Domestic Homicide Review

Martin/June 2018

Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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Contents

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Martin Brown

The key purpose of a Domestic Homicide Review (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.

Scope

This report of a domestic homicide review examines agency responses and support given to Martin Brown, a resident of Kent prior to the point of his death in June 2018.

In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

This review examines the contact and involvement that organisations had with Martin Brown and his family between 1st March 2011 and his death in June 2018. In order to meet its purpose, this review also examines the contact and involvement that organisations had with immediate family members.

Timescales

This review began on 3rd September 2018 following the decision that the case met the criteria for conducting a DHR. Due to the circumstances of the death, specialist pathology was required to establish cause of death. This in turn would influence decisions taken by the Police and Crown Prosecution Service (CPS) relating to criminal charges. Furthermore, an investigation of a complaint made to the Independent Office for Police Conduct (IOPC) added to delays in completion of this review. However, Panel meetings were held on the 14th February 2019 and 15th July 2019 to progress the review as far as possible within the constraints and ultimately the review was completed on 25th January 2020, with the action plan to be completed shortly after in early 2020. The Coronavirus, public health crisis interrupted the progress and ability to complete the action plan, which was finally completed in August 2020.

Attempts were made to contact and engage with the family as per the Home Office guidance; the first letter was sent in January 2019 to inform them of the review, the second letter to follow up and give them the opportunity to contribute to the review was sent in April 2019 and the third letter was sent in August 2019, this was to inform the family that the report was nearing completion and would shortly be submitted to the Home Office and ask if they wished to review the report before this is done.

1. Methodology

1.1 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 the 3rd September 2018. It confirmed that the criteria for a Domestic Homicide Review had been met.

1.2 That agreement was ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office was informed.

1.3 This Overview Report is an anthology of information gathered from Independent Management Reports (IMR) prepared by representatives of the organisations that had contact and involvement with Martin Brown and the family between 1st March 2011 and Martin's death in June 2018.

1.4 An IMR is a detailed examination of an organisations contact and involvement with Martin and immediate family. It is a written document submitted using a template. A member of staff from each relevant agency writes the IMR. That person will have not been involved 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.

1.5 Information from meetings with family members was sadly unavailable as despite efforts to encourage the family to contribute to this review, they declined to participate.

1.6 The terms of reference for this review are set out in Appendix A to this report.

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

1.8 This report has been anonymised and all pseudonyms were agreed by the Panel in lieu of family involvement. Names that are widely used in society have therefore been utilised to support anonymisation.

2. Involvement of Family

2.1 It is the desire of the Chair, Panel Members and all engaged in the preparation of this review to extend their condolences to the family of Martin for their loss in such difficult circumstances and at such a young age.

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

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

2.3 The Independent Chairman contacted Donald Brown by telephone requesting the opportunity to meet with him and any other family members having explained the role and purpose of the review. This was followed by sending all respective family members formal information regarding the DHR Process and an invitation to participate. A further call was received from Donald Brown, who was seeking clarification about the review process, which was provided to him by the Chair, with a further invitation to meet. Sadly, none of the family have chosen to contact the Chair or supporting staff regarding this review. This decision after such a tragic event is respected. Due to the limited contact, discussion around further support and advocacy has not been possible. It is noted that the valuable insight and perspective offered by the family is not available to this review. Therefore, a proportionate review has been undertaken with the aim to draw learning as best possible.

2.4 During the course of the review an update and further invitation to participate was sent to the family.

2.5 Following the final Panel meeting, the Independent Chairman wrote to the family offering a further opportunity to meet. The intention being to discuss the Overview Report's contents, conclusions and recommendations. There has been no response to date, and as the family were initially disinclined to engage in the process, the review and report has been completed without that input.

3. The Review Process

3.1 Contributors to the review

3.1.1 Each of the following organisations completed an IMR or a 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.

The authors of each individual IMR, or short report, were independent and prepared by an appropriately skilled person who has not had any direct involvement with Martin Brown or the family, (except in the case of Clarion Housing, where the small staff group available did not allow this flexibility) and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

3.1.2 Access to an IOPC investigation was given to the Chair of the Review Panel and information therein considered in the completion of this review.

3.2 The Review Panel

3.2.1 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.

3.2.2 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)

3.3 Author of the Review

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 between 1977 – 2013, having been a Governing Governor, worked closely with Ministers in a Prison Service Headquarters setting and finishing 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 Kent Community Safety Partnership (other than in the capacity of Independent Chair for DHRs) and has never worked for any of the agencies involved with this review.

3.4 Review Meetings

The Review Panel met first on 19th October 2018 to discuss the Terms of Reference, which were then agreed by correspondence. The Review Panel met on 14th February 2019 to consider the IMRs. The next meeting of the Panel was held on 15th July 2019, where the first draft of the Overview Report was reviewed, considered and amendments proposed. Over the next few months Panel members engaged via email to assist in the shaping of the final version of the report, and a final circulation of the report for agreement was undertaken during January 2020.

3.5 Parallel Reviews

This review has progressed, focussing on the events prior to the death. The IOPC commenced an investigation under the Death or Serious Injury protocol, utilised where an individual dies following contact with the Police; and relating to a complaint that was made regarding the conduct of the Police. The outcomes of their investigation have been used to draw conclusions and recommendations within this Domestic Homicide Review.

A Coroner's Inquest into the death of Martin Brown was scheduled for April 2020. However, this did not take place until September 2020, likely due to the Covid 19 Pandemic. The medical cause of death was given as multiple organ failure and hypoxic brain injury, cardiac arrest (resuscitated), prone restraint with positional asphyxia in a person with high body mass index and mixed drug use.

3.6 Equality & Diversity

The review has considered the nine protected characteristics under the Equality Act 2010. The Panel considered that there may have been aspects of this case that surrounded understanding of the Gypsy Roma and Travelling community and how agencies actions relate to the culture, beliefs and concerns of these community groups. The impact that this may have had on access to services and agency engagement is considered throughout this review. Whilst the Panel did not consult directly with experts in the Travelling and Roma communities, this report recognises that this would have been good practice. Additionally, Martin's age and his transition from youth to adult services is considered within the review.

3.7 Publication

This Overview Report will be publicly available on the Kent County Council website and the Medway Council website.

4. Background Information

4.1 Events Surrounding the Death of Martin Brown

4.1.1 At the time of the fatal incident, Martin was not living at his parents' home. His Parents, Donald Brown and Joyce Williams were living in Kent with their other children. Martin was the eldest son but had been excluded from the home by way of a court injunction following an incident where he had caused damage to the property.

4.1.2 On an evening in June 2018, Police were called to the home of Donald Brown where there was a report of a disturbance. Martin Brown had gained access to the house. An argument ensued which turned violent and Donald Brown had restrained Martin Brown and called for Police assistance. Donald continued to restrain Martin whilst waiting for the Police to arrive. It is apparent that this continued restraint led to Martin suffering cardiac arrest and asphyxia. Despite the efforts of the South East Coast Ambulance Service to resuscitate Martin, he was transported to Hospital where he subsequently died.

4.1.3 The Police response and time taken for emergency services to attend the scene are matters that are the subject of the IOPC following a complaint from the family.

4.2 Summary of Relevant History

4.2.1 Martin Brown

4.2.2 At the time of his death Martin was a white male 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.

4.2.3 Martin was brought up within a family which had links to the travelling community and where agencies can be viewed with caution. Whilst described as well-mannered and having an early excellent attitude towards school, concern was soon apparent about his attendance.

4.2.4 Martin attended school from 2001, aged six. In 2006 Martin moved to secondary school, where his attendance again caused concern. He was consistently averaging around 80% attendance, well below the target average currently set at 90%. In December 2006, the first incident of physical aggression was recorded after Martin punched another student in the head, leaving him "red and swollen". Martin began to demonstrate more disruptive behaviour leading to detentions as a recurring theme. In February 2008, Martin carried out a physical assault on another student hitting him with a hockey stick. Martin received a 1.5-day exclusion. From this point until June 2010, Martin failed to attend detentions set by staff and received numerous isolations on a regular basis. Whilst his school reports did record that he worked excellently in subjects he liked, his overall demeanour and behaviour was disruptive.

4.2.5 In March 2010, Martin's maternal grandfather, to whom Martin was closely attached, died. The event had a significant impact on Martin though there appears to be no record of any interaction being taken in support of Martin either at home or within the school environment. In the same month as this event occurred Martin is recorded as being abusive and disruptive and given a one-day exclusion from school. In April 2010, Martin was identified as being able to benefit from an eight-week anger management program of specialist intervention at another school site. Whilst this is recorded within his school records it is not clear how long he attended and what outcomes were achieved.

4.2.6 In June 2010, when Martin was sixteen, his aggressive behaviour reached a peak. An incident occurred where another student was alleged to have kicked a football at Martin's sister. Whether this action was intentional or accidental it enraged Martin who punched the student to the floor causing bleeding and other significant injuries. The matter was referred to the Police and due to the viciousness of the assault and lack of remorse from Martin outlined in the Vice Principal's statement, Martin received a Final Warning from the Police with any further action until Martin was eighteen resulting in Court action.

4.2.7 Martin was excluded from school but was offered a place at a Pupil Referral Unit (PRU). Their involvement closed in October 2010. Martin was required to receive statutory education until June 2011, but there is no record either from the Attendance and Behaviour Service, Children Missing Education (CME) or the Electively Home Educated (EHE) team to show whether Martin was reported to be off role and it appears that Martin simply fell out of the education system at this point.

4.2.8 It appears that Martin drifted into a life of drug use and was suspected of also supplying drugs to others. His behaviour was described as anti-social and he soon became known to Police. Martin first became known to the courts on the 9th December 2010 following his arrest for possession of cannabis. Between 2010 and May 2018 Martin had been arrested on eight occasions for offences ranging from public order, violence and drugs.

4.2.9 Often Police would be called to the home of Martin's parents who would call Police reporting their son was being violent towards them or that he was causing damage to the home. The cause of this behaviour is reported to be that Martin was demanding his parents give him money. They refused to do so as they feared he would spend it on drugs. The parents expressed their concern about Martin's continued use of drugs, his mental health and his anger management issues. Martin's parents did not support prosecutions for these incidents, also withdrawing complaints on occasion. Martin's behaviour is now more commonly recognised as Adolescent to Parent Violence and Abuse (APVA) and support mechanisms such as Family Lives are now in place, though Martin did not benefit from such initiatives.

4.3.1 Donald Brown

4.3.2 Donald Brown was a white British male in his early 40's at the time of the death of his son Martin. There is little in terms of information available relating to Donald, but he was known to Police following an incident with his partner to which Police were called in 2002. There is no record of any further action being taken after the complaint was withdrawn.

4.3.3 Donald is the partner of Joyce Williams. Together they have a family, and Martin is their eldest child.

4.4.1 Other Family Members

4.4.2 The opportunities for agencies to engage and act are complex and need to be weighed against their understanding of the wider family group and whether there were warning signs that could have been acted upon within their engagement with the family. Understanding the family and the complexities surrounding them is important in understanding how agencies may learn from this death.

4.4.3 Of the other children, for long periods they were electively home educated and therefore likely to have been exposed to the actions and behaviour of Martin within the home. The actions of agencies in identifying and acting upon the impact of issues within that setting are necessarily a focus of this review.

5. Chronology

5.1 Introduction

5.1.1 This section considers, in detail, the contact and involvement that both Martin, Donald and the family had with agencies during the period covered by the Terms of Reference. There has been some additional background information recorded in this review that pre-dates the time periods set out in the Terms of Reference, but it is felt that this information is contextual in setting the scene for later events leading to the tragic death of Martin. The facts are based on IMRs submitted by organisations.

5.1.2 Each IMR included a detailed chronology of contact and involvement with Martin and the wider family.

5.2 Chronology/Agency Contact

5.2.1 Martin was required to receive statutory education until June 2011, but as described in 4.2, attendance became an issue. Records show that across the different schools that Martin attended, attempts were made to engage with the parents about this issue., Unfortunately despite his attendance being monitored by the Attendance and Behaviour Service in 2009, there appears to have been little success in increasing his attendance.

5.2.2 Martin first became known to Specialist Children's Services (SCS) in March 2011 as a result of a consultation by a Community Midwife, following concerns around the pregnancy of Martin's mother. The exact details of the concern are unable to be identified due to loss of paper records and the failure to transfer the information from an old computer system to the Liberi system now in place.

5.2.3 The first signs of Martin's behaviour transferring from external disruptive behaviour to that of APVA, became apparent in May 2011, when the first defined request to SCS for support was received from Martin's father. A call was made to the Kent Contact and Assessment Service (KCAS), with his father clearly in distress and struggling to manage the behaviour of his son, then aged sixteen. The father explained that Martin had been arrested for drug-related offences, cited his concerns about aggressive behaviour towards younger siblings and the rest of the household. The request was for urgent action to be taken to find Martin accommodation away from the family home. Records show the call was received by a call handler, there is a record of advice being taken by the Duty Intake and Assessment Team (DIAT). There was no referral opened on the family with the advice being the need to self-explore alternative accommodation and seeking help through Martin's GP and addiction services.

5.2.4 During the period March to July 2011, there were five separate contacts with SCS and it is apparent from records that Youth Offending Services (YOS) were continuing to work with Martin. In June 2011, contact from a Youth Offending Team (YOT) Worker raised concerns about Martin's behaviour reflecting those raised to KCAS by his father. The YOT Worker also added that Martin's violent outbursts included the presence of a knife and threats to kill. This led to a referral being opened. The referral was made to the DIAT and in accordance with S47 of The Children Act (1989), progressed to a Strategy Discussion.

5.2.5 Decisions taken at the Strategy Discussion resulted in SCS leading a single agency child protection enquiry alongside a social work Core Assessment. The aim being to assess the impact and risk presented by Martin to his parents and his younger siblings, alongside the parent's perceived inability to manage this. Organisations who sat at this strategy discussion are listed as SCS, YOT and Police.

5.2.6 During the Strategy Discussion held on the 3rd June 2011, it became evident that Police had several involvements as a result of Martin's violent and drug related behaviour and that they considered the risk to be so significant that children might be removed. There are no records of the response to this expressed view, but certainly provides a clear indicator of the concerns.

5.2.7 Having opened a line of communication with the Police, SCS were advised of other incidents known to the Police when further information came to light. On the 24th June 2011, in an e-mail, Police disclosed information of an incident on the 30th May 2011 where Martin had been arrested in the street close to the family home. Martin had become abusive and aggressive, leading to his arrest and charged with offences under the Public Order Act. On the 23rd June 2011 he appeared before the court following the events of the 30th May 2011, when he had been arrested for anti-social behaviour. At this appearance a previous six month referral order was extended by three months. The Police list seven previous calls to the family home related to Martin's violent behaviour between February to the end of May 2011. This included one incident on the 6th May, when a Domestic Abuse, Stalking and Harassment Risk Assessment (DASH) was conducted and recorded as Medium. It is notable that these incidents were largely unknown to SCS, some involving the father sustaining injuries at the hands of Martin. Little in terms of action was progressed due to the family either being unwilling to progress the complaint or stating that Martin was seeking medical help and not being prepared to make a statement for the Court.

5.2.8 Simultaneously to the Police information being disclosed, SCS were undertaking the Core Assessment on all the children in the family, including Martin. Records show that none of the additional information seems to have been included or explored within the assessment or the S47 enquiry, despite the additional concern and context provided.

5.2.9 The Core Assessment was completed on the 8th July 2011 within required timescales and having seen all the children within the process. It concluded that there was no identified risk of harm to the children and that the family were supportive and well-integrated. However, the assessment also stated that it was "not able to clarify the underlying factors and background factors that had led to the current situation". Martin is recorded as being clear that he did not wish to engage with SCS support and no further involvement from SCS was recommended.

5.2.10 Prior to closure of the case on the 21st July 2011, an Outcome Strategy Discussion was held on the 15th July 2011. This meeting confirmed the view that the children were not judged to be at risk of significant harm. Despite their previously stated concerns the Police did not challenge this outcome. It is recorded that the Police were not present at the meeting with the outcome being communicated to them via a telephone call during the meeting. Similarly, the YOT Worker who initiated the process was also not present and there is no note as to the views of YOT regarding the outcome.

5.2.11 Within a week of the closure of the case, SCS received a further contact from YOT following a visit to Martin at his home about his agitated and verbally aggressive behaviour. The call records concern about the presence of a toddler and that his mother, then pregnant, failed to intervene to correct this behaviour. This report appears to contradict the findings of the Core Assessment and to indicate possible ongoing risk within the family. There is no indication from records viewed that there was any further response or action taken in respect to this call.

5.2.12 From the records examined during this review, it is apparent that Martin's mother was concerned for her son's mental health. Martin first came to the attention of his GP following an incident during 2011 and the GP offered support. This appears to have been ignored by Martin and no medical intervention was further considered until July 2012.

5.2.13 By this time Martin was identified by Police intelligence as being a cannabis user and dealer in the area, resulting in several incidents such as a 25-person street disturbance thought to be related to drugs. Despite having the intelligence pertaining to Martin, little by way of action appears to have been taken.

5.2.14 On the 30th July 2012, Martin attended his GP surgery as an appointment had been made for him by his mother. Here he expressed frustration and anger at the way he perceived life was treating him. He was upset about the death of his grandfather and expressed concerns relating to his lack of employment, relationships with his parents and girlfriend and use of cannabis. The doctor records Martin as being a difficult angry man with slight signs of raging self-trauma. Martin was offered but declined bereavement counselling and the GP initiated treatment with an anti-depressant, fluoxetine hydrochloride. This treatment was monitored and reviewed by the GP until October 2013, with appropriate dosage adjustments made and support given.

5.2.15 Police record a further call to the family home in August 2012 where Martin is reported to have pulled and kicked his mother. She refused Police action stating that her son was suffering from Mental illness and wanted help for him. Follow up enquiries confirmed she had made an appointment for him with the GP.

5.2.16 By 2012, Martin is recorded as having a girlfriend though the exact nature of the relationship was unclear. By August 2012, Martin is no longer resident at his parent's home. There was telephone conversation with the Housing provider where Martin's mother informed them that he had left. It seems likely that Martin was residing between his girlfriend's home and his grandmother's house, which was close to his parents' home.

5.2.17 In August 2013 Police attended in response to a verbal argument between Martin and his girlfriend Kayleigh. Kayleigh was spoken to separately and she stated the argument was very minor. A DASH assessment was conducted and assessed as standard. In 2015, the couple had a child. Martin and Kayleigh would attract Police attention in relation to suspicious activity, drugs and related arguments and fights.

5.2.18 In August 2014, his GP records that Martin had been unable to work due to a back injury. He was no longer taking his anti-depressants and his mood was recorded as good. From this point on Martin's engagement with agencies becomes limited, though intelligence recorded by Police show incidents of anti-social behaviour, drug dealing and domestic incidents. His parents continued to seek assistance in managing his aggressive behaviour and demands for money.

5.2.19 On the 11th March 2015 both Martin and Kayleigh were stopped by a Police patrol. In conversation Kayleigh declared she was pregnant. It appeared that Martin was the father as she referred to him as her partner. It is unlikely that this random patrol would have had access to the history surrounding the couple, as if known, it would have enabled there to have been consideration for a child protection referral.

5.2.20 Records show that during the latter part of 2015 and through 2016, whilst Martin is seen as the main drug dealer in his local area, contact with agencies appears limited. Intelligence continued to be gathered by Police. In August 2017 an incident occurred at the home of Martin's parents. Martin is recorded as being under the influence of drugs and was aggressive and verbally abusive to the Housing Association representative who had attended the property in response to complaints. Neighbours had complained about dogs being kept at the property and causing a nuisance. Whilst the situation was resolved without any violence, information regarding the drug use was passed to the Community Safety Unit, and as Martin was not the tenant at the property the Housing Association took no formal action. As the complainants were not prepared to make formal statements no other action was pursued.

5.2.21 Later that day Police responded to the home of Martin's parents. There had been a fight in the street between Martin and his father. Both sustained injuries. Martin and his father were arrested but would not support a prosecution against the other party. Martin's father was advised that, as Martin no longer lived at the home address, he could consider an injunction preventing Martin coming to the house. DASH was refused by both parties, but an assessment was conducted that was shown as Medium risk due to the number of previous incidents.

5.2.22 On the 30th August 2017, Martin was taken to Hospital following an emergency call to the Ambulance Service. Martin had taken a deliberate overdose of Promethazine and Co-Codamol. On arrival at hospital he is recorded as wanting to see the Crisis Team and stating he wished to end his life. Martin was seen by the Liaison Psychiatry Team prior to discharge and referred to the Community Mental Health Team (CMHT). Martin attended an appointment with the CMHT on the 1st September 2017, where-after it was planned to offer a further appointment jointly with the psychiatrist for a medication review and accordingly an appointment was sent by post.

