

# **KENT & MEDWAY DOMESTIC HOMICIDE REVIEW**

**Emily/2017**

Executive Summary

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Commissioned by:  
Kent Community Safety Partnership  
Medway Community Safety Partnership  
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## EXECUTIVE SUMMARY

### 1. The Review Process

- 1.1 This summary outlines the process undertaken by the Domestic Homicide Review panel in reviewing the homicide of Emily Dale, who lived in Kent.
- 1.2 The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family members:
- |             |            |
|-------------|------------|
| Victim      | Emily Dale |
| Perpetrator | Clive Dale |
- 1.3 Emily was a mixed-heritage British woman, who was 19 years old at the time of her death in July 2017. Clive was a white British man, who was then aged 63.
- 1.4 Criminal proceedings were completed on 5 February 2018, when Clive was sentenced to 10 years imprisonment combined with a hospital direction under S.45A of the Mental Health Act 1983.
- 1.5 The DHR Core Panel met on 6 September 2017 and agreed that the criteria for a DHR were met. The Chair of the Kent Community Safety Partnership then made the formal decision that a DHR would be conducted. All agencies that potentially had contact with Emily and/or Clive prior to Emily's death were contacted and asked to confirm whether they had contact with them.
- 1.6 Those agencies that confirmed contact with the Emily and/or Clive were asked to secure their files.

### 2. Contributing Organisations

- 2.1 Each of the following organisations were subject of an IMR:
- Kent Police
  - Kent & Medway NHS and Social Care Partnership Trust
  - East Kent Hospitals University NHS Foundation Trust
  - South East Coast Ambulance Service NHS Foundation Trust
  - Kent County Council Adult Social Care and Health (Primary Care Mental Health Team)
  - Kent County Council Children, Young People and Education (Early Help and Prevention Services)
  - Kent County Council Children, Young People and Education (Education Safeguarding Team)
  - GP Practice 1 (Emily and Clive's GP) \*

\* To protect the anonymity of Emily and her family, GP practices are not named.

- 2.2 In addition to the IMRs, reports were provided by Sussex Partnership NHS Foundation Trust, Thinkaction and Porchlight.
- 2.3 Having considered the IMRs and reports, the DHR Panel decided the involvement East Kent Hospitals University and South East Coast Ambulance Service NHS Foundation Trusts had with Emily was not relevant to the DHR. Neither had a record of contact with Clive. The involvement of these organisations is not considered in this report.

### **3. Review Panel Members**

- 3.1 The Review Panel was made up of an Independent Chairman and senior representatives of organisations that had relevant contact with Emily and/or Clive. It also included a senior member of Kent County Council Community Safety Team.
- 3.2 The members of the panel were:
- Sallyann Baxter South Kent Coast CCG (Clinical Commissioning Group)
  - Wendy Bennett Canterbury and Coastal CCG
  - Louise Fisher Kent County Council Children, Young People and Education (Early Help and Prevention Services)
  - Janet Guntrip Kent County Council Adult Social Care and Health (Safeguarding Unit)
  - Susie Harper Kent Police
  - Paul Pearce Independent Chairman
  - Shafick Peerbux Kent County Council Community Safety
  - Claire Ray Kent County Council Children, Young People and Education (Education Safeguarding Team)
  - Liza Thompson Sateda Domestic Abuse Service
  - Cecelia Wigley Kent and Medway NHS & Social Care Partnership Trust
- 3.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Emily or Clive. They met on three occasions during the DHR.

### **4. Independent Chairman and Author**

- 4.1 The Independent Chairman and author of this overview report is a retired senior

police officer who has no association with any of the organisations represented on the panel and who has not worked in Kent. 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-organisation approach to dealing with domestic abuse.

- 4.2 The Independent Chairman has a background in conducting reviews (including Serious Case and Safeguarding Reviews), investigations, inquiries and inspections. He has carried out senior level disciplinary investigations and presented at tribunal. He has completed the Home Office online training on DHRs, including the additional modules on chairing reviews and producing overview reports.

## **5. Terms of Reference**

These terms of reference were agreed by the DHR Panel following their meeting on 22 September 2017.

