Domestic Homicide Review

Jean Carter

2018

Overview Report

Chair: David Stevens

Author: Dr Liza Thompson

Commissioned by:

Kent Community Safety Partnership

Medway Community Safety Partnership

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1. Introduction

1.1 This domestic homicide review examines agency responses and support given to Jean Carter, a resident of Kent, prior to the point of her death in 2018.

1.2 The review has involved the examination of past events to identify any relevant background or trail of abuse before the death, whether support was accessed within the community and whether there were any barriers to accessing support.

1.3 In early 2018 a body was found which was identified as Jean Carter. The circumstances surrounding her death remain largely unknown and on 16th May 2019 the Coroner returned a verdict of misadventure.

1.4 Her partner at the time fled the scene and handed himself in to police 24 hours later.

1.5 Although the Kent Coroner made a ruling of misadventure in May 2019, the DHR commenced in April 2018 on the understanding that whether the findings were suicide, homicide, or misadventure, the events leading up to Jean's death presented opportunities for significant learning related to domestic abuse.

1.6 A ruling of misadventure refers to an accident that occurred due to a risk that was taken voluntarily.

1.7 In his summing up, the Kent Coroner found that at the time of her death, Jean's judgement was affected, and she may not have intended death to be the outcome of her actions.

1.8 This Overview Report articulates the collective deliberations of the Domestic Homicide Review Panel who, in the main, have based their findings on a number of Individual Management Review reports (IMRs) produced by representatives of organisations that had contact or involvement with Jean Carter, her two children or David Baker who was her partner at the time of her death.

1.9 On 18th May 2018, the Review Panel met to decide the terms of reference, and it was agreed that the review should concentrate on the period from the 1st January 2017 to the time of Jean's death in 2018. The terms of reference stipulate that

pertinent events occurring prior to 2017 should also be considered and summarised in the IMRs and Overview Report. In finalising terms of reference, the views and concerns of Jean's mother were also taken into consideration.

1.10 The key purpose of a DHR is to enable lessons to be learned from deaths where a person has or may have been killed as a result of domestic violence and abuse. In order for lessons to be learned, professionals need to be able to understand the circumstances of these cases, and to ascertain what needs to change in order to reduce the risk of such tragedies happening in the future.

1.11 Jean was not the victim of a homicide (where a person is killed by another). And although Jean's death was ruled a misadventure, this review is framed by the 2016 Home Office Domestic Homicide Review Statutory Guidance which states:

> "Where a victim took their own life and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable."[1]

2. Timescales

2.1 This Domestic Homicide Review began on 24th April 2018 following a meeting of the DHR Core Group. It was agreed by the Core Group that this case fell within the definition of a Domestic Homicide Review and the Chair of the Community Safety Partnership (CSP) was duly notified of their decision. Following notification, the Chair of the CSP formally commissioned a review and the Home Office was informed in accordance with established procedure.

2.2 The review was initially concluded in November 2018 when the final draft was produced. This was further developed and shared with Jean's Mother in the Spring of 2019.

[1] See Mary (2018) for a recent example of a Multi-Agency Review where coercive control was a factor in a relationship ahead of the suicide of the victim. https://www.kent.gov.uk/__data/assets/pdf_file/0018/110376/Domestic-Homicide-Overview-Report-Mary-2018-case.pdf

2.3 The Home Office provided feedback to be addressed in early 2020. Following further feedback from the Home Office later in 2020, an additional independent chair and author was appointed to undertake the further work required in order to address the Home Office's feedback sufficiently and be granted approval for publication.

3. Confidentiality

3.1 The findings of this Domestic Homicide Review are confidential. Information is available only to participating officers/professionals and their line managers until after the review has been approved by the Home Office Quality Assurance Panel and published. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved.

3.2 The level of detail within the report has been kept vague, especially around the incident and nature of Jean's death, David's evidence, and his criminal background. This is intentional and allows for publication of the report without raising issues of reidentification and confidentiality.

3.3 The following pseudonyms have been used in this review for the victim, and others materially associated with the case in order to protect their identities and those of their family members:

Victim:	Jean Carter
Victim's Partner:	David Baker
Victim's Eldest Child:	Child A
Victim's Youngest Child:	Child B
Victim's Ex Partner:	Roy Davis
Victim's Ex Partner:	Paul Williams

3.4 Jean was a white British female in her early thirties at the time of her death.

3.5 David Baker was of a similar age at the time of Jean's death. He is a white British male with connections to the gypsy/traveller community. David was Jean's partner at the time of her death.

3.6 Child A, Jean's eldest child, was of primary school age at the time of their mother's death.

3.7 Child B, Jean's youngest child, was of nursery school age at the time of their mother's death.

3.8 Roy Davis is a white British male who is an ex-partner of Jean and the father of Child A.

3.9 Paul Williams is a white British male who is an ex-partner of Jean and the father of Child B.

4. Terms of Reference

4.1 Written terms of reference were produced and can be found at Appendix A.

4.2 Terms of reference make clear that Domestic Homicide Reviews are primarily conducted for the following reasons:

- To establish what lessons are to be learned from the death regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- To 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;
- To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- To prevent domestic violence and abuse, and homicide. To 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;
- To contribute to a better understanding of the nature of domestic violence and abuse; and
- To highlight good practice.

4.1 Key Lines of Enquiry

4.1.1. Were practitioners sensitive to the needs of Jean and David?

4.1.2. Were practitioners 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 practitioners, given their level of training and knowledge, to fulfil these expectations?

4.1.3. How accessible were the services for Jean?

4.1.4. Did agencies have policies and procedures in place for dealing with concerns about domestic abuse?

4.1.5. Did agencies comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

4.1.6. Did actions or risk management plans fit with the assessment and decisions made?

4.1.7. 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?

4.1.8. When, and in what way, were Jean's wishes and feelings ascertained and considered?

4.1.9. Was Jean informed of options/choices to make informed decisions?

4.1.10. Was Jean signposted or referred to services specific to her needs?

4.1.11. Were agency procedures sensitive to Jean's needs linked to her protected characteristics, for example was consideration given to her vulnerabilities as a victim of domestic abuse who was also struggling with substance misuse and mental health?

4.1.12. What were the key points or opportunities for assessment and decision making in this case?

4.1.13. Do assessments and decisions appear to have been reached in an informed and professional way?

4.1.14. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Jean and promote her welfare, or the way it identified, assessed and managed the risks posed by David?

4.1.15. Where could practice have been improved, and what are implications for improving the ways of working, training, management and supervision, working in partnership with other agencies and resources, to better support victims of abuse?

5. Methodology

5.1 The main focus of this review has been on Jean Carter and David Baker who first met in July 2017. Jean had two children of her own from previous relationships. The children were the subjects of local authority attention both before and after their mother's death.

5.2 The IMRs, on which this overview report is based, were completed on a prescribed template and by the organisations that had contact with Jean Carter, David Baker, Child A and Child B. IMR authors based their information and conclusions on a scrutiny of relevant documentation and by interviewing members of their organisations.

5.3 The initial Review Panel met on three occasions, firstly on the 18th May 2018 to agree terms of reference and then on 20th August 2018 to consider the IMRs. Finally, they met on 1st October 2018 to consider the draft Overview Report.

5.4 Following feedback from The Home Office, the amended review was considered by a second independent chair and author and a panel was reconvened to review the redrafted version on 14th April 2021 and again on 17th June 2021.

5.5 A glossary of abbreviations and acronyms is included at Appendix B.

6. Involvement of Family, Neighbours and Support Groups

6.1 On behalf of the Domestic Homicide Review Panels the Authors would like to extend their sincere condolences to members of Jean's family and thank them for the assistance they have given in conducting this review.

6.2 At the commencement of the review, the Independent Chair, alongside a Police Family Liaison Officer, visited Jean's mother (next of kin) to explain the DHR and what it involved. Jean's mother was also kept informed of the homicide investigation by the Family Liaison Officer. At this initial meeting, Jean's mother was given contact details of the Independent Chair and a copy of the Home Office DHR leaflet. The Independent Chair also explained the importance of her views and how she would be consulted prior to the publication of any findings. At this meeting, the mother's comments were recorded, and her main concerns were that:

- She felt her daughter was a victim of domestic abuse both with regard to her previous partners and David Baker.
- She felt agencies could have better co-ordinated their efforts to help Jean and her children.
- She felt Jean was manipulated by David Baker.
- She felt Children's Social Services were bullying her daughter.

6.3 On 12th March 2019, the Independent Chair and the Police Family Liaison Officer again visited Jean's mother at her home address to discuss the findings of the review thus far. A copy of the Overview Report was given to Jean's mother and the Independent Chair gave a summary of its content. The report was then left with Jean's mother to consider in her own time.

6.4 On 9th April 2019, the Independent Chair once again spoke with Jean's mother who by now had read the report. She was content that the Overview Report was very comprehensive and covered the issues she had previously raised. In particular, she was pleased how the issue of interagency communication and coercive control had been addressed by the recommendations. She explained she was still very upset with the agencies particularly since the death of her daughter.

Whilst she was approving of the report, she explained nothing including this review would bring her daughter back.

6.5 On 4th February 2021 the newly appointed Independent Chair and Author contacted Jean's mother to explain that the review process was continuing and to offer the support of an advocate. She agreed to the Chair making a referral into Advocacy After Fatal Domestic Abuse (AAFDA). This was completed on 8th February and AAFDA contacted her on 15th February.

6.6 On 5th March 2021, the Chair interviewed Jean's mother about Jean in order to better understand the family dynamic and Jean's experiences prior to her death.

6.7 On 27th September 2021 the Independent Chair hand delivered a copy of the report for Jean's mother to read through with her AAFDA Advocate.

6.8 Between September 2021 and March 2022 both the Independent Chair and the AAFDA Advocate contacted Jean's mother on numerous occasions with offers of support to read through and discuss the report. On each occasion Jean's mother either did not respond to the calls and text messages or replied that she did not feel able to read the report in full and needed more time.

6.9 On 10th March the Independent Chair and the AAFDA Advocate agreed that Jean's mother should be given a final opportunity to engage with the process before the review was prepared for submission to the Home Office.

6.10 To date, Jean's mother has not responded to the final offer of engagement with the process, however she has recently been reminded that the anonymised report will be published, which she had previously agreed to when she met with the newly appointed Independent Chair in March 2021.

7. Contributors to the Review

7.1 IMR authors were independent of any operational or supervisory involvement in this case. Each IMR has been signed off by a senior manager from the various organisations involved. Each of the following organisations completed an IMR or shortened report:

- Kent Police
- Sussex Police (shortened report only)
- East Kent University Foundation Hospital Trust (EKUFHT)
- Kent Community Health NHS Foundation Trust (KCHFT)
- South East Coast Ambulance Service (SECAmb) (shortened report only)
- Town A Clinical Commissioning Group
- Kent and Medway NHS Social Care Partnership Trust (KMPT)
- KCC Integrated Children Services (ICS): includes Early Help services
- KCC Early Help and Preventative Services
- Town A and Town B Domestic Abuse Services
- KCC Education Safeguarding Team (shortened report only)
- Town A Borough Council (shortened report only)
- Town B Borough Council (shortened report only)
- Kent Surrey & Sussex Community Rehabilitation Company (KSS CRC) (shortened report only)

8. The Review Panel Members

8.1 The initial Review Panel (2018/19) consisted of an Independent Chair and senior representatives of the organisations that had relevant contact with Jean Carter, David Baker, Child A and Child B. It also included a specialist domestic abuse worker from the local voluntary sector and a senior member of the Kent Community Safety Team. Members of the panel held senior positions in their organisations, were independent of any operational or supervisor involvement in the case, and have not had contact or involvement with Jean, David, or any members of Jean's family.