5.2.23 It appears that in between his hospital admission and the appointment on the 1st September 2017, Martin attended his GP surgery. His GP noted the follow up appointment with the Mental Health Team and initiated treatment with the anti-depressant sertraline. Martin was seen at his GP surgery by a nurse the following day. The outcome of his attendance was recorded with the Mental Health Nurse. A short course of the anxiolytic drug, diazepam, was prescribed.

5.2.24 On the 14th September 2017, Martin attended his GP surgery, where it was noted that Martin had an appointment the following day with the Mental Health Team. Martin reported that he was feeling better and able to walk the dog for ten minutes or so. It was noticed that Martin remained restless and made some eye contact but was eager to leave the consultation. The decision was to wean Martin off the Diazepam and hold a further review in two weeks. It is recorded in the CMHT notes that Martin failed to attend for his scheduled appointment on the following day. This was later attributed to Martin having an upset stomach. Further attempt to re-arrange an appointment by telephone on the 22nd September was unsuccessful.

5.2.25 By the 5th October 2017, Martin had failed to attend any appointments with the CMHT, who had also been unable to contact him. As such the decision was taken to implement the "Did Not Attend" protocol. A letter was sent to both Martin at his stated address and to his GP, providing reasons as to why he had been discharged from the CMHT and offering advice in terms of organisations who might offer useful support.

5.2.26 On the 11th November 2017, Martin, his mother and his father were all arrested and charged with assault and affray following an incident in the street, in which three people were assaulted being hit with an iron bar and shot at with a catapult using ball bearings. On the 14th November Martin is recorded as having attended his GP surgery stating he had been attacked by 'drunken yobs'. Martin was described as being anxious and seeking diazepam but was dissuaded from this course of medication by the GP who provided Sertraline tablets as the preferred medication.

5.2.27 On the 29th December 2017, Martin was found unconscious but breathing in a caravan in the garden of his parent's house. He had been drinking but had also taken a range of differing medications and was taken to hospital. At the hospital Martin was recorded as being aggressive during the admission and refusing to adhere to medical advice. However, staff were able to identify that Martin had aspiration pneumonia, secondary to the mixed overdose. Martin was treated with both a naloxone infusion and a course of antibiotics to treat his chest infection. Martin refused to remain at hospital and self-discharged having been deemed to have the mental capacity to make that decision. It is not clear how Martin responded to treatment but on the 3rd January 2018 an NHS 111 call centre record notes that a 23-year-old man rang advising he had pneumonia but had discharged himself from hospital a few days earlier. He described feeling unwell and was advised to contact a Primary Care Service within two hours. There is no record of any further contact being made by Martin following this call.

5.2.28 On the 25th January 2018 there was an incident at the family home where Martin assaulted his mother and damaged property. Police were called and the Emergency repair team from the Housing Association responded to assess damage and secure the property. Martin was arrested and found to be in possession of drugs. Despite Police efforts to follow up on the initial allegations of assault, both parents retracted their support for a prosecution, leaving Martin only to face charges for drug possession for which he later received a 12-month conditional discharge and ordered to pay a total of £105.00 costs.

5.2.29 This incident led to a DASH assessment being conducted which was assessed as Medium. Safeguarding advice was given including consideration for protective court orders. Martin was described as abusing prescription medication and seen as being increasingly unpredictable with reference being made to other offences to which he was under investigation emanating from the events of the 11th November.

5.2.30 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. In addition, Martin's father also raised his concerns for the safety of his family with the Housing Office of the Local Council, explaining his fears and asking for removal to temporary housing. Following enquiries by the Housing Office with the Police, the decision was made that as Martin was bailed to his grandmother's house and prevented from attending his parent's home for fear of re-arrest then there was no requirement for temporary accommodation. The temporary injunction was achieved within two days with a power of arrest attached should Martin seek to break the conditions set. A full hearing was set for the 6th February 2018.

5.2.31 On the 4th February 2018, a telephone call was received by the Single Point of Access (SPoA) Team from Martin's father advising that Martin was having suicidal thoughts. The clinician spoke to Martin who disclosed that he was considering jumping from a bridge to end his life but said his 'little sister' was with him and stopped him. Martin disclosed that there was an injunction against him returning to his parents' home. Given the nature of the content of the call an urgent referral was opened for him to see the CMHT at 11.00hrs the next day.

5.2.32 Martin attended his appointment together with his sister. Martin discussed many of the issues causing him concern. That he was unable to find a job, had low self-esteem, had no fixed abode and that he was not in receipt of benefits, all of which made him feel stressed. Martin reported that he had self-harmed by cutting in the past and that he occasionally used cannabis. He stated that he hoped the assessment would be able to support him in finding a home and accessing benefits. The action plan developed and agreed with Martin was that he would book an appointment with his GP to discuss medication. Martin was also to self-refer to named organisations to address employment support and to present at the gateway to seek support for housing and benefits advice. The Social Worker agreed to provide a letter to support Martin with his housing application. It does not appear that this was received. [1]

5.2.33 On the 7th February 2018, a further call to the SPoA was received from Martin's father seeking help as he was concerned about Martin. As the case was already open to CMHT the advice was to contact them or emergency services if there is a risk of harm to either himself or others. Later that day contact was made with the CMHT where Martin's father expressed his concerns that Martin was feeling suicidal and that he was found with a belt around his neck. He had tried to hang himself but the belt broke.

[1] It was noted during Panel discussions that since the 'Duty to refer' under the Homeless Reduction Act 2017, enacted in October 2018, it would have been expected for Martin to be referred to a local housing authority. However, this incident occurred before the date of enactment.

It appears that the advice provided following this conversation was to reference the action plan from the previous assessment on the 5th February 2018 with the addition that if Martin feels overwhelmed by his symptoms, Martin should contact the Crisis Team. It appears that Martin agreed with this on the telephone and the Social Worker emphasised to his father that he should keep Martin safe and contact the crisis team if need be.

5.2.34 On the 9th February 2018, Martin is recorded as attending his GP surgery. At that time his GP had not received the referral letter from the SPoA call of the 4th February. It is clear from the notes that the GP was not aware of the matters relating to Martin being barred from his parent's home by injunction. Medication was discussed as well as Martin's feelings around deliberate self-harm. Martin was advised on his medication and a further appointment made for the 12th February. Martin failed to attend the next appointment. He was unable to be contacted via his phone and on the 13th February 2018 a letter was sent to Martin asking him to book another appointment.

5.2.35 On the 14th February 2018, a Multi-Disciplinary Team (MDT) meeting in the CMHT agreed a plan following the assessment with Martin. It was recorded that prior to Martin being able to access Secondary Mental Health Services he must first provide evidence of; support with drug use (as continued use will impact on his mental health); compliancy with medication following self-referral to his GP; referral to primary care nurse/social work to address social care needs. There is no evidence within the records to show that the outcomes were communicated to Martin either by telephone or in writing although this would be an expectation. He had however been advised/signposted following his assessment on 5th February to the drug agency, the Gateway and GP.