### **5.1 Background**

In July 2017, Emily Dale, aged 19 years, was found dead in a house in Kent, which was the home of her father, Clive Dale. Clive had earlier been arrested on suspicion of Emily's murder and the attempted murder of Emily's mother, who was his ex-partner. Clive was subsequently charged with these crimes.

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 6 September 2017. It agreed that the criteria for a DHR have been met and, the Chair of the Kent Community Safety Partnership confirmed that a DHR would be conducted.

That agreement has been ratified by the Chair of the Kent Community Safety Partnership and the Home Office has been informed.

### **5.2 The Purpose of a DHR**

The purpose of a DHR is 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 agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.

### **5.3 The Focus of the DHR**

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

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

The full subjects of this review will be the victim, Emily Dale, and the alleged perpetrator, Clive Dale.

### **5.4 DHR Methodology**

The DHR will be based on information gathered from IMRs, chronologies and reports submitted by, and interviews with, agencies identified as having had contact with Emily and/or Clive in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. The DHR Panel will decide the most appropriate method for gathering information from each agency.



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Independent Management Reports (IMRs) and chronologies must be submitted using the templates current at the time of completion. Reports will be submitted as free text documents. Interviews will be conducted by the Independent Chairman.

IMRs and reports will be prepared by an appropriately skilled person who has not had any direct involvement with Emily or Clive, 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 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 Emily or Clive from 1 January 2014 to the date of Emily's death in July 2017. If any information relating to Emily being a victim, or Clive being a perpetrator, of domestic abuse before 1 January 2014 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 Emily and/or Clive. 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 2015, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, for example disability, sexual orientation, cultural and/or faith 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 Independent Chairman. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

### **5.5 Specific Issues to be Addressed**

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

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- i. Were practitioners sensitive to the needs of the Emily and Clive, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Emily and Clive? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency forums?
- iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?
- iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
- vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?
- viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?
- ix. Was this information recorded and shared, where appropriate?
- x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

- xii. Were senior managers or other agencies and professionals involved at the appropriate points?
- xiii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- xiv. Are there ways of working effectively that could be passed on to other organisations or individuals?
- xv. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- xvi. Did any staff make use of available training?
- xvii. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?
- xviii. How accessible were the services to the Emily and Clive?

## **6. Summary Chronology**

- 6.1 Emily was born in 1997 and she suffered from mental health issues from childhood. Emily suffered from anxiety, which meant she did not go out alone to socialise. After leaving school aged 16, she attended college for three years, where she struggled to communicate with her peer group. After leaving college, her mental state deteriorated significantly during the last few months of her life
- 6.2 During the early part of the review period, Emily was treated by the Sussex Partnership Foundation Trust, which at that time delivered Child and Adolescent Mental Health Service across Kent and Medway. She made progress as a result of the treatment and was discharged appropriately in early 2015.
- 6.3 From late 2014, Emily received support from Early Help and Preventative Services, which is a team managed by Kent County Council (KCC). This began well, but an organisational transformation in mid-2015 coincided with the service she received deteriorating. There were shortcomings and missed opportunities, which have resulted in two recommendations from this DHR.
- 6.4 Emily was registered at the same GP practice from the age of four years and she saw various GPs during her life. As well as mental health problems, she

presented at her GP practice for physical health conditions. She was diagnosed with hypothyroidism in 2014.

