any further details that Stephen gave.
- 6.19 The third occasion was during a mental health assessment by a KMPT doctor and an Approved Mental Health Practitioner, just over a year after the second. There is no record that Stephen was asked more about this and this was again a missed opportunity to get a fuller background on which to base a judgement about what action was appropriate. There is no record that this allegation of childhood abuse was shared with any organisation, or that the possibility of doing so was discussed with Stephen.
- 6.20 In summary, in three separate contacts with health professionals in consecutive years, Stephen disclosed that his father had used violence against him when he was a child. The last occasion on which he made this allegation was four years before he killed his father. There was no record that this was ever explored further or that consideration was given to sharing the information with Kent Police.
- 6.21 The incidents of domestic abuse involving Roger and Stephen during the period covered by this DHR do not indicate a pattern of coercive control by

either. There was no escalation in the severity of the incidents until the event that led to Roger's death. These incidents were an indication of a family that had tensions; they were not of a nature that should have caused professionals to conclude that either Roger or Stephen were vulnerable victims.

- 6.22 At his trial, part of Stephen's defence was that his father bullied him and he felt he was treated differently to Graham. What Stephen described in court showed coercive control and would have constituted domestic abuse of which he was the victim. However, no organisation was aware of the detail of what Stephen alleged had taken place, although there had been opportunities to explore this.
- 6.23 The Review Panel concludes that none of the professionals involved with Roger or Stephen could have reasonably foreseen the event that led to Roger's death.

7. Recommendation

7.1 The Review Panel makes the following recommendation from this DHR:

	Paragraph	Recommendation	Organisation
1.	5.5.37	Kent and Medway NHS and Social Care Partnership Trust must ensure that if patients disclose child abuse to professionals, the nature of this should be explored. Any further detail should be recorded and consideration given to sharing this information if serious criminal offences are disclosed because the patient may not have been the only victim.	KMPT

8. Lessons Learned

8.1 Professionals must know what action to take when people disclose being victims of domestic and/or childhood abuse.

- 8.1.1 Stephen repeatedly referred to family tensions when speaking to health professionals, both at his GP surgery and when engaging with secondary mental health services. GPs will hear many patients tell them that family issues are the cause of stress or depression. Such cases will not often result in death or serious injury and it is unrealistic to suggest that GPs should treat each case as if it is likely to.
- 8.1.2 However, when people disclose to professionals who have a responsibility for safeguarding, that they are or have been victims of violence at home, there is a greater onus to consider what action is appropriate. It takes considerable courage to disclose being a victim of violence in a family setting and it should be recognised as a cry for help in the most literal sense.
- 8.1.3 A professional to whom a person makes such a disclosure has a responsibility to obtain as much detail as the person is willing to give. This is essential to decide how the person can best be supported and how the disclosures they have made are best managed.
- 8.1.4 Organisations who employ staff who have responsibility for reporting safeguarding concerns must ensure that those staff have a clear understanding for how reports or referrals should be made following disclosure by a service user.
- 8.1.5 Continually raising staff awareness of the signs of domestic abuse and other safeguarding issues is important in learning this lesson. In Kent, members of the Kent and Medway Safeguarding Adults Board (KMSAB), which includes all the organisations in this review except for Circle Housing Russet, are required to report on levels of training in relation to safeguarding, domestic abuse and the Prevent Strategy. Performance is monitored using a dashboard maintained by a committee that reports to the Board.
- 8.1.6 During the summer of 2016, Kent Police, as part of the Kent and Medway Domestic Abuse Strategy Group, will be repeating their 'You're Not Alone' campaign, first run in 2014. This aims to signpost victims of domestic abuse to the resources available in Kent and Medway to support them but it is also relevant to staff from agencies that deal with potential victims of domestic abuse.

8.2 The importance of accurately recording contact with service users, and the rationale for decisions.

- 8.2.1 The primary reason why accurate recording is important is that the record forms the history of a person's involvement with a professional service. It is possible that future engagement with that service will be made by a different professional. If they have frequent engagement, it may be with a number of professionals within that organisation.
- 8.2.2 Accurate record keeping allows those future engagements to be conducted with the fullest possible knowledge of the person's history. While it may take longer to make a full record of a contact, in the long run it will save time and allow subsequent engagements to be based on previous professional input.
- 8.2.3 While the benefit to service users is the main outcome achieved by accurate recording, there is also a benefit to professionals, particularly in recording the rationale for decisions.
- 8.2.4 Any subsequent investigation, enquiry or inquest is likely to look closely at why decisions were made. If a decision was made years before, it is unlikely that the professional will remember the rationale if they did not make a contemporaneous record. In any event, in an adversarial scenario, reliance on memory may be the subject of a strong challenge. An accurate and concise record of the rationale for a decision, made contemporaneously, will better enable such a challenge to be met.

Kent & Medway Domestic Homicide Review

Victim – Roger Hills

Terms of Reference

These terms of reference were agreed by the DHR Panel following their meeting on 4 August 2015.

Background

On 19 May 2015, police officers went to a house in Town A, Kent, which was the home address of the victim, Roger Hills, and the perpetrator, his adult son Stephen Hills. They found that the victim had been stabbed by the perpetrator and both were in the house. A second adult son of the victim, Graham Hills, had also been stabbed by the perpetrator. As a result of the stabbings, Roger Hills died and Graham Hills suffered serious injuries.

Stephen was arrested for Roger's murder and causing grievous bodily harm to Graham. He was subsequently charged with these crimes and remanded in custody.