5.2.36 There is some evidence to show that Martin may have attended his GP surgery on the 20th February 2018 as there is an entry on the practice's electronic appointment module. However, there are no recorded notes of the consultation. On the 22nd February 2018, there is a record of a telephone call from the surgery to Martin updating him on a DWP certificate relating to his benefits.

5.2.37 On the 23rd February 2018 the Social Worker at the CMHT updated the risk assessment for Martin following her meeting with him on the 5th February. Within this assessment there is no mention of the injunction against Martin nor the reasons why it was in place. It is unclear why this assessment was not updated earlier following the appointment on the 5th February 2018, but in an e-mail dated the 5th March 2018, it is apparent that the delay prevented further referral to the Primary Care Mental Health Team until later that day. He was referred to the KMPT Primary Care Nurse and also to Kent Enablement and Recovery Service (KERS) to address his social care needs. He was discharged from the CMHT. Both referrals were accepted. Appointments were offered and contacts were attempted. KMPT record that they followed up non-attendance at an appointment which was sent to Martin by post, with telephone call attempts. These were successful in eventually speaking directly to Martin, but not successful in gaining Martin's attendance at an appointment. It appears that Martin was offered three appointments with KERS but did not attend, leading to his referral being closed for non-attendance.

5.2.38 Three incidents were reported to Police on the 15th April 2018. The first related to an anonymous call that Martin was threatening an Aunt. When Police attended, Martin was not there and the caller did not provide further information. The Aunt could not be identified. Two calls were also received from Martin's partner/ex-partner Kayleigh. She reported an assault and a verbal argument as successive incidents. Kayleigh declined to give details of the offender, but it was apparent from the information provided that the individual was Martin. Kayleigh reported that her relationship had ended but that she had just found out she was pregnant. DASH was undertaken and assessed as Medium. Due to no formal information being given the case was filed. Relevant information was shared with Specialist Children's Services.

5.2.39 Martin attended his GP surgery on the 25th April 2018 to review his anxiety and depression. He had not attended any appointments with the Primary Care Mental Health Team and his doctor encouraged him to do so. The doctor discussed whether Martin felt able to return to work, but Martin stated he felt unable to do so and was again certified unfit. This was to be the last occasion Martin attended his GP surgery.

5.2.40 After several unsuccessful attempts to contact Martin by telephone the Primary Care Mental Health Team nurse finally spoke with Martin on the telephone (mobile) and an appointment arranged for the 23rd May 2018.

5.2.41 On the 15th May 2018, a call was received by Police from Martin's father advising that Martin was at the home address and was "kicking off". On attendance Police officers were informed that there had been a mistake. Martin's father stated that he had not been at the house but had received a phone call from his wife telling him that Martin was causing problems. As there was an injunction against Martin from attending the property, he had called the Police. Later that day Police received a call from the father stating Martin was threatening him with a knife following an altercation with Kayleigh, who was also at the house. Martin had attempted to drag Kayleigh by her hair during an argument, but his father intervened. When officers arrived at the property Martin ran away but was later seen and arrested. Statements were taken from Kayleigh and Donald and the matter passed to the CPS, but due to inconsistencies in the accounts the CPS refused to charge. Safety planning was completed with Kayleigh at the scene, though she answered 'no' to all DASH questions.

5.2.42 On the 16th May 2018 Martin's mother phoned the CMHT and spoke to a duty contact. She explained that Martin had an injunction against him to stay away from her home, but that the previous evening he had breached it and "kicked off smashing the place up". His Mother expressed the view that Martin needed professional help and may be suicidal. The duty nurse agreed to speak with Martin and did so, providing him advice about his anger issues which he raised and a contact number where he could arrange anger management support. Martin became agitated by the fact that he would have to wait to receive help which he said he needed immediately.

5.2.43 Martin did not attend his appointment with the Primary Mental Health Care Team on the 23rd May 2018 and no contact made. The decision was that as Martin had missed previous appointments, he should be discharged back to his GP in accordance with the Primary Care Mental Health Team (PCMHT) 'did not attend' policy.

5.2.44 One day at the end of June 2018 at 18.19hrs, Police received a call from a neighbour of Kayleigh reporting that a male could be heard shouting from inside the property. It was later established that this was Martin who had attended Kayleigh's home prior to the fatal incident at his parents' home.

5.2.45 At 18.54hrs a call was made to Police by Martin's mother stating that her son was "off his head" and causing damage at her home. Further calls were received from a neighbour. At 19.00hrs the dispatch operator initiated the process for requesting support from the neighbouring Police division. At 19.05hrs it is apparent that Martin is being restrained by his father and Martin states that he cannot breathe. Between 19.12 and 19.39hrs two separate patrol vehicles acknowledged they were on route to the address. At 19.25hrs a further call was received from Martin's sister asking when Police would attend. At 19.43hrs the first patrol arrived, immediately followed by an ambulance and CPR commenced. At 19.47hrs the second patrol arrived. At 19.51hrs information is received that Martin is in danger of passing away from asphyxia. Martin was taken to Hospital but at 07.46hrs he was pronounced dead.

5.2.46 Martin's father was subsequently arrested and released under investigation, pending forensic and pathology reports as to potential cause of death. CPS have also since advised that Donald is not to be charged in relation to Martin's death.

6. Analysis

6.1 Following the family decision to not participate in the review, a proportionate review was undertaken and it is acknowledged that the analysis relating to this tragic death will therefore have its limitations. As such, analysis of agency IMRs, and other relevant and disclosable documents provide the core source of evidence for this analysis.

6.2 Family

6.2.1 Martin came from a large family and was the eldest child. It is reported that he had positive relationships with the other children of the family. It is documented that Martin had particularly close bonds with his maternal grandfather, who died when he was sixteen. It is at this point that Martin is recorded as starting to record symptoms of depression.

6.2.2 The cultural background of Martin's family is not clearly or consistently recorded. Agencies had 'indications' or 'third party information' of such a background which was left unexplored. Greater consideration of these indications and their implications may have assisted the agencies in their engagement with the family.

6.2.3 The health of Martin's mother appeared to have been negatively impacted by the incidents relating to Martin's ongoing behaviour, which can appropriately be considered to have been Adolescent to Parent Violence and Abuse (APVA). The cross-Government definition of domestic violence and abuse is "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 psychological, physical, sexual, financial and emotional abuse". While this definition applies to those aged 16 or above, APVA can equally involve children under 16. The Home Office

provide guidance in relation to APVA[2]. It is clear from the evidence that particularly when Martin was desperate for money to fund his drug usage, he would turn to his parents for money and when refused would use verbal, emotional and physical intimidation against them. Whilst both parents appear to have suffered from both physical and verbal abuse fitting within the identified APVA modelling, they may not have recognised these actions as such. If they did, they would have likely faced barriers in relation to reporting the behaviour. The Home Office guidance, which draws upon the work of Professor Rachel Condry, notes that "it is important to recognise that incidents of APVA reported to the Police are likely to represent a small percentage of actual incidents.....All forms of domestic violence and abuse are under-reported and parents are, understandably, particularly reluctant to disclose or report violence from their child. Parents report feelings of isolation, guilt and shame surrounding their child's violence towards them… Many parents worry that their victimisation will not be taken seriously or, if they are taken seriously that they will be held to account and their child may be … criminalised…. Parents report mixed responses from the Police, which often confirms their fear of being blamed, held to account or disbelieved." It is of course understandable why Martin's parents, whilst seeking Police help to ensure their safety from his attacks, may have later been unwilling to formalise their complaints.