8.2 The members of the panel were:

Agency	**Name**	**Job Title**
	David Stevens	Independent Chair
Town A Clinical Commissioning Group	Sallyann Baxter	Designated Nurse Adult Safeguarding
Kent County Council Early Help and Preventative Services	Nigel Baker	Head of 0-25: East Kent

Agency	Name	Job Title
Kent County Council Community Safety	Shirley Brinson	KCC Community Safety Team Leader
Town C Borough Council	Toni Carter	Housing Solutions & Private Sector Manager
Kent County Council Adult Safeguarding	Catherine Collins	Adult Strategic Safeguarding Service Manager
Domestic Abuse Volunteer Support Services (DAVSS)	Henu Cummins	Independent Domestic Abuse Specialist
KSS CRC	Victoria Green	Investigations Officer
Kent County Council Safeguarding	Annie Ho	Head of Adult Safeguarding
CENTRA	Leigh Joyce	Locality Business Manager
Rising Sun Domestic Abuse Service	Anne Lyttle	Service Director
Town B Borough Council	Raymond O'Shea	Housing Operations Manager
Kent County Council Education Safeguarding	Claire Ray	Head of Service
Kent Police	Lee Whitehead	Detective Superintendent
Kent & Medway Partnership Trust	Cecelia Wigley	Head of Safeguarding

8.3 The members of the review panel (2020/21) for the amended report are:

Agency	Name	Job Title
	Dr Liza Thompson	Independent Chair
Kent Community Safety Team	Kathleen Dardry	Community Safety Practice Development Officer
Kent & Medway Clinical Commissioning Group	Lisa Lane	Designated Nurse Safeguarding Adults
Kent & Medway Partnership Trust	Alison Deakin	Head of Safeguarding

Agency	Name	Job Title
Kent County Council Integrated Children's Services	Kevin Kasaven	Assistant Director Of Safeguarding, Professional Standards & Quality Assurance
Kent Police	Christopher Rabey	Detective Inspector
DAVSS	Henu Cummins	Chief Executive Officer & Independent DA Specialist
Education People	Claire Ray	Head of Service

9. Independent Authors

9.1 The Independent Chair and initial Author of this report is a retired senior police officer who has no current association with any of the organisations represented on the Review Panel. He is the former head of the Kent Police Public Protection Unit and as such was responsible for domestic abuse policy and operational activity. He retired as a serving officer in 2003 and from this time until April 2016 was employed by Kent Police to complete DHR IMRs, Serious Case Reviews (child and adult safeguarding) together with contemporary and historic homicide reviews. The Independent Chair also undertook Home Office DHR e-training. Since retiring in April 2016, the Author has had no professional association with either the Kent Police or any other police force, thus ensuring his independence in conducting this review.

9.2 The Independent Chair and Author who reviewed the report following Home Office feedback has worked within the field of domestic abuse as a specialist provider for over ten years. She is a Safelives accredited IDVA and Service Manager and led a specialist domestic abuse charity for seven years. She delivers domestic abuse and coercive control training to a variety of statutory, voluntary sector and private sector agencies. Her doctoral thesis examines the experiences of abused mothers within the child protection system, and she currently lectures within the university faculties of Law, Social Care, Policing and Criminology. She has completed accredited AAFDA DHR Chair training and is up to date with all Kent County Council training required of Independent Chairs authoring reviews for KCC.

9.3 The Independent Chair has no connection with the Community Safety Partnership and agencies involved in this review, other than previously being involved in DHR panels as an independent domestic abuse specialist; and currently being commissioned to undertake Domestic Homicide Reviews and Multi Agency Reviews.

10. Parallel Reviews/Enquiries

10.1 Following Jean's death, the police mounted a homicide investigation, however, no third party was identified as being responsible for Jean's death.

10.2 On 16th May 2019 the Kent Coroner returned a verdict of misadventure.

10.3 As far as the Authors are aware, no other reviews or investigations have or are taking place with regard to this case.

11. Equality and Diversity

11.1. The IMR writers and the review panel considered the protected characteristics - age, disability, gender reassignment, marriage and civil partnership, maternity, race, religion and belief, sex and sexual orientation – and which of these characteristics may have shaped Jean's life experiences. It was agreed that sexual orientation, marriage, race, religion, age and gender reassignment were not pertinent to Jean.

11.2. However, the fact of her being a female and a mother shaped her experiences of domestic abuse and engagement with services.

11.3. Gender is the term used to refer to the socially constructed cluster of characteristics,[2] or norms, which are deemed to be masculine or feminine. Although a separate concept from the biological definitions of male and female, gender is interlinked with sex because gendered norms are based upon what is expected of each sex.[3]

[2] Fineman, M A *The Autonomy Myth: A Theory of Independence* (2004) p.56

[3] Greenberg, J A "Defining Male and Female, Intersexuality and the Collision Between Law and Biology" *Arizona Law Review* 42 (1999) p.265

11.4. Attributed masculine characteristics include toughness and the expectation that men will be violent.[4] Germaine Greer argues that women are expected to be submissive in order to fulfil male fantasies of what is female "normality."[5] This includes an expectation of the inevitability of male violence[6] and the belief that women need to be protected by other men from this violence.[7]

11.5. The fear of male violence in society and in the home therefore puts men in the position of either predator or protector of women. Jennifer Nedelsky argues that this culture of male violence is a constitutive force which shapes women's and men's lives.[8] Women take the fear of male violence for granted; they structure their lives in a way that aims to mitigate the risk of being a victim of this inevitable violence.[9] Yet many in society deny the gendered nature of violence against women.[10]

11.6. The effects of incidents of male violence shape women's relationships on two levels. The individual woman's feelings of violation and shame exist on one level, whilst society's reaction to the violence, which amounts to judgement, minimisation and shame, exists on a deeper level. Elizabeth Stanko argues that on both levels women view themselves, and in turn other women, through the lens of the male dominated ideology of how women should behave.[11] This gendered view about women's involvement in male violence which dictates that "good women avoid sexual and physical abuse; bad women don't"[12] is prevalent throughout institutional, societal and individual relationships.

11.7. There is also a societal expectation upon women to be caregivers and Martha Fineman argues that "women's historic roles in the family anchor them to that institution in ways that men's historic roles do not."[13]

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[4] Hearn, J *The Violence of Men* (1998) p.36
[5] Greer, G *The Female Eunuch* (1993) p.11
[6] Stanko, E *Intimate Intrusions: Women's Experience of Male Violence* (1985) p.9
[7] Nedelsky, J *Laws Relations: A Relational Theory of Self, Autonomy and Law* (2011) p.210
[8] *Ibid* p.204
[9] Stanko, above n 7 p.70
[10] Monckton, J, Williams, A and Mullane, F *Domestic Abuse, Homicide and Gender* (2014) p.19
[11] Stanko, above n 7 p.72
[12] *ibid*
[13] Fineman, M A *The Autonomy Myth: A Theory of Independence* (2004) p.56

11.8. The role of a "mother" is a universally possessed symbol[14] and has a value attached to it. Motherhood itself is affected by gendered norms to a greater extent than fatherhood.[15] As Alison Diduck argues, there is an assumption in the relationship between a mother and her child of "never-ending love…timeless and universal duty… (a) romantic ideal…"[16] This gendered expectation of motherhood structures the mothers' lives inside and outside of the home – and more acutely when the mother is also a victim of domestic abuse.