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 13 July 2015. It confirmed that the criteria for a DHR have been met.

That agreement has been 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.

The Purpose of a DHR

The purpose of this review is to:

- i. Establish what lessons are to be learned from the death of Roger Hills 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.

The Focus of the DHR

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 Roger Hills.

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.

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. If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

In addition to the homicide victim and perpetrator, Graham Hills will be a subject of this review to ensure that any agency contacts with him, which might have had a bearing on the circumstances of the homicide, are considered.

DHR Methodology

Independent Management Reports (IMRs) must be submitted using the templates current at the time of completion.

This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Roger, Graham or Stephen 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 Roger, Graham or Stephen, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

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.

Each agency required to complete an IMR must include all information held about Roger, Graham or Stephen from 1 January 2008 to 19 May 2015. If any information relating to Roger or Graham being victims, or Stephen being a perpetrator, of domestic abuse before 1 January 2008 comes to light, that should also be included in the IMR.

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 Roger and/or Stephen. 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).

Any issues relevant to equality, for example 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.

When each agency that has been required to submit an IMR does 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.

Specific Issues to be Addressed

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 Roger, Graham and Stephen, 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 Roger or Stephen (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?
- 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 Roger, Graham or Stephen (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 Roger and promote his welfare, or the way it identified, assessed and managed the risks posed by Stephen Hills? 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 Roger, Graham and Stephen (as applicable)?
- xi. To what degree could the death of Roger have been accurately predicted and prevented?

GLOSSARY

Abbreviation/Acronym	Expansion
A&E	Accident & Emergency
AMHP	Approved Mental Health Practitioner
CHR	Circle Housing Russet (<i>Housing Provider</i>)
CMHT	Community Mental Health Team
CRHT	Crisis Resolution and Home Treatment Team
CSP	Community Safety Partnership
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
GP	General Practitioner
IMR	Independent Management Report
KMPT	Kent & Medway NHS & Social Care Partnership Trust
KCC	Kent County Council
MHA	Mental Health Act 1983
NHS	National Health Service
NPS	National Probation Service
RR SAR	Reducing Reoffending Specified Activity Requirement
SCT	Sustainable Communities Team
WKCCG	West Kent Clinical Commissioning Group

This glossary contains explanations 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.

Domestic, Abuse, Stalking & Harassment (DASH) Risk Assessments

The DASH (2009) – Domestic Abuse, Stalking and Harassment and Honour-based Violence model has been agreed by the Association of Chief Police Officers (ACPO) as the risk assessment tool for domestic abuse. A list of pre-set questions will be asked of the victim, the answers to which are used to assist in determining the level of risk. The risk categories are as follows:

- Standard** Current evidence does not indicate the likelihood of causing serious harm.
- Medium** There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances.
- High** There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

Secondary Incident Report

A secondary incident report is completed by a police officer following attendance at a domestic abuse incident in addition to the DASH risk assessment, when there is no evidence that a criminal offence had been committed.

Genesis

This is the proprietary name for the computer system that Kent Police use to create and store crime reports, secondary incident reports and criminal intelligence. There is a comprehensive search facility on Genesis. For example, 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 also 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.

Specified Activity Requirement

When a Community Order is imposed as a sentence for a criminal offence, the convicted person will serve their sentence in the community rather than in prison. However, as part of

the Order, the court will impose one or more of 13 specified Requirements on the person. If the person does not comply with the Order, they can be sent to prison.

A court will decide which Requirement(s) to impose, dependent on the nature of the offence and the circumstances of the convicted person. One of the 13 Requirements which a court can impose as part of the Community Order is 'Specified Activity'. The person will be required to carry out activity under the supervision of the National Probation Service.

The range of Specified Activity is wide. For example, it could be victim-focused reparation work or offender-focused activity such as attending sessions aimed at improving literacy and numeracy.

The maximum number of days that a person can be required to perform Specified Activity during the period of the Community Order is 60 days.

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 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](#).

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>

Crisis Resolution and Home Treatment Team (CRHT)

The Crisis Resolution and 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/>

Approved Mental Health Practitioner

Approved Mental Health Professional (AMHP) is a role developed by the 2007 Mental Act amendment; prior. Prior to this the role was known as Approved Social Worker or ASW. The amendment to the Act broadened the role beyond social workers to other registered Mental Health Professionals, such as Nurses and Occupational Therapists who have undergone specific training.

The AMHP has for responsibility co-ordinating a Mental Health Act assessment and demonstrating the principles of the Mental Health Act e.g. the least restrictive principle and the participation principle. The AMHP must ensure that the person is appropriately interviewed and if admitted to hospital that they are conveyed there in the most humane and dignified manner.

The Approved Mental Health Professional role is quite different to that Responsible Clinician during a Mental Health Act assessment. The AMHP must consider all the factors present to ensure that the least restrictive principles are applied. They need to ensure the person is aware of their rights, treated with respect and dignity and has access to an advocate.

Section 12 Doctor

A doctor who is 'approved' under Section 12 of the Mental Health Act 1983 is approved on behalf of the Secretary of State (or the Welsh Ministers) as having special expertise in the diagnosis and treatment of 'mental disorders'. Doctors who are approved clinicians are automatically also approved under Section 12. Section 12 approved doctors have a role in deciding whether someone should be detained in hospital under Section 2 and Section 3 of the Mental Health Act.

DOMESTIC ABUSE – DEFINITIONS

The cross-Government definition of domestic violence current from the start of the period covered by this DHR until 2013 was:

Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

This definition changed in 2013 to:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional.