Domestic Homicide Review

Martin/June 2018

Executive Summary

Author: Paul Carroll CBE

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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On behalf of the members of the Domestic Homicide Review Panel, the individual organisations involved in this case and myself, as author of this report, I would like to express my sincere condolences for the tragic events that led to the death of Martin and the impact this has had on the wider family group.

1. The Review Process

1.1 This summary outlines the process undertaken by the Kent Community Safety Partnership Domestic Homicide Review (DHR) Panel in reviewing the death of Martin Brown who was a resident in their area.

1.2 The following pseudonyms have been used for the family members in this review as per the table below. Pseudonyms have been used to protect their identities.

Name	**Relationship to Martin Brown**
Donald Brown	Father
Joyce Williams	Mother
Kayleigh Howard	Girlfriend
Rachel Moody	Grandmother

1.3 The process began with an initial meeting of the DHR Core Panel on 3rd September 2018 and a decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Martin Brown (deceased) or the family, prior to the point of death were contacted and asked to confirm whether they had contact with them.

1.4 All agencies who confirmed contact with the deceased or the immediate family were asked to secure their files.

2. Contributors to the review

2.1 Each of the following organisations completed an IMR or short report for this DHR:

- Kent and Medway NHS and Social Care Partnership Trust (KMPT)
- NHS Clinical Commissioning Group (CCG)
- Kent County Council (KCC) Education Safeguarding
- Kent Police
- Kent Adult Safeguarding (short report)
- South East Coast Ambulance Service (SECAmb)
- Kent County Council Children's Social Work Services and Early Help & Preventative Services
- Town A Borough Council
- Clarion Housing Association

2.2 Access to an Independent Office for Police Conduct (IOPC) investigation was provided to the Chair of the Review Panel and was considered by him in the writing of this report.

2.3 Each IMR was written by an independent person from within the organisation concerned. It is a detailed examination of an organisation's contact and involvement with Martin and his immediate family. A member of staff from each relevant agency writes the IMR. That person will have had no previous involvement with anyone subject of the review. Once completed, the review is signed off as approved by a senior manager of the organisation before being submitted to the DHR Review Panel.

3. The Review Panel Members

3.1 The Review Panel consisted of an Independent Chairman and senior representatives of the organisations that had relevant contact with Martin Brown or the wider family. It also included a senior member from Kent County Council Community Safety Unit.

3.2 The members of the panel were:

Paul Carroll	Independent Chairman
Risthardt Hare	KCC Children's Social Work
Kevin Kasaven	KCC Children's Social Work (Later stages of review)
Claire Keeling	Town A Borough Council
Kathleen Dardry	KCC Community Safety
Annie Clayton	Kent Police
Claire Axon-Peters	NHS Clinical Commissioning Group (CCG)
Claire Ray	The Education People - Education Safeguarding, on behalf of KCC
Catherine Collins	KCC Adult Safeguarding
Sarah Fowler	Kent and Medway NHS and Social Care Partnership Trust (KMPT)

4. Author of the Overview Report

4.1 The Independent Chair and author of the Review is a retired Senior Civil Servant, having no association with any of the organisations represented. His career path was within HM Prison Service in which he served from1977 until retirement in March 2013. Roles undertaken during this period included being a Governing Governor, working closely with Ministers in a Prison Service Headquarters setting, before ending his career as an Assistant Director responsible for oversight of 12 Prison establishments. His experience and knowledge include issues relating to domestic abuse and surrounding legislation. He has a clear understanding of the roles and responsibilities of those involved in working within a multi-agency approach required to deal with domestic abuse. He has a background of conducting formal reviews, investigations, and inspections, including the process of disciplinary enquiries. The Chair has no connection to the Community Safety Partnership, other than chairing DHRs, and has never worked for any of the agencies involved with this review.

5. Terms of Reference for the Review

5.1 The terms of reference for this review are set out in Appendix A of the Overview report. However, the specific issues and purpose of a DHR are set out below.