11.9. Mothers are expected to protect children even if the family's difficulties are caused by other people.[17] A failure to measure up to this expectation can easily be construed as "pathological",[18] potentially leading to the removal of the children from the mother's care.[19]

11.10. The British Association of Social Worker's warn that: "Claims of 'failure to protect' reinforces the notion that the responsibility to safeguard a child is firmly located with the woman. This has several dangers, including failing to recognise and respond to the harm the perpetrator is causing to the survivor and their child, and increasing the barriers facing the woman in engaging with services and getting the support she needs."[20]

11.11. Protecting children must be at the very heart of interventions – however, this cannot be achieved if the relationship between services and victims is fractured and lacking in trust.[21]

11.12. Although the challenges Jean faced with mental ill health and problematic substance use are not included in the Equality Act's protected characteristics, it

[14] Fineman, M "The Neutered Mother" *University of Miami Law Review* 46 (1992) pp.653-54
[15] Boyd, S "Gendering Legal Parenthood: Bio-Genetic Ties, Intentionality and Responsibility" *Windsor Yearbook of Access to Justice* 25 (1) (2007) p.65
[16] Diduck, A *Law's Families* (2003) p.83
[17] Scourfield, J "Constructing Women in Child Protection Work" Child and Family Social Work 6 (2001) p.82
[18] Clarke, K "Childhood, Parenting and Early Intervention: A Critical Examination of the Sure Start National Programme" Critical Social Policy 26 (2006) p.701
[19] Scourfield above n8 p.78
[20] BASW *England Domestic Abuse Practice Guidance: for Children and Family Social Workers* (March 2021) p.29 Available: Layout 1 (basw.co.uk)
[21] Robbins, R. and Cook, K "'Don't even get us started on social workers': domestic violence, social work and trust – an anecdote from research" *The British Journal of Social Work* 48(6) (2018) 1664-681

could be argued that Jean's struggles with these issues made her particularly vulnerable and would have shaped her life experiences.

11.13. Research shows the pertinence of a toxic trio of mental health and substance misuse problems where women are killed.[22] Although Jean took her own life, albeit possibly unintentionally, this was in circumstances underscored by long term and enduring domestic abuse.

11.14. The Government recognise that there are often associations between complex needs and domestic abuse.[23] The 2016 National Crime Survey revealed adults who had taken illicit drugs in the last year are more likely to report being a victim of partner abuse.[24] And substance use features in around half of intimate partner homicides.[25]

11.15. However, the relationship between substance use, problematic alcohol use, mental health and domestic abuse is not straight forward.[26] Mental health issues resulting from the psychological distress of domestic abuse and the use of drugs and/or alcohol as a coping mechanism during - and following - domestic abuse, may then impact a survivor's risk of future domestic abuse.[27]

11.16. Being intoxicated or under the influence of drugs is not an invitation to be assaulted, however Iverson argues that women are more vulnerable to assault when intoxicated because they are less diligent at pursuing safety strategies.[28]

11.17. Some women who were abused or neglected as children attempted to cope with feelings of vulnerability;

> "through the creation of highly dependent relationships with men…who…offer protection, and through getting into states of mind

[22] Brandon, M et al "building on Learning from Serious Case reviews: A Two-year Analysis of Child protection Database Notifications 2007-2009" *Department of Education* (2010)
[23] Home Office *Transforming the Response to Domestic Abuse* (2018) p.10
[24] Gadd, D et al "The Dynamics pf Domestic Abuse and Drug and Alcohol Dependency" *The British Journal of Criminology* (59) (2019) p1037
[25] Robinson, A et al "Findings from a Thematic Review into Adult Deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews" *Cardiff University* (2018)
[26] Gadd et al above n 10
[27] Iverson K et al "Predictors of Intimate Partner Violence Revictimisation: The Relative Impact of Distinct PTSD Symptoms, Disassociation and Coping Strategies" *Journal of Traumatic Stress* (2013)
[28] *ibid*

where these feelings can be pushed away…through drugs or alcohol."[29]

11.18. Cocaine can alleviate anxiety in the short term and yet exacerbates underlying problems with depression and paranoia.[30] Whilst regular use of drugs and alcohol can impinge upon mental wellbeing and intimacy, generating indirect and belated relationships between victimisation and substance use that can extend beyond the periods of intoxication.[31]

11.19. Gadd et al therefore argue that there requires a sensitive analysis of the dynamics of power that pertain in the lives of couples where domestic abuse towards a partner occurs alongside substance misuse, in the form of the "gendered dynamics of drug use".[32]

11.20. In January 2018 Jean was diagnosed with Emotionally Unstable Personality Disorder (EUPD).

11.21. EUPD is characterised by pervasive instability of interpersonal relationships, self-image, mood, and impulsive behaviour. Sufferers experience rapid fluctuations from confidence through to despair, fear of abandonment and rejection. They have particularly strong tendencies towards suicidal thinking and self-harm, with transient psychotic symptoms, brief delusions, and hallucinations.[33] People with EUPD are particularly at risk of death by suicide,[34] or (presumably) death by misadventure.

11.22. The simultaneous use of cocaine and alcohol creates cocaethylene, which raises the levels of the brain chemicals "dopamine" and "serotonin", these in turn increase stimulant effects in the body which can lead to impulsive behaviour.

[29] Motz, A *Toxic Couples: The Psychology of Domestic Violence* (2014) p.69
[30] Sacks, S et al "Violent Offences Associated with Co-Occurring Substance Use and Mental Health Problems" *Behavioural Sciences* 27 (1) (2000)
[31] Gadd et al above n 10 p.1038
[32] *Ibid* p.1039
[33] See Borderline personality disorder information at Patient | Patient Accessed 28th April 2021
[34] Leichsenring F, Leibing E, Kruse J, et al; "Borderline personality disorder" *Lancet* 1377(9759) (January 2011) 74-84

11.23. It remains largely unknown what happened at the scene of Jean's death. No one will know for certain what motivated Jean to take the actions which led to her death. However, throughout the review the panel remained mindful of the complexities of Jean's personal characteristics, her environment and the relationships which were interwoven in her life. This review will apply a sensitive analysis of all these factors when examining agency responses to Jean's and her family's, needs.