6.2.4 Martin was considered both a user and a supplier of drugs. Evidence shows that Martin would often become violent, especially in the home, when either his father or mother refused to provide money on demand to fund Martin's drug use. Evidence shows that on several occasions Martin and his father's disputes ended in physical conflict.

6.2.5 The family would seek assistance from the Police to help resolve such outbursts of violence. Prosecutions, or other ways of taking these incidents forward with the Police were not supported by the family in the majority of cases. It is not surprising that a parent would not want to support criminal charges against their child.

6.2.6 Martin was known to be the father of a child, together with his girlfriend Kayleigh. Arguments were reported, as well as the assault that Kayleigh reported in April 2018. These incidents necessitated both family and Police involvement to maintain order between them. At the time of his death, a further child was expected. Martin's relationship with Kayleigh appears to be one of an off/on nature as Martin did not appear to co-habit with her on a regular basis.

6.2.7 It is evident that Martin had significant issues with which he was attempting to cope and was himself a very vulnerable person. These issues include Adverse Childhood Experiences (ACEs) which are highly stressful, and potentially traumatic, events or situations. The Centres for Disease Control and Prevention (CDC) in the United States note that ACEs have a tremendous impact on future violence victimisation and perpetration, and lifelong health and opportunity[3]. They also link more than four ACEs with an increased risk of suicide attempts and early death. Martin's suicide attempts are further discussed in section 6.5.

[2] Home Office guidance – APVA
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf
[3] CDC ACEs information https://www.cdc.gov/violenceprevention/aces/index.html

6.3 Education

6.3.1 Martin initially attended school at the age of six and although attendance was an issue, reports throughout his primary education provide an impression of a child who was described as “well-mannered”, “conscientious” and with an “excellent attitude”, all of which provided a positive outlook for his future. Martin transferred to secondary education in September 2006 and his behaviour is noted to have begun to deteriorate from December of the same year. The school employed internal strategies to deal with Martin’s behaviour, including the school reward system and support of a variety of teaching and pastoral staff, but it appears no consideration was given to a referral to other agencies, including Specialist Children’s Services.

6.3.2 Throughout his secondary education, Martin was consistently in trouble for numerous issues, but of particular note were those relating to anger and violence. During Years 9 and 10, from 2008 to 2010, Martin’s behaviour and attendance improved to an extent, but deteriorated significantly from March 2010 onwards. Following a fixed term exclusion for “verbal abuse/threatening behaviour against an adult” Martin was referred to a specialist intervention designed to address his anger with an eight-week course of anger management. Whilst there are reports of this intervention having a positive effect on Martin, by June 2010 he carried out a serious assault on a fellow student. This event resulted in Police involvement, with Martin receiving a Final Warning. He was also permanently excluded from school.

6.3.3 Martin was required by law to receive statutory education until June 2011 and was offered a place at a Pupil Referral Unit. However, there are no records as to whether Martin ever attended the unit as the Attendance and Behaviour Service records, CME and EHE Team files all provide no information as to Martin. It can only be assumed that Martin was able to go “off the radar” of those supposed to be monitoring him, and other evidence seems to indicate that during this time Martin remained at home or was on the streets, unoccupied.

6.3.4 Systems in place now require pupils who attend Pupil Referral Units to also be on a school roll, with the school retaining responsibility for the pupil. Additionally, from September 2019, the revised Ofsted inspection framework judges the effectiveness of leadership and management in schools as to whether learners are able to “complete their programmes of study”, including not allowing off-rolling when the removal is primarily in the interests of the provider rather than in the best interests of the learner.

6.3.5 Within such a large family group, given the situation with Martin’s behaviour, the lack of success in seeking to engage with his parents and the parallel trends being shown by siblings in terms of their school attendance and behaviour, it is difficult to see why consideration was not given to safeguarding referrals at several stages across the period which may have identified interventions and support for the family as a whole.

6.3.6 Whilst not directly relevant to this case, during this review the Panel were advised of an area of concern relating to Elective Home Education, that does not support local authorities in meeting their education and safeguarding duties for children. There is no legislation in place requiring parents to apply for a school place when a child is of statutory school age. Therefore, if they do not do so but decide to educate at home, then the EHE Team will not become aware that the child is not in education and so the education provided

is not monitored. This means that potentially, the education of a large number of children may not be monitored. This appears to be being addressed by the Department of Education who have proposed relevant legislation. These proposals have been subject to a consultation between April and June 2019.[4]

6.4 Specialist Children's Services

6.4.1 Between March 2011 and Martin's death in June 2018, there were some nine contacts with SCS over three key time frames. There was one period of brief allocated involvement with the family in which any formal assessment was undertaken, this being in 2011. Given the extent of the difficulties known regarding the family prior to this time, it is of concern that SCS were not involved and aware of this family earlier.

6.4.2 In May 2011, there was an opportunity for some positive engagement. Martin was 16 and the family were in evident crisis and asking for help. The parents recognised that Martin posed a risk to his younger siblings and that they were unable to ensure safety in the home. Given the family heritage in the travelling community, taking this step to seek assistance was significant. Indeed, later contacts with the family by SCS were met with suspicion and resistance. Sadly, it appears that the opportunity to engage at this stage was missed.

6.4.3 After concerns were raised by Martin's father and the YOT (in May and June 2011 respectively), a Core Assessment was completed in July 2011. This offered the opportunity to seek to understand the problems faced by the family, identify strategies to seek to build interventions and work with the family who at that time seemed open to engagement to solve the crisis they felt they were in. It is of concern then that the Core Assessment did not examine any chronology of events, nor recognise Martin's individual needs, Martin being in transition between Children's and Adult Services. There was no exploration of family history and little consideration of Martin's drug use or how that may have contributed to his behaviour and heightened risk within the family. Communication with other agencies such as the Police who had additional information available did not feed into the analysis either. The Core Assessment did acknowledge some concern around Martin's aggressive behaviour, but the identification of key factors for a sixteen-year-old boy, such as the death of his grandfather, to whom he was close, seem to have been missed.

6.4.4 The Core Assessment recorded that there was an acceptance that violence and aggression in the household was ongoing. This appeared to be between Martin and his parents, and it was concluded that there was "no risk" to the younger siblings. This determination seems based upon the older children saying "they got on well" with their brother and "they had not witnessed" the arguments. There appears not to be any evidence, or specific or direct work that took place to explore the children's experiences further. Consideration of the emotional impact of living in a house where regular and persistent APVA incidents occurred, drug use was evident, and violence seemed an ever-present risk all seem not to have been considered. Poor attendance of the school age children, one child being under school age and therefore at home and the pregnancy of the mother, with the potential risk of "violence in utero", all appear to be factors that remained unexplored. The Risk Assessment focused on Martin's risk to the other children rather than his own needs.