5.2 Purpose of the Review

- 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;
- 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;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

5.3 Focus of the Review

- The review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Martin Brown.
- 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, the review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

6. Summary Chronology

6.1 At the time of his death Martin, a white male, was in his early 20s. Agency records of his ethnicity include ‘British’, but also recognise a Gypsy Roma and Traveller background. He apparently lived at a variety of addresses wherever he could be accommodated as he had no fixed abode. He is recorded as having a girlfriend (Kayleigh) with whom he had a child. At the time of his death Kayleigh was expecting a further child.

6.2 Martin was born in the 1990s, the first-born child in the relationship between Donald Brown and Joyce Williams. The family had links to the travelling community and Martin was recorded as being close to his grandparents as part of that wider family group.

6.3 Martin did not come to the attention of the authorities or supporting agencies during his early years. In 2001, aged six, he began to attend school where he was described by staff, as being, well-mannered and having an excellent attitude towards school. However, it was not long before concerns began to emerge about his level of attendance. There appears to have been limited success in engaging with him or his parents and the situation continued.

6.4 Martin moved to secondary school in 2006, where his attendance continued to raise concerns, being well below the accepted target level of 90%. In December 2006 the first indication of violent behavior occurred when Martin punched another student in the head. A pattern of disruptive behaviour emerged leading Martin to a recurring number of detentions. In February 2008, Martin carried out a physical assault on another student causing significant injury when hitting his fellow pupil with a hockey stick. Martin was given a one-and-a-half-day exclusion for this attack. Following this incident and his return to school Martin continued to be disruptive but also ignored any detention orders made against him and simply did not attend.

6.5 In March 2010, Martin's maternal grandfather, to whom he was close, died. The event is seen as having a significant impact on Martin, yet there is little evidence of any supportive interaction being given either at home or at school. In the same month Martin is recorded as being continually abusive at school and received a further one-day exclusion as a result of his behaviour. In April 2010, Martin was recorded as being an appropriate pupil for referral to an eight-week anger management program of specialist intervention at another school site. Whilst this event is recorded on his school record, there appears no record of how long he attended or any outcomes or follow up from that event.

6.6 In June 2010, following an incident between his sister and a fellow pupil, Martin attacked the pupil causing significant injuries. This was the first occasion that Martin would have contact with the Police. Martin received a Final Warning from the Police and as a result of the attack; excluded from school and referred to a Pupil Referral Unit (PRU). Whilst Martin was required to receive statutory education until June 2011, there is no record of his attendance at the PRU and it appears that Martin simply fell out of the education system at this point.

6.7 Martin appears to have drifted into a life of drug use and supply, coupled with bouts of anti-social behaviour. He is recorded as appearing before the courts in December 2010 following arrest for possession of cannabis. In March 2011, Martin first became known to Specialist Children's Services (SCS), as a result of a referral from a Community Midwife, who expressed concerns around the pregnancy of Martin's mother. Records of this referral are not available having been lost during data transfer between computer systems.

6.8. Martin's behaviour towards his parents became a concern in May 2011, with the first defined request to SCS for help from Donald Brown, his father. These concerns related to aggressive behaviour towards his parents and fears of safety for the younger siblings in the home. In June 2011, a further referral was made by a Youth Offending Team (YOT) Worker, who was engaged with Martin, expressing concern about Martin's violent outbursts and the presence of a knife with which he had made threats to kill. A strategy meeting convened on 3rd June 2011 was

provided with information from the Police that disclosed that Martin had been involved in an incident close to his home for which he had been arrested and he received an extension to a previous referral order. The Police also listed a number of occasions that they had been called to the family home relating to Martin's violent behaviour between February and May 2011. It was clear that the view expressed by the Police was that they considered the risk to other siblings within the family to be such that they might be removed for their safety. In July 2011 SCS completed a Core Assessment and concluded that there was no identified risk to the children from Martin. As Martin did not wish to engage further with SCS no further involvement was recommended.

6.9 Martin's mental health was a cause of concern for his mother, who during February 2011 sought help from the family GP following a violent incident at the home and expressing concerns about his use of drugs and violent outbursts. The GP appears to have offered help and support, but this was dependent upon Martin's agreement which was not forthcoming. In July 2012 Martin's behaviour had continued to bring him into conflict with the Police following ongoing incidents both internal and external to the home. He did attend a GP appointment on the 30th July 2012 made for him by his mother. Treatment was initiated with an anti-depressant medication. Bereavement counselling relating to the issues surrounding the loss of his grandfather was offered but declined. The management of the anti-depressant medication was continued by Martin's GP until October 2013, with appropriate adjustments being made.

6.10 In August 2012 there was a further attack on his mother at the family home apparently following demands for money to buy drugs. Though Police were called, his mother refused to support Police action stating her son needed help for his mental illness and that he was going to see his GP. It appears that in August 2012, Martin had moved out of the family home as he is recorded as having a girlfriend and it seems likely that Martin was spending his time living between his girlfriend's home and that of his grandmother. From this point Martin appears to have had minimal contact with the Police and other agencies apart from an incident in 2013 to which Police were called following an argument between Martin and his girlfriend. In August 2014, Martin's GP records show him as being unable to work due to a back injury, but that he was no longer taking anti-depressants and his mood was recorded as good. Though Police Intelligence continued to highlight Martin as being involved in anti-social behaviour, drug dealing and domestic incidents, Martin appears to have avoided serious conflict with authority. In 2015 Martin became a father but he did not continue to live with the mother and child on a regular basis.

6.11 Martin does not appear to come to the attention of agencies from the end of 2015 until August 2017, when he was recorded as being under the influence of drugs and became abusive to a Housing Association representative who had attended the property of Martin's parents following complaints of noisy dogs. As Martin no longer formally resided at the property and as the complainants were unwilling to give formal statements no action was taken. Later the same day Martin became involved in a fight in the street with his father, Donald. Again, as neither party in the dispute were willing to offer statements the Police were unable to pursue the matter.

6.12 On the 30th August 2017, Martin was taken to Hospital having taken an overdose of prescription drugs. At hospital he is recorded as stating he wished to end his life and was seen by the Liaison Psychiatry Team prior to discharge and onward referral to the Community Mental Health Team (CMHT). Martin was booked a

follow up appointment for the 1st September with the CMHT and also voluntarily attended his GP surgery prior to the CMHT appointment. His GP initiated treatment with an anti-depressant and a short course of diazepam. At his appointment with the CMHT the same day, the outcome was that a further appointment should be made jointly with the Psychiatrist for a review and accordingly an appointment was sent by post.

6.13 Martin attended his GP surgery on the 14th September 2017 where his GP advised Martin to come off the Diazepam. It was noted that Martin was in a better mood and feeling more active. A further appointment with the CMHT was scheduled for the following day, but Martin failed to attend, nor did he attend a further appointment on the 22nd September and the 5th October 2017. Having failed to attend any appointment the 'Did Not Attend' protocol was implemented and Martin discharged from CMHT.

6.14 On the 11th November 2017, Martin, his mother and father were all arrested and charged with assault and affray following an incident in the street in which three people were assaulted. Three days later Martin attended his GP surgery claiming he had been attacked and he was described as appearing anxious. Martin was seeking treatment with Diazepam, but his GP dissuaded him from this course of treatment prescribing an alternative medication. On the 29th December 2017 Martin was found unconscious in a caravan in the rear garden of his parent's house. He had taken a range of differing medications mixed with alcohol. Despite being diagnosed as having pneumonia secondary to the overdose, Martin discharged himself from hospital care following treatment.

6.15 On the 25th January 2018, Police were again called to Martin's parent's home. Martin had assaulted his mother and caused damage to the property, requiring attention from the Housing Association Emergency Repair Team. Martin was arrested and found in possession of drugs. Despite Police attempts to obtain formal statements from both parents as to the nature of the assault they declined to do so and as such Martin was charged with the offence of drug possession. Following this incident, and in discussion with the parents, the Housing Association decided to seek an urgent without notice injunction (ASB, Crime and Policing Act 2018) against Martin to prevent him entering the property with a power of arrest should Martin seek to break the conditions set.

6.16 Concerns were raised about Martin by his father via telephone to the Single Point of Access (SPoA) Team on the 4th and 7th February. These concerns were for his mental health as on one occasion Martin was recorded as considering jumping from a bridge to end his life, and on the other that he had tried to hang himself with a belt which had broken during the act. Martin attended the CMHT and an action plan was agreed to address the issues identified which included low self-esteem, lack of benefits and having no fixed abode. On the 5th March 2018 after a Social Work assessment had been updated Martin was referred to the Kent Enablement Recovery Service (KERS) for the purpose of addressing his social care needs. It appears that Martin, despite being offered three appointments, did not attend leading to closure of the referral.

6.17 Further incidents were reported to the Police between the 15th April 2018 and the final incident leading to Martin's death in June 2018. On the 15th April, three incidents were reported on a single day. One appears to be a call about threats to an Aunt although there appears to be little substance in this allegation, whilst the other two calls concerned disputes between Martin and his partner who reported an assault and a verbal argument as successive incidents. On the 15th May a call was received from Martin's father stating Martin was at the parent's home and

causing trouble. This turned out to be erroneous but later that day, an incident did occur at the house when Martin threatened his father with a knife and assaulted his partner by dragging her by the hair. Martin was arrested and on this occasion statements taken from both his father and his partner, but the CPS considered that due to inconsistencies in the statements it would be unsafe to charge Martin.

6.18 One day at the end of June 2018 Martin was involved in two incidents that ultimately led to his death. At 18.19hrs that evening Police were called by neighbours of Martin's partner Kayleigh, stating they could hear shouting and were concerned. It was later established that Martin had been at the property before leaving and arriving at his parent's home, where at 18.54hrs, Police received a call from Martin's mother stating Martin was 'off his head' and causing damage at her home. At 19.05hrs it was apparent that Martin had been restrained by his father and Martin was stating that he could not breath. At 19.43hrs the first Police response enters the property and CPR commenced at 19.47hrs, Martin was taken by ambulance to hospital but at 07.46hrs on the following day he was pronounced dead. Donald Brown was initially arrested and charged with the death of his son, but ultimately the CPS advised that he was not to be charged in relation to Martin's death.

7. Key Issues Arising from the Review

7.1 The key issues arising from this review are as follows

- Whether Martin and his family were offered sufficient levels of support and referral to Specialist Children's Services in dealing with the early signs of aggression during his early years in secondary school.

- How and why Martin was allowed to go "off radar" after his referral to the Pupil Referral Unit and the associated poor level of record keeping.

- The lack of depth associated with the Core Assessment and the failure to consider key aspects of the family relating to safety and the lack of exploration of causal factors associated with Martin's needs.

- Whether, given the link to the travelling community apparent within the review, agencies utilised the skills of those experienced within diverse communities for advice and guidance.

- The process driven approach associated with Martin seeking help through Mental Health Services, given the complex nature of his needs, his depth of education and his transient lifestyle all of which required greater levels of professional curiosity to ensure Martin understood outcomes and was contactable by telephone or in writing.

- Failure in communication between agencies that could have taken the opportunity to share information in a formal setting, such as a MARAC, that could have identified interventions to meet Martin's needs and safeguard his family.

- There is an issue for the Police in relation to considering the response to the fatal incident in June 2018. The incident was identified by Force Control room staff as an 'Immediate Response' yet resources were unavailable to meet the need. Kent Police should, in light of this incident, review this case and where necessary report to the Police and Crime Commissioner in regard to resourcing issues.

- The lack of the family's input into this review is regrettable and leaves the review unable to gain valuable insight into the relationship with agencies from the family perspective.

8. Conclusions

8.1 This is a tragic and difficult case involving a father and his son. Conclusions have been drawn where possible, based on the information available to the review.

8.2 It seems apparent that Martin came from a family with complex needs. Martin's aggression towards his family would most probably be correctly identified as Adolescent to Parent Violence and Abuse (APVA) during his younger years. Greater opportunity may have been available for drug treatment, anger management and violence reduction interventions through this program and ultimately events may have not unfolded so tragically.

8.3 Martin's family identified as having Gypsy Roma Heritage. It is understood that they would hold traditional cultural values, which made them protective of their heritage and seeing established authorities such as school and Police as perhaps seeking to change those heritage beliefs or to restrict them by legal process. The importance of family is paramount within this culture and an understanding of such beliefs and working with them is important. It is apparent, that whilst there is mention of recognising this cultural background in several agency reports, little if anything was done to use specialist staff who were available to liaise and work with the family.