12. Publication

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

12.2 Family members will be provided with the website address and offered hard copies of the report.

12.3 Further dissemination will include:

a. The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Clinical Commissioning Group and the Office of the Kent Police and Crime Commissioner amongst others.
b. The Kent and Medway Safeguarding Adults Board.
c. Kent's and Medway's Safeguarding Children Multi-Agency Partnerships.
d. Additional agencies and professionals identified who would benefit from having the learning shared with them.

13. Contextual Information

The police investigation revealed the following facts:

13.1 On the night before and throughout the day of her death, it is believed Jean Carter and David Baker had been drinking and using cocaine. During the day Jean and David Baker argued over one of her previous boyfriends. During the early evening David and Jean left the area in David's car, leaving her two children behind with Jean's mother.

13.2 Jean's body was found at around 6pm. David had left the scene. The following day, David attended a police station where he was arrested on suspicion of murder. To date no criminal proceedings have been taken against any third party, it is believed Jean took her own life, albeit possibly unintentionally as the Coroner's verdict of Misadventure indicates.

13.3 The Kent Coroner cited Jean's EUPD diagnosis, her history of domestic abuse and "difficulties of interpersonal relationships" and the fact that at the time of her death her judgement was affected. He summed up she was suffering from difficulties due to the amount of alcohol and cocaine she consumed. He stated that although no one knew what happened at the scene, there appeared to be no third-party involvement and Jean died due to an action she had taken without intending the consequence to be death.

13.4 Jean first met David Baker in July 2017. At the time, Jean was living in Town A with her two children and David Baker was living in Town B. By September 2017, David Baker moved in with Jean and her two children.

13.5 In October 2017, Jean applied to participate in a house exchange with a tenant in Town B. This mutual exchange completed in December 2017; however, Jean and the children never completed the move and at the time of her death it is believed that they were residing with David at a temporary address in a neighbouring County (County B).

13.6 On 15th November 2017, Jean was assaulted at her home address and taken to hospital with serious facial injuries. Circumstantial evidence indicated the man responsible was David although Jean consistently denied that he was her assailant, insisting her injuries were caused by a man with whom she was having an affair. Despite extensive enquiries by the police the person responsible for this assault on Jean has never been prosecuted. This assault triggered a multiagency response which was intended to identify risks to Jean and to safeguard both her and her children. Agencies were concerned over the possible threat David represented to both Jean and her children and were endeavouring to keep them apart. It is the response by agencies to this assault that is the focus of this review.

14. Background

14.1 Jean Carter

14.1.1. Jean was a white British female in her early thirties who grew up in South London. As a child she was subjected to sexual abuse and neglect from both inside and outside of her family. Police hold information pertaining to Jean being at risk of domestic abuse from her mother's partner(s) when she was a child. Between the ages of twelve and fifteen, Jean was in Local Authority care.

14.1.2. Research shows that a high percentage of people living with a mental illness have experienced physical or sexual assault during their lifetime and this is often associated with a history of childhood abuse and substance misuse.[35] Childhood abuse is one of several significant risk factors for mental disorders, including personality disorders.[36]

14.1.3. When speaking to the review author, Jean's mother described her own history of relationships with violent and abusive men. Presumably, Jean's experiences of male violence therefore started in childhood, possibly leading to the time she spent in care and resulting in trauma which went on to affect her in adulthood.

14.1.4. Jean lived with long term mental health issues and as introduced above, less than two months before her death Jean was diagnosed as having a condition known as Emotionally Unstable Personality Disorder (EUPD), it was thought she may have also been experiencing symptoms of bipolar disorder.

14.1.5. EUPD is thought to be caused by a maladaptation of personality traits due to, and in line with, a person's environment. Personality traits are complex structures which represent the building blocks of a person's personality; each individual, genetic and environmental factor transact to form a complex biopsychological system which produces observable trait-based behaviour.[37] Mental health charity Mind describe the possible causes of EUPD as; difficult childhood experiences and stressful or traumatic events, which may lead to a

[35] Howard et al. "Domestic Violence and Severe Psychiatric Disorders; prevalence and Interventions" *Psychol Med* 40 pp.1-13 (2009)
[36] Koizumi, M and Takagishi, H "The Relationship Between Child Maltreatment and Emotion Recognition" PLoS ONE 9 (1) (2014)
[37] NHS Highland *Personality Disorder: Integrated Care Pathway* (July 2015) p.4

child often feeling afraid or upset, unsupported or invalidated; this could be due to family difficulties, or instability, or sexual, physical or emotional abuse or neglect.[38] These experiences interrupt or shape the development of the personality.

14.1.6. When speaking to KMPT during the latter part of 2017, Jean described her mood as lows, quickly followed by highs. She explained that she had erratic behaviour, slept poorly and had many suicidal thoughts and attempts. As is often the case with people living with EUPD/Bipolar Disorder[39], Jean's mental health issues made it difficult for her to sustain employment and at the time of her death she was in receipt of welfare benefits.

14.1.7. Jean had episodes of self-harming and suicide ideation/attempts which included an incident on 1st January 2018 when she cut her wrist. She also had a medical condition which caused her some pain and the need for minor surgery. As is also often the case with people living with EUPD[40], Jean had periods of misusing alcohol and cocaine, alongside periods of sobriety.

14.1.8. Jean's mother told the review author that Jean was a "pleaser" and that in the past this had led to her making bad choices for herself in order to please others.

14.1.9. Between March 2007 and April 2008, Kent Police received five reports of violence and abuse against Jean perpetrated by Roy Davis - the father of Child A.

14.1.10. During Jean's relationship with Paul Williams – the father of Child B, there were incidents of domestic abuse reported to the police perpetrated by Paul upon Jean. This relationship ended in 2015.

14.1.11. Jean's mother described Roy Davis and Paul Williams as both being controlling of Jean. She explained that after the relationships ended both fathers continued to exert control over Jean until she met David and he made threats towards both men. Jean's mother viewed this as David protecting Jean.