[4] DoE Consultation – Children not in school https://consult.education.gov.uk/school-frameworks/children-not-in-school/supporting_documents/EHE2019consultationpaperv9.5.pdf

6.4.5 SCS were engaged in support of Martin's mother regarding health issues, which she relates as being caused by concerns and arguments with her son, Martin. SCS came to the decision that the threshold for further intervention was not met.

6.4.6 In April 2018, SCS became involved with Martin through referrals in respect of domestic abuse against his "partner" Kayleigh. Kayleigh was the mother of his eldest child and was also expecting a further child. The first referral was as a result of a domestic abuse incident in the street relating to access to his child. The second was raised in May 2018, involving an incident at the house of Martin's parents. During an argument both Kayleigh and Donald were assaulted by Martin. The SCS Central Duty Team does not appear to have considered Martin's full history in making a decision regarding next steps. Other than a transfer to Early Help, no further action was taken by SCS with no contact being made with Kayleigh to discuss the incident and assess the risk to her child and the unborn baby. The case was closed on the 1st June 2018, with the rationale that due to Kayleigh and Martin living separately, there being no previous domestic abuse reports and there had been no injuries, the case did not meet the threshold for Tier 3 services.

6.4.7 The IMR identified a record keeping issue in that there were in fact two separate sets of records on file for Martin on the Liberi Case Management system that SCS use. This presents as an organisational weakness in this case as it could not be established what information sat with which record and how, if at all, information held by the two records were connected and inter-linked. This, given the fundamentally weak Core Assessment can only have provided a basis for further poor decision making in dealing with this family with complex needs.

6.5 Health Care

6.5.1 Martin is recorded as being identified at an early age (16) of cannabis use, self-harming and acting in a violent manner. Over the years that followed, a picture continued to emerge of a young man who was angry, anxious and depressed. This was not helped by his ongoing use of cannabis and a bereavement. Evidence shows that his GP attempted to treat Martin through medication. The offer of bereavement counselling was refused. It is recorded that a period of relative calm in medical terms prevailed until 2017 when, in August, Martin attempted to take his own life via a mixed overdose of drugs. This episode brought him to the attention of specialist psychiatric services. A pattern of missed appointments and lack of engagement with the treatment offered, made ongoing contact with Martin largely limited to his GP who attempted to implement the drug treatment suggested by the Mental Health Team. However, it seems the main purpose of his sporadic GP visits was not to engage with treatment to address the significant issues of Mental Health and drug use, but for the purpose of obtaining medical certificates in order to access continued benefits.

6.5.2 Martin's mental health and drug abuse issues had a significant impact upon the family. The levels of violence displayed towards his parents, often witnessed by the younger siblings, will have created certain levels of stress. The anxiety and problems created by Martin's behaviour left his father in need of medical attention after one incident between them. His mother needed specialist support due to the impact his behaviour was having on her over the years.

6.5.3 The chronology shows four potential suicide attempts; overdoses, hanging and jumping from a bridge. Martin was in his early 20s. The Samaritans' 'Suicide Statistics report'[5], December 2018, records that suicide rates are increasing among young people in the UK and Republic of Ireland. The Samaritans plan to monitor this and increase their understanding as to what is driving this increase. However, from their previous studies they note that "suicide is complex, and it is a problem of inequality. Research shows that it affects the most vulnerable and disadvantaged people in society, both male and female, disproportionately". A 2012 report produced by the Samaritans highlight key areas where males have increased vulnerability to suicide. Many of these factors appear evident in Martin's case and those relevant are listed:

- Background – Men, such as Martin, who in early life lived in deprived/poor circumstances and therefore considered to be at a much higher risk.

- Socio-Economic Factors – e.g. job, class, education, income or housing. Being at the bottom of any or all of these as Martin appears to have been, increases the risk of suicide.

- Emotional Literacy – Reluctant to talk about emotions, men do not recognise or deal with their distress, but let it build up to breaking point. Men are far less positive about getting formal emotional support for their problems and when they do as with Martin, it is at the point of crisis.

- Relationship Breakdown – Whether this be a partner or within a family, the loss of emotional support and separation from children may add to suicidal thoughts or acts.

6.5.4 The Panel considered the attempts by agencies to communicate with Martin to arrange appointments, and how these may have been affected by Martin's living arrangements and the injunction preventing him from entering his parents' home. Some agencies did record attempts to make contact by telephone. Some agencies were not aware of the injunction. Engagement with service users has been highlighted as a common learning theme across Kent and Medway DHRs, Safeguarding Adult Reviews and Serious Case Reviews. A recent learning document is available to support professionals to give broader consideration of what barriers to engagement may exist[6]. This has been co-produced by the Kent Community Safety Team, Kent & Medway Safeguarding Adults Board and Kent Safeguarding Children Multi-Agency Partnership.

6.6 Kent Police

6.6.1 Kent Police had been aware of Martin since 2010. He had been arrested on eight occasions for offences ranging from public order disturbances to violence and drug related matters. Seeking to charge Martin with the offences relating to the arrests proved difficult as the family would either withdraw statements or simply not wish to provide evidence. There remain significant areas where more could have been done especially in terms of safeguarding and the recognition of APVA.

[5] Samaritans – Suicide statistics report
https://www.samaritans.org/documents/268/Suicide_statistics_report_FINAL.pdf
[6] Kent & Medway joint learning document
https://www.kmsab.org.uk/assets/1/joint_learning_from_dhr-sar-scr-engagement.pdf

6.6.2 When Martin first became known to the Police, he was sixteen years old. Martin was already using cannabis and displaying violent behaviour towards other pupils at school. By 2011, Martin was over 16 years old and the violence he was displaying would be categorised as domestic violence. His mother on one occasion rang the Police to record Martin as being "out of control" due to drugs. It is at this early age that there was a need for a multi-agency approach to seek to address Martin's problems and support the family. Whilst there is reference to safeguarding referrals being made and contact with Martin's Youth Offending Support Worker, other agencies such as SCS record being unaware of the information held by Police with little communication taking place between agencies. Despite the number of attendances and the volume of calls about domestic abuse incidents in 2011 there appears to be little in terms of escalation in response, when raising this situation to High Risk would have ensured a Multi-Agency Risk Assessment Conference (MARAC), approach.

6.6.3 As Martin became older, his lifestyle became more chaotic. Police intelligence indicates he was both a drug user and supplier around his local area and that there were often displays of violence surrounding him. With his displays of violence towards his family usually relating to demands for money to buy drugs. The family would call the Police to intervene to prevent further harm to the family but would not support onward prosecutions. There could have been a number of reasons for this, but it is not unique that a parent would not want to support prosecution of their child. It is possible that interventions might have been attached to an order of the court, to support and assist Martin with his addictions and mental health issues had prosecutions been pursued. Martin became a father and reports of domestic abuse against his partner are also recorded. Ultimately Martin's behaviour saw him with a court injunction preventing him from entering his family home.