8.4 Martin demonstrated early potential at school, but his attendance became irregular and his behaviour unacceptable. It appears the school authorities or attendance officers had little if any success in identifying Martin's problem with his parents. Soon Martin was in trouble continuously until such time as he was excluded from school following an assault, following what he believed to be an act of disrespect against his sister. It was at this point that the Education system appears to lose sight of Martin and where other support agencies were also left unsighted and therefore unable to pick up the pieces.

8.5 Communication between agencies appears poor and there is some suggestion within IMRs that the interventions and support available today were not available to Martin at that time, and that if they were, then agencies would have recognised the issues and referred him appropriately. However, this is not entirely accurate as at that time a significant number of agencies were engaged in delivering addiction intervention, anger management and counselling but in order to commence such interventions the individual needs to be identified and referred, which requires positive communication between agencies, engagement with the individual and ongoing support mechanisms. None of these conditions appeared to be in place for Martin at that time. What is apparent is that since 2010, inter-agency working has improved, particularly around areas of mental health and

domestic abuse referral. It is this aspect of Martin's case that would seem to be of significant concern as IMRs indicate lack of professional curiosity, failure to complete an in-depth Core Assessment and lack of information sharing that may have led to a MARAC review and other possible interventions that would have been available to him.

8.6 Martin's family saw the signs of increased drug use, depression and anger. Often being at the receiving end of the violence as Martin pressured them for money to pay for his drug use. The family are recorded as seeking help either through contact with Health and Mental Health professionals or using the Police and Housing Association to intervene to prevent Martin attending the family home. The family would often prevent the Police from proceeding with charges. They may have been reluctant to contribute to a criminal record for their son. This however, meant that the potentially helpful interventions available to Martin following assessment, ordered by the courts, may well have allowed Martin the opportunity to tackle the issues he was facing on a daily basis and improved the quality of life for the whole family.

8.7 The family, and particularly Martin's mother, sought help for Martin through Mental Health support agencies. However, the treatment they sought depended totally on Martin's engagement, which evidence shows he was not prepared to do and as such Martin was removed from appointments under the NHS 'Did not Attend' protocols. Whilst the help needed had been recognised the ability to deliver appears to have been rejected by Martin. There was some discussion as to whether communications from agencies were always successfully received by Martin. It would not be surprising that Martin did not access correspondence sent to him as it seems likely to have been sent to his parents address where he no longer resided.

8.8 Martin's behaviour leading up to the incident that caused his death show a man becoming increasingly angry with his life situation and increasingly a threat to others. It is of some concern that despite two incidents of domestic abuse against Kayleigh, little action was taken regarding the safeguarding of their child and unborn baby. Whilst Kayleigh appears also suspicious of authority figures and played down the severity of such incidents, her view should not have prevailed over the assessments made by agencies of the safety of her children.

8.9 Following the death, the IOPC commenced an investigation under the Death or Serious Injury protocol, utilised where an individual dies following contact with the Police. The IOPC also considered other aspects of complaints made by the family against the Police. This review has considered the IOPC report relating to the issues surrounding the response to the call from the family for assistance on that evening in June 2018. This review records that the time taken to attend the incident was due to no resources being available to be deployed and that the situation was ongoing for a significant length of time as officers attended other incidents. It cannot be established whether an earlier Police presence would have ensured Martin's survival.

9. Lessons to be Learnt

9.1 The review was informed that at the relevant time the police had insufficient resources to respond to calls classified as needing an 'Immediate Response' due to them being committed to other incidents. This case should be a matter for the Chief Constable to consider and review in order to provide confidence to the public relating to the ability of Police to respond quickly to a serious incident considered by the Police guidance as requiring 'Immediate' response.

9.2 That where a child is excluded from a school and remains of statutory school age, then it is unacceptable not to manage and provide governance around that child until he/she attains school leaving age. Kent now operate a policy of no permanent exclusion for its pupils, with all schools, academies, PRUs and the Local Authority signing up to the protocol. In practice, this means that where there is a pupil at risk of permanent exclusion, education providers work together to ensure the child's education can continue. The child in question remains on the referring school roll until a permanent alternative provision can be found. This together with the systems in place outlined in 6.3.4 of the Overview report provide a safety net for all pupils in the County. In addition, since 2013 it has been a legal requirement for young people aged between 16 and 18 to be in education, employment or training and the local authority is responsible for overseeing those who are not in education, employment, or training (NEET).