- 6.5 About the time of her eighteenth birthday, a GP referred Emily to Thinkaction, a charity specialising in talking therapies. She was interviewed but did not meet the criteria for their services. Because of her anxiety, Emily often attended appointments with her father. This was the case at Thinkaction, and a recommendation is made that the organisation should seek time alone with potential clients, to help assess if they might be under duress. A second recommendation for Thinkaction is to consider a specific prompt for interviewers to consider the possibility that a potential client might be a domestic abuse victim.
- 6.6 In a period of a year between late 2015 and 2016, Emily was referred three times by her GP to Kent and Medway NHS & Social Care Partnership Trust (KMPT), the secondary mental health services provider. On each occasion, she was assessed as not meeting the criteria for its services.
- 6.7 Following the third occasion, the GP was recommended to refer Emily for further cognitive behavioural therapy and to the KCC Primary Care Mental Health Team (PCMHT). This team is staffed by qualified social workers, who provide support in the community to people suffering from mental health conditions. Emily was assessed by PCMHT staff and referred appropriately to the Kent Enablement & Recovery Service (KERS), which is managed by KCC. The KERS response began well, but there was no clear rationale supporting her case being closed. A second referral to KERS was refused, which showed a lack of flexibility. A recommendation is made about these issues.
- 6.8 KMPT provided secondary mental health care services in the last five months of Emily's life, when her mental health problems deteriorated significantly. During this period, she met or spoke to many professionals; there was no consistency due to the delay in the appointment of her Care Coordinator. A request for a carer's assessment was not actioned, which was significant because of the pressure Clive was under. The CMHT that was managing Emily's case was understaffed to the point where it could not deliver an appropriate level of service; there was no recorded effort to use KMPT's greater resilience to deal with this. A lot of learning points were identified for KMPT, resulting in 10 recommendations.
- 6.9 Emily was involved with Kent Police during the review period and its actions were appropriate. In 2017, she self-referred to Porchlight, a charity for homeless people. Its staff were sufficiently concerned about her mental health issues to make a safeguarding referral, which was good practice. A recommendation for Porchlight is to consider putting a prompt on its computer system to consider

asking callers to its service about domestic abuse.

- 6.10 Throughout her life, Emily relied heavily on her parents, particularly Clive. In her interactions with organisations, he was nearly always present and spoke for her. This continued when she was an adult, to the extent that a GP discussed with Clive the implications of prescribing medication to Emily – a recommendation arises from this.
- 6.11 Clive changed his working hours to night shifts, so he could take Emily to and from college, where he would sleep in his car during the day. He was Emily's primary carer and as her mental health deteriorated, he expressed the difficulty he was having performing this role. During this period, Emily was sharing her time between the homes of her mother and father, who had separated more than ten years previously.
- 6.12 In July, Clive strangled Emily at his home. He then went to her mother's home, where he attempted to kill her. She was able to escape and run to a nearby police station. Clive went there a short time later and told officers that he had killed Emily. They found her body at his home. There is no recorded evidence from organisations of Emily being a victim of previous domestic abuse.

## 7. Conclusions

- 7.1 This was a tragic case because all the information available to the review, both from agencies and family members, suggests that Clive loved Emily and was devoted to trying to provide the best care he could for her. There is no evidence that she was the victim of domestic abuse at any time before the act that led to her death. Equally, there is nothing to suggest that Clive had planned her death.
- 7.2 Two incidents that may have been physical assaults are highlighted in the review, one committed by Clive, the other by Emily. Both fit the definition of domestic abuse, but neither Clive nor Emily could be described as domestic abusers. The incidents were minor and took place in a very stressful family environment. What separates family conflict from domestic abuse is coercion and control of one party by another. There is no evidence of deliberate coercion and control in this case.
- 7.3 When sentencing Clive, the trial judge said to him *'In any view, Emily had considerable needs. You supported her, as any good father would, and you spent a vast period of time with her. You tried to seek out the best treatment possible. You tried to the best of your ability and within the framework of the income you had.'* No information available to this review contradicts that.
- 7.4 The involvement of individual agencies is considered in detail in the Overview

report and recommendations are made where it appears there are opportunities to improve the treatment, care and service provided in the future. However, two key issues arise from this case. First, the treatment and care available to people living in the community, who suffer from chronic mental health conditions.

Second, how agencies can better identify and support carers who are suffering from stress and approaching a point where they can no longer cope.