[38] See Causes of BPD | Mind Accessed 28th April 2021
[39] See Borderline personality disorder in the workplace | Mind Accessed 21st Feb 2021
[40] Trull, T et al. "Borderline Personality Disorder and Substance Use Disorders: An Updated Review *Borderline Personality Disorder Emot Dysregul* (5) 15 (2018)

15. A Chronological Overview of Agencies' Involvement

15.1. To allow an understanding of the circumstances leading up to Jean Carter's tragic death it has been necessary to review the activities of several organisations who had contact with Jean Carter, David Baker and Jean's two children. Each of these organisations were required to complete an IMR or a shortened report. The information in these reports has been used to write the following section, which is presented with Jean as the central focus. The chronology also includes pertinent information which falls outside of the ToR dates, in order to present a full picture of Jean's life and experiences.

15.2. When Jean was 12 years old, it is reported that she spent time in foster care.

15.3. In February 2001, Jean made an allegation of rape against a friend of her mother's, which she said had occurred in 1998 when she was 12 years old. The alleged perpetrator was arrested and charged; however, the case was discontinued by the Crown Prosecution Service (CPS).

15.4. In 2005, when Jean was 19 years old, she met Roy Davis who was more than 10 years her senior. In November 2005, Jean experienced an episode of depression which is recorded in her GP notes; it is recorded that Jean is thought to have experienced mental health concerns since the age of 12.

15.5. Between March 2007 and April 2008, Kent Police received five reports of domestic abuse which involved Jean being the victim of violence perpetrated by Roy.

15.6. During this time Child A was born. Five days before the birth Jean was assaulted by Roy, this resulted in her leaving the area to live with her grandmother. As a result of this, the family's health visitor made a safeguarding referral in respect of Child A which referenced how Jean had told the health visitor that she had deserved to be assaulted. Jean and Roy later resumed their relationship. This relationship ended and in March 2010 Jean and Paul Williams began a relationship.

15.7. In September 2010, Roy Davis alleged that Child A faced a risk of harm due to the relationship between Jean and Paul. Within his referral to the Integrated Children Services (ICS), he cited the abuse Jean experienced as a child. There was no further action taken as the referral was assessed as "unsubstantiated and malicious" on Roy's part.

15.8. In August 2013, Paul assaulted Jean and damaged property. Upon police attendance Jean was reluctant to answer DASH risk assessment questions (see Glossary) and did not want any further action. Paul Williams was arrested the following day; he denied any offences and was refused charge.

15.9. On 4th January 2014 police were called to Jean and Paul's home. Paul had consumed alcohol whilst on medication and he was behaving in a threatening manner towards Jean. This did not result in an arrest however a safeguarding concern was raised with the Central Referral Unit (CRU) (See Glossary). Following a conversation with Jean, the duty social worker noted that she:

> "seems to be aware of the consequences should this type of incident occur again due to alcohol. She appears to have acted appropriately and is supportive towards her partner with the help from other family members."

15.10. On 10th January 2014, Jean accompanied Paul to his assessment meeting with the Community Mental Health Team (CMHT), where she disclosed that she: "had recently lied to Social Services when she said it was all ok". Paul was unable to be assessed at this meeting as he was intoxicated.

15.11. On 13th January 2014, Jean contacted police and reported that during her four-year relationship with Paul Williams, he had been violent towards her on a least three occasions. When she tried to end the relationship, he assaulted her. A risk assessment was completed, Paul was arrested and was refused charge due to insufficient evidence.

15.12. On 23rd March 2014, a further incident occurred, when Paul had left the rehab where he was being treated for alcoholism and immediately started drinking. He damaged property, for which he was arrested. Jean supported a prosecution and Paul was charged. Jean told police she had been warned by social workers about

her relationship with Paul and she was concerned about losing the care of her child.

15.13. A little later, Jean withdrew her support for a prosecution, and it is understood the relationship continued, which led to a Children and Family Assessment (see Glossary) which was completed on 28th March 2014. Jean insisted that her priority was Child A, she had good support from Paul's parents and Paul agreed to take steps to address his difficulties. The social worker completing the assessment considered "the required changes took place and concerns have been addressed properly" and concluded Jean could manage Paul's behaviour in the future by asking him to leave.

15.14. Jean and Paul separated in 2015, by which time they had had a child together, Child B.

15.15. In August 2016, Jean's GP made an Early Help referral after Jean approached services requesting support with her drug and alcohol use. The referral stated that Jean was currently receiving treatment for drug and alcohol use and the GP was concerned about the effect of this substance misuse on the children – the GP stated:

> "she assures me that she would never put her children at any risk or in any contact with alcohol or drugs; however, I would be very grateful for your specialist assessment of this situation".

15.16. Following an Early Help assessment, it was agreed that Jean's priorities for support were; assistance with a house move, help with financial issues and the impact of substance misuse on parenting. The case was closed in September 2016 with notes describing Jean as having been "dry for 50 days" and that all "outcomes were achieved".

15.17. In April 2017, Jean attended her surgery for a routine appointment and told the Practice Nurse she had been tearful, down and emotional during the prior three weeks. Jean had a follow up telephone consultation with her GP on in May 2017 where she described migraine and depression symptoms. It was noted the GP re-prescribed Fluoxetine, which Jean had previously been prescribed. A follow up appointment was undertaken in June 2017 where Jean said she had been feeling better, but that recently her mood had worsened again. She requested an

increase in medication, reported that she had support and was attending counselling.

15.18. In July 2017 Jean and David Baker began an intimate relationship.

15.19. Jean attended her GP practice in August 2017, reporting a weight loss of 2 stone over 2 months which she believed to be due to the Fluoxetine. Blood tests were taken, and she was advised not to stop taking medication whilst awaiting results. She explained to the GP that her ex-partner had previously forced her to disclose an addiction to drugs and alcohol, she stated this was untrue and requested this data be removed from her health records. The GP advised that this information could not be deleted but agreed to record this new information on Jean's file.

15.20. In October 2017, Jean called her GP for a telephone consultation stating she was concerned that when she drank alcohol with her anti-depressant medication it made her act strangely. Jean wondered if she had a Personality Disorder or if the medication was not working well. She stated she was fine when not consuming alcohol. The GP advised Jean to cease alcohol intake, which she agreed to do and advised she would contact the GP if the situation did not improve.