9.3 Elective Home Education (EHE) provides freedom for parents to educate their children at home and such a freedom should not be constrained. However, the governance and monitoring arrangements and the effectiveness of the provision identified within this case identifies some worrying issues around the ease at which a child can slip under the radar. This DHR welcomes plans to review and monitor how EHE is delivered.

9.4 That where a child is transitioning to adult services, a risk of a gap in service arises where thresholds may differ, not recognising that needs and risks for an individual do not suddenly decrease when a certain age is reached. This has been recognised in research[1] and is being reflected in Kent and Medway's Safeguarding Adults Policies.

9.5 The agencies involved, whilst recognising the cultural heritage associated with this family, did not discharge their responsibilities in appreciating the diversity issues and utilising the advice of specialist staff in seeking to tackle the issues associated with this family.

9.6 Communication between agencies was not cohesive leading to missed opportunities to intervene early with Martin and his family, at a time when they were conducive to support. The failure to take a "Think Family" approach to the actions of Martin and the safeguarding of his siblings is evidenced within agency IMRs. An example of good practice and a suitable avenue for improved communication may be through the broadening of agency involvement in the Community Safety Meetings held by Community Safety Units. Locally these may be known as the Community MARAC or Vulnerability Forum.

9.7 The issue of professional curiosity amongst professionals is raised in IMRs submitted by agencies. It is evident that such enquiry may have led to key issues of concern being disclosed possibly leading to further enquiry and intervention. Such an approach should be encouraged across agencies. 'Professional Curiosity' as a term is undefined with many staff perhaps frightened to exceed the remit of their role for fear of causing offence, or perhaps considers probing further to be inappropriate. Limitations on resources and capacity will also play a part. It is a subject that should engage all organisations working within the social sectors, medical and support agencies which should be defined and form a part of core staff training. As this is becoming a common theme raised in DHRs as well as Safeguarding Adults Reviews and Serious Case Reviews, work to try and address this issue locally is underway.

[1] Transitional safeguarding - adolescence to adulthood, Research in Practice for Adults. https://www.rip.org.uk/resources/publications/strategic-briefings/transitional-safeguarding--adolescence-to-adulthood-strategic-briefing-2018/

9.8 The engagement of family in these reviews is of great importance. This review provides as clear a picture of events as have been documented. However, the importance of being able to gain clarity on issues and their perceptions about the work of the agencies involved is starkly illustrated within this review where such input was not available.

10. Recommendations

The Review Panel makes the following recommendations from this DHR:

No.	Recommendation	Agency
1	The Chief Constable should review this case and ensure Kent Police understand the issues behind why officers could not deploy to an 'Immediate Response' call in the required timeframes. The Chief Constable to provide the outcome of this review to the Police and Crime Commissioner and report on whether resourcing could be structured differently to mitigate this risk.	Kent Police Chief Constable
2	The Department of Education should seek to progress the implementation of their proposed legislation intended to address the issues raised regarding registration of school age children and the monitoring and assessment of those engaged in EHE.	DoE
3	All agencies should review their policies to ensure that recognition of the travelling community and other hard to reach communities is included and that the policy identifies and allows utilisation of existing resources available in support of their work with these cultural groups.	All Agencies
4	Agencies need to be aware of the Home Office guidance around Adolescent on Parent Violence and Abuse and develop strategies within their organisation to both recognise and support parents and children within this setting.	All Agencies
5	The definition and use of the concept of 'Professional Curiosity' should be defined for use within all agencies nationally. Care professionals should embed the defined concept within their policies and staff understand this good practice through ongoing training and work-place delivery.	Home Office
6	That agencies should ensure they have up to date contact details for a client to ensure that correspondence or telephone calls are sent to the appropriate location or telephone number. This is particularly relevant where it is apparent that a client may not have stable accommodation arrangements in place.	All Agencies