- 7.5 Emily had suffered from mental health issues, for which she had received treatment, since she was a child. She was treated by CAMHS and her discharge before she reached adulthood was appropriate.
- 7.6 There is evidence from staff at the college she attended that her anxiety, particularly around relationships with her peer group, was severe. This was to the extent that she could not study for a qualification it was likely she would have gained based on her academic ability.
- 7.7 It was after leaving college that Emily's mental health deteriorated to a point where she needed support from Kent and Medway NHS Social Care & Partnership Trust (KMPT), the secondary mental health care provider in Kent. She came under KMPT treatment and care when her local Community Mental Health Team was facing a dire staffing situation, which ultimately led to it withdrawing services from current patients. Patients were able to contact the Crisis Resolution and Home Treatment Team if in crisis, but by this time Emily was in crisis almost daily. She needed a coordinated and sustained approach to her treatment and care and this was withdrawn from her.
- 7.8 The decision to do this was not based on individual patient need; there is no evidence that a risk assessment was carried out on patients before the decision to withdraw treatment and care was made. The review does not draw conclusions from the proximity of the decision, taken in early July 2017, to Emily's death less than three weeks later but it would have been clear to her (and Clive) that any coordinated treatment she was receiving was being withdrawn.
- 7.9 NHS staff, from those delivering services to patients to senior leaders, are facing the challenge of increasing demand on limited resources. This has been building for several years and continued as this review was conducted. Difficult choices are having to be made and deciding to withdraw a service provided by the CMHT that was treating Emily was one of those. It is important that individual patient care is demonstrably the overriding factor.
- 7.10 Through no fault of Emily's, caring for her placed great demands on Clive. She craved his presence and attention, relying on him to organise her life. The strain

he was under increased as Emily grew older and his change to night working shows that he was doing his best to adapt to her needs.

- 7.11 There was frequent reference by professionals dealing with Emily about the tension between her parents. There is no evidence that this was explored after family therapy was abandoned in early 2014 and this may have been because as an adult, the role of her parents in her life ceases to have the significance for professionals that it does for children and adolescents. However, as her parents were her carers, some support might have been helpful.
- 7.12 Caring for a loved one with a long-term illness, physical or mental, can be very demanding. This has been recognised and the Care Act 2014 places a duty on local authorities to assess whether a carer has support needs. Identifying these is fundamental to ensuring that the person with care needs is safeguarded. S.10 of the Act sets out the duty in relation to an adult caring for another, S.58 does this for carers of children who are likely to require continuing care after they reach the age of 18 years.
- 7.13 The Act places the duty to conduct carer's assessments on local authorities, but all agencies with a responsibility for safeguarding children and adults must be aware of its requirements. For example, the police or a health agency may become aware of concerns about a carer's resilience or ability to cope before the local authority. They should then make a referral.
- 7.14 For months before Emily's death, Clive had been telling professionals that he could no longer cope. His work involved caring for children with special needs, so most of his waking life was spent caring. When Emily left college, the support she had there and the relief this gave Clive stopped.
- 7.15 The agencies that engaged with Clive, either directly or as Emily's father and carer, knew that he was under strain because he told them. Opportunities were missed to offer him a carer's assessment and when he accepted an offer, it was not followed through. The tragic outcome of this case must reinforce to agencies, the value of carers, who provide a vital part of the treatment, care and support of those suffering serious, chronic health conditions both mental and physical. Failing to consider the carer's needs could have a serious adverse effect on the patient.
- 7.16 As well as these key issues, there are some other considerations that do not lend themselves to recommendations, but which are worthy of reflection and consideration.
- 7.17 There was frequent reference by professionals dealing with Emily about the tension between her parents, who were her carers. This was relevant enough to

be recorded on numerous occasions, but no agency sought to address this, even by speaking to them about it separately or together. The tension that was evident in the presence of professionals and Emily, would almost certainly have been taking place in the home. The significance of tension between carers looking after a person suffering from extreme anxiety seems to have been lost.

- 7.18 Family therapy was abandoned in early 2014 because of the tension between Emily's parents. Once she became an adult, the role of her parents in her life ceased to have the significance for professionals that it does for children and adolescents. However, as her parents were her carers, some support for them might have been helpful.
- 7.19 Emily was spoken to with Clive present on many occasions and it is positive that some professionals recognised that this was not always helpful. Others made no attempt to speak to her alone and while she wanted him present, this indicated a lack of appreciation of safeguarding issues. In addition, it would have encouraged dependency on him, which in turn may have increased the strain he was feeling.