15.21. On 2nd November 2017, Jean attended a local minor injuries service with a contusion to the right wrist that was tender. She explained she had been in a fight the day before whilst under the influence of alcohol. She assured the nurse she was safe but was embarrassed and apologetic.

15.22. On 15th November 2017, police were called to Jean's home, and she was admitted to hospital following a sustained assault which resulted in swelling and bruising to her face and various areas of her body. Police completed a DASH risk assessment which assessed Jean as being faced with a high risk of harm, which resulted in a referral to the Multi-Agency Risk Assessment Conference (MARAC) (See Glossary). It is recorded in police records that Jean's main concern was in relation to her children who are not thought to have been at the property when the assault occurred.

15.23. On 16th November, a Domestic Abuse Notification (DAN) (see Glossary) was received by the CRU with details of the report made by Jean to police at the time of the incident. The DAN indicated that the children were at school at the time of the incident. When spoken to at the scene the day before, Jean identified her

current partner as the assailant and described him as controlling, he did not allow her to take her prescribed anti-depressant medication, he made threats to kill her children and other family members, two weeks previous he assaulted her causing an injury and smashed her mobile phone to stop her contact with other people. Jean indicated on the DASH risk assessment tool that she was depressed and/or having suicidal thoughts.

15.24. Due to the MARAC referral, a referral was also received by a local Independent Domestic Violence Advisor (IDVA) (See Glossary) who contacted Jean by telephone the same day to discuss support. Jean consented to this support and together they agreed a safety plan (see Glossary). Jean told the IDVA that the assailant was not her current partner, David Baker, but another man with whom she was having an affair. She vocalised her concern that the children would be removed from her care due to the incident. Jean discussed her mental health struggles with the IDVA and disclosed a suicide attempt the previous month. The IDVA advised Jean to request a referral into mental health services, via her GP, and sent Jean a text with Samaritans and mental health crisis team details. The IDVA booked a face-to-face meeting with Jean for the following week at the local One Stop Shop (OSS) (see Glossary).

15.25. On 19th November 2017, a referral was received by the ICS Team and the case was allocated to a social worker for assessment, with a home visit being arranged for 21st November 2017.

15.26. On 21st November, Jean met with the IDVA at the local OSS as arranged. She repeated the explanation that the assailant had not been David Baker. She reiterated her primary concern being the removal of her children from her care following the assault upon her. Jean indicated that she did not believe she had a substance misuse problem but indicated she had previously binge drank. The IDVA suggested a referral into drug and alcohol services, Jean declined this offer but agreed to a referral to the Freedom Programme (see Glossary). Jean explained that she was in the process of the mutual exchange process (see Glossary) to move from Town A where she currently lived, to Town B where David's family lived – she indicated this mutual exchange would be completed within the next six weeks. Jean insisted she was not supporting a prosecution against either David or the other man who she alleged was the assailant. She declined a panic alarm installation at her home as she was staying with her nan.

She told the IDVA David Baker was very supportive of her but was currently on holiday and the IDVA suggested that he should speak to the police upon his return. The IDVA updated the officer in charge of the case (OIC) and contacted the allocated social worker to introduce herself as Jean's IDVA.

15.27. On the same day, the allocated social worker attended Jean's home. The social worker recorded that Jean had changed her story about the alleged perpetrator and recorded that she did not believe Jean's account of the events.

15.28. On 22nd November 2017, David Baker was arrested for Grievous Bodily Harm (GBH) (see Glossary). He made no comment during the interview and the CPS made the decision that there was insufficient evidence to charge him. He was released on conditional bail.

15.29. On 23rd November 2017, the IDVA contacted Jean for an update and Jean explained that when speaking to the police following the incident, she had been intoxicated and although it may have sounded as if she was referring to David, she was in fact referring to an ex-partner. The IDVA attempted a discussion about safety planning, Jean stated she did not want a panic alarm fitted at her property, she repeated that David was not abusive, and argued that he was bailed away from her home anyway. The IDVA discussed the installation of a panic alarm in respect of the alleged abusive ex-partner and Jean agreed to this.

15.30. Following this meeting, the IDVA updated the OIC that Jean agreed to an alarm being fitted. The OIC in turn advised her of the CPS decision to drop charges and subsequent bail conditions related to David. The IDVA suggested the OIC link in with the allocated social worker to update. The IDVA then contacted the social worker to update on her discussion with Jean, she advised the social worker that the bail conditions had ended, and the social worker updated the IDVA regarding the ten historic social care referrals for Jean's children, which were all linked to domestic abuse and substance misuse, and all of which were closed with no further action. The social worker updated the IDVA about her initial meeting with Jean which took place two days before. Jean's mother and grandmother were present at this meeting and indicated that Jean needed help with her mental health and substance misuse, but that David was a good person. The IDVA advised the social worker of the upcoming MARAC meeting, suggesting that the social worker attend this, and they agreed to keep each other updated.

15.31. A strategy meeting was held (see Glossary) on 27th November 2017 where it was agreed the case reached S.47 threshold (See Glossary) and a child protection conference would be arranged to consider whether Jean's two children met the threshold for a child protection plan.

15.32. The allocated social worker visited Jean's home to update her about this decision and explained the Initial Child Protection Conference (ICPC) (see Glossary) following the S.47 enquiries. The social worker discussed safety planning with Jean and discouraged her from having contact with David.

15.33. Also on 27th November 2017, Jean attended her GP surgery and described herself as having low mood followed by episodes of being on a high. She described erratic behaviour including irresponsible spending and sexual activity outside of her relationship. She explained she had recently been assaulted by an ex-partner and that she had the involvement of social workers and the police. She described sleeping poorly, having suicidal thoughts, recent suicide attempts and reported she did not wish to seek medical attention for this as she feared it would lead to the removal of her children. A GAD-7 questionnaire was completed (see Glossary) and her score placed her at the top of the severe range. The GP referred Jean to the CMHT, recommenced her Fluoxetine prescription, made a Think Action referral (see Glossary) and planned to review the situation by telephone in two weeks.

15.34. On 28th November, Jean contacted the OIC stating she had removed the alarm, she again insisted David was not the perpetrator and she was not at risk from domestic abuse.