6.6.4 A key issue for the family is the Police response to the final incident and whether a quicker response following the initial call could have prevented Martin's death. Martin died as a result of asphyxiation and the pathology report concluded that the restraint of Martin by his father was linked to his death. Evidence received from the Force Control Room operatives indicate that Martin is heard telling his father to "let me go, I can't breathe". This was recorded at 19.07hrs yet Police and Ambulance staff only arrived at the home at 19.43hrs, some thirty-six minutes later, despite the call initially having been adjudged as an immediate response.

6.6.5 This matter has been the subject of an IOPC investigation, which concludes that Force Control Room staff, followed procedures correctly, but simply were left with no resources to dispatch to the incident. Indeed, only earlier at 18.16hrs Police were called to an incident at an address, later identified as Kayleigh's home, where reports of a violent argument were reported. At that stage all available resources were unavailable to respond. It was not until 19.20hrs that Police attended the scene by which time both Martin and Kayleigh appear to have left the property. It appears that Kayleigh returned to Martin's family home and that Martin, seeking to continue his grievance, began to smash his way into the house at 18.54hrs. Martin's father is recorded as contacting the Police at that time seeking urgent assistance.

6.6.6 Over the ensuing thirty-six minutes Force Control received several further calls from Martin's sister, asking when Police would be attending. The call from Martin's father was still "live" and so Force Control continued to hear signs of the struggle. Twenty minutes into the call Martin's father requested that an ambulance be called. Ultimately, having seemingly exhausted all calls both within district and across divisional borders for a response, the Duty

Inspector agreed to unusually dispatch two sergeants, whose role was primarily managerial not operational response. At 19.11hrs the response was deployed and upon checking the Police computer system GENESIS, the officers advised that given the warning markers for Martin about being violent and potential possession of weapons, they would be drawing TASER and requested an armed response support, both of which were approved.

6.6.7 An ambulance crew had been dispatched at the request of the Police. The Police provided additional information of warning markers for the address regarding weapons and violence. The ambulance crew were not happy to approach without the Police. They waited at a rendezvous point until Police arrived. They were therefore unavailable to assist Martin at that stage. At 19.43hrs the initial Police vehicle arrived at the house with the armed response team arriving four minutes later at 19.47hrs. The Police entered the property and saw Martin's father trying to give CPR to Martin. Police and ambulance staff immediately assumed responsibility for CPR.

6.6.8 This review has been informed that the IOPC concluded that on the shift in question in June 2018, the Force Control Room (FCR) repeatedly attempted to deploy a Police response, escalating their request in line with force policy. With the attempts to deploy remaining unsuccessful due to lack of resources, the FCR sought to deploy two Police Sergeants. A request that was contrary to the expectation of their roles but resulted in Police attendance at the incident. The delay meant that Martin was restrained throughout this period by his father who was sat on Martin constricting his airways and unknowingly causing asphyxia. Whilst it seems that Police staff on duty followed all known procedures in order to provide an immediate response, simply put the required resource was not immediately available, nor could be found across Police boundaries.

7. Conclusions

7.1 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.

7.2 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 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.

7.3 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 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.

7.4 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.

7.5 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.

7.6 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.

7.7 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.

7.8 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 his 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.

7.9 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 the 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.

8 Lessons to be Learnt

8.1 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.

8.2 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 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).

8.3 Elective Home Education (EHE) provides freedoms 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.

8.4 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[7] and is being reflected in Kent and Medway's Safeguarding Adults Policies.

8.5 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.

[7] 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/

8.6 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.

8.7 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.

8.8 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.

9. Recommendations

9.1 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 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

Appendix A DHR Terms of Reference

Kent & Medway Domestic Homicide Review

Victim – Martin Brown

Terms of Reference - Part 1

1. Background

1.1 In the summer of 2018, Police officers attended a home in Town A, Kent. They found that the deceased had been engaged in a violent struggle in which he had been forcefully restrained and as a result of that restraint he received injuries that led to his death.

1.2 Donald Brown was the father of Martin Brown and is on Police bail pending further investigation into this incident including awaiting the outcome of the post mortem.

1.3 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 3rd September 2018. It confirmed that the criteria for a DHR had been met.

1.4 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. In accordance with established procedure this review will be referred to as DHR Martin/June 2018.

2. The Purpose of this DHR

2.1 The purpose of this review is to:

i. establish what lessons are to be learned from the domestic homicide of Martin Brown regarding the way in which local professionals and organisations work individually and together to safeguard victims;

ii. 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;

iii. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;

iv. 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;

v. contribute to a better understanding of the nature of domestic violence and abuse; and

vi. highlight good practice.

3. The Focus of this DHR

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

3.2 If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

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

4. DHR Methodology

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

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

4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR

will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all relevant information held about Martin Brown and Donald Brown from March 2011 to the summer of 2018. If any information relating to Martin Brown as the victim(s), or Donald Brown being a perpetrator, or vice versa, of domestic abuse before March 2011 comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the death, 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 Martin Brown and/or Donald Brown. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).

4.6 Any issues relevant to equality, i.e age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation must be identified. If none are relevant, a statement to the effect that these have been considered must be included.

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

5. Specific Issues to be Addressed

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

i. Were practitioners sensitive to the needs of Martin Brown, 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 Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Martin Brown? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being

effective? Was Martin Brown and/or Donald Brown subject to a MARAC or other multi-agency fora?

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 Multi Agency Public Protection Arrangements (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?

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. 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?

xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?

xiv. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Martin Brown and promote their welfare, or the way it identified, assessed and managed the risks posed by Donald Brown? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

xvi. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to Martin Brown and Donald Brown?

6. Document Control

6.1 The two parts of these Terms of Reference form one document, on which will be marked the version number, author and date of writing/amendment.

6.2 The document is subject to change as a result of new information coming to light during the review process, and as a result of decisions and agreements made by the DHR Panel. Where changes are made to the document, the version number, date and author will be amended accordingly and that version will be used subsequently.

6.3 A record of the version control is included in the appendix to the document.

Appendix B

Glossary

APVA	Adolescent to Parent Violence and Abuse
CCG	Clinical Commissioning Group
CME	Children Missing Education
CMHT	Community Mental Health Team
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DASH	Domestic Abuse, Stalking and Harassment Risk Assessment
DHR	Domestic Homicide Review
DIAT	Duty Intake and Assessment Team
EHE	Electively Home Educated
FCR	Force Control Room
IMR	Individual Management Report
IOPC	Independent Office for Police Conduct
KCAS	Kent Contact and Assessment Service
KCC	Kent County Council
KERS	Kent Enablement and Recovery
KMPT	Kent and Medway NHS and Social Care Partnership Trust
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MDT	Multi- Disciplinary Team
PCMHT	Primary Care Mental Health Team
PRU	Pupil Referral Unit
SCS*	Specialist Children's Services

SECAmb	South East Coastal Ambulance Service
SPoA	Single Point of Access
YOS	Youth Offending Service
YOT	Youth Offending Team

*SCS is now known as Integrated Children's Services (ICS) within KCC. The Central Duty Team within ICS is now known as the Front Door Service.