## **8. Lessons Identified**

- 8.1 Professionals must understand that the demands of caring for a loved one can place such strain on a carer that tragic consequences may result.**
- 8.1.1 The strain that Clive was under is a significant issue in this review and professionals must recognise that such pressure may put both the carer and the cared for at risk.
- 8.1.2 The provisions of the Care Act 2014 relating to carers must be understood and implemented by professionals dealing with cared for people.
- 8.2 Professionals should seek to speak to patients, clients and service users alone for at least part of their consultation whenever possible.**
- 8.2.1 This may not always be possible because the patient, service user or client may not wish to be alone. Professionals should respect this but be alert for any indication that they are being pressured into this decision. The aim is not to exclude family or others who care for and about the person but to ensure that the person's safeguarding is not at risk.
- 8.3 Professionals must not assume that patients, clients or service users understand the structure of the organisation providing them with treatment, support or service.**



8.3.1 Professionals must ensure that patients, clients and service users understand what service they are receiving and from whom. The difference between departments and teams in an organisation will be clear to those working in them but not to a person suffering the strain of a traumatic incident or chronic condition.

**8.4 Organisations must consider the impact that service withdrawal may have on individuals and carry out risk assessments where appropriate.**

8.4.1 Withdrawing service from a person currently using a service may have serious implications for that person. Organisations must ensure that patients, clients and service users understand what it will mean for them and how they can access the service in an emergency or crisis.

**9. Recommendations**

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

	<b>Recommendation</b>	<b>Organisation</b>
1.	Clinical Commissioning Groups in Kent and Medway should advise GPs of the need to share any information they may receive about a patient who is being treated by KMPT, if that information might be relevant to the patient’s mental health treatment or risk assessment.	Kent and Medway CCGs
2.	CCGs in Kent and Medway must ensure that GPs are aware of the legal framework and their duties in assessing the mental capacity of their patients, which takes into account the legal position of parental responsibilities.	Kent and Medway CCGs
3.	CCGs in Kent and Medway must ensure GPs discuss with a patient who has mental capacity, the potential implications and side effects of medication they intend to prescribe that patient, regardless of whether the patient has consented to details of their	Kent and Medway CCGs

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	case being discussed with another person.	
4.	CCGs in Kent and Medway must include the provisions of the Care Act 2014 relating to carer's assessments in local GP training.	Kent and Medway CCGs
5.	EHPS must remind staff of the importance of asking for consent from clients to allow information to be obtained from GPs and other relevant services, to better inform ongoing action.	EHPS
6.	EHPS should examine this case to identify the shortcomings and missed opportunities. It should then confirm that changes have been made to ensure that the voice of the child is clearly heard under the transformed service.	EHPS
7.	in every initial assessment, the Thinkaction assessor should ask for the person being assessed to agree a short time alone with the assessor	Thinkaction
8.	Thinkaction should consider including a heading of 'Domestic Abuse' on its assessment form to prompt the assessor to consider this as a specific issue.	Thinkaction
9.	KMPT must ensure CMHTs participate in conference calls with the SPoA.	KMPT
10.	KMPT should review its use of fax as method of communication and seek to phase it out as soon as possible.	KMPT
11.	KMPT must ensure that access to its Psychological Service is based on the needs of a patient, not on an administrative process.	KMPT
12.	KMPT must review its procedures to ensure that it is clear to their staff what action must be taken when a patient discloses information that causes their risk to be raised to High.	KMPT
13.	KMPT must ensure all its consultant psychiatrists have a clear understanding of how safeguarding should be incorporated into their assessments and	KMPT

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	the actions they should take if concerns arise.	
14.	KMPT must change its Single Point of Access webpage to ensure that it is immediately clear to those in with urgent or emergency mental health needs, what number they can call or text to receive the help that need at that time.	KMPT
15.	KMPT must ensure that clinical professionals and public facing staff understand the Approved Mental Health Practitioner service referral criteria in order that they can advise patients and service users correctly.	KMPT
16.	KMPT must ensure that its staff understand and implement the provisions of the Care Act 2014 relating to carer's assessments	KMPT
17.	KMPT must establish why the request for a carer's assessment was not actioned in this case and ensure that a robust process is put in place to ensure that future applications are correctly managed, and decisions recorded	KMPT
18.	KMPT must consider how it will better manage its resilience in future to ensure that a Community Mental Health Team experiencing a temporary staffing crisis that risks the shutdown of part of its service can be supported and this action averted.	KMPT
19.	KERS must ensure that its staff who make decisions about referrals and case closures understand both the requirements of the operating protocols and the full circumstances of a case before making decisions.	KERS
20.	Porchlight should consider whether an appropriate prompt can be included in the initial screening for the call handler to consider domestic abuse.	Porchlight