15.35. Later that day, the social worker and OIC visited Child A at school. The child was engaging but it was felt by the social worker that they were hiding information and was loyal to their mother. The same day Roy Davis contacted Kent Police to raise a concern about his child due to the risk of harm from David. He advised about a previous situation where Jean had two black eyes and David had damaged her car. A welfare check was undertaken by Kent Police during the evening and no causes for concern were raised.

15.36. Also on 28th November, a referral was made to CMHT by the GP requesting Jean be assessed by secondary mental health services. The GP cited long standing

mental health difficulties which Jean had experienced since her teens. Several different anti-depressants had proven ineffective. Jean indicated various erratic and unpredictable behaviours including two suicide attempts in October 2017 which she had not sought help for as she believed this would lead to her children being removed from her care.

15.37. On 29th November, the ICS team took a call from Roy Davis raising a concern about his child continuing to reside with Jean due to David Baker's violent behaviour and Jean's drinking, he stated he had spoken to Paul Williams who was also concerned about his child residing with Jean.

15.38. On 30th November 2017, the IDVA attempted to liaise with the social worker and spoke with the OIC, in an attempt to ascertain whether the relationship between Jean and David had resumed. On the same day, the social worker met with her line manager for supervision and discussed the risk of significant harm "due to mother planning to reconcile with her partner, and mother not admitting that her partner is the offender". A plan was made for the social worker to liaise with the housing department in Town A regarding the planned mutual exchange, she would also engage further with the children to understand their views and experiences of home and would engage with the children's fathers to seek their views on the situation.

15.39. On 1st December 2017, the IDVA contacted the social worker who confirmed there were bail conditions which prohibited David entering Town A, aside from pre-arranged appointments with his solicitor. The police were awaiting forensic evidence in respect of the 15th November assault on Jean. The Child Protection Conference was planned for two weeks' time and Jean openly informed the social worker that she intended to remain in the relationship. The social worker stated she had information from several sources that Jean visited David regularly and the physical abuse was continuing. The IDVA updated the social worker with the MARAC date and suggested it would be of benefit for the social worker to attend.

15.40. On 4th December 2017, a planning meeting was held with the children's fathers and the allocated social worker. Both fathers expressed concerns for their children and shared 'significant' information with the social worker. Roy Davis was recorded as having "a significant criminal history" and Paul Williams as "a recovering alcoholic".

15.41. On 6th December 2017, the IDVA called Jean who stated she had not seen or heard from David. It is recorded the IDVA heard a male voice in the background. Jean told the IDVA she received a letter from CMHT, and her initial appointment had been set for 15th December 2017. The IDVA told Jean she would be representing Jean's wishes and feelings at the MARAC meeting and Jean told her that her wishes were for David to return to the family home so that Jean, David and the children could get on with their lives.

15.42. On 7th December, a letter was received by the GP confirming Think Action had closed their case as Jean had informed them that she was receiving support from another source.

15.43. The MARAC was held on 7th December 2017. The police representative shared that Jean was not in support of the police decision to bail David with conditions to stay away from her. The police shared David's history of violence. The IDVA shared that Jean was engaging well with her but was denying any abuse at the hands of David. She shared that Jean believes she may have bi-polar disorder, but this had not been diagnosed, and Jean was concerned if she were diagnosed with mental health issues her children would be removed. The attendees were updated that a mutual exchange was agreed and was taking place the following week, which would require a transfer to the MARAC in Town B. The Health Visiting Team and School Nurse Team were updated about the contents of MARAC and were advised of the upcoming ICPC.

15.44. On 11th December, the IDVA contacted Jean and updated her with the outcomes of the MARAC meeting. Jean expressed her worry about the upcoming ICPC and advised that she still planned to move to Town B on 18th December 2017. The IDVA recorded that she called the social worker to feedback her conversation with Jean and the social worker invited the IDVA to the ICPC planned for 13th December. The social worker told the IDVA that the children had disclosed information regarding the incident on 15th November and about other incidents. The IDVA recorded that she explained to the social worker Jean's possible fear of ending the relationship or that she may not be able to recognise his behaviour as abusive, and the social worker responded, regarding the children's experiences, it did not matter why Jean was not recognising the risks, the issue was that she was not recognising them, and the children were therefore at risk.

15.45. The social worker completed the ICPC report on 11th December 2017. The report stated it was positive that Jean was able to meet all the children's basic care needs. The children were described as well-mannered and adorable children who had a loving relationship with their mother. The report stated the social worker was worried the children have previously been exposed to domestic abuse relationships between (Jean) and their fathers (Roy Davis) and (Paul Williams) and that Jean was in a new relationship which was abusive. The report raised a concern that Jean was not being truthful about David, was not following safety advice and that she believed she deserved the abuse because of "her own underlying issues with her behaviour, i.e. mental health issues and substance misuses."

15.46. On 12th December 2017, the IDVA called Jean to obtain an update ahead of the ICPC – she described the ICPC to Jean, who stated she would do anything she needed to do to keep her children. The IDVA advised Jean that she would support her at the conference but that she would also have to be clear about the risks to the children.

15.47. The ICPC was held on 13th December 2017, in attendance were Jean, Jean's mother, the Independent Chair of the ICPC, the IDVA, the social worker, the Health Visitor, Child A's school, Town A's housing department and both children's biological fathers. There was no CMHT representative. Throughout the meeting Jean maintained David was not abusive. The social worker challenged her on this and discussed the disclosures made by the children. Roy Davis stated he received calls and texts from Jean saying she had been beaten up by David. Jean and her mother argued against all the allegations and Jean argued that Roy was using the situation to obtain residency of Child A. Paul Williams did not offer any evidence against David, however, stated he was worried about Child B's welfare with whom he said he would like to have more contact. The school fed back that Child A was doing well at school, was athletic, had some issues with friendships but nothing to be concerned about. The school shared on behalf of the nursery, that Child B was headstrong and had an outgoing personality. The social worker and police representative stated openly they did not believe what Jean has said about David not being abusive and they wanted Jean to sign a written statement agreeing not to have David in the family home, or around the children. The social worker raised the potential need for legal proceedings, and it was agreed by all professionals in attendance that a child protection plan was to be created as the children were at

risk of emotional abuse and neglect. Jean stated she did not agree with this, that the children were well looked after, doing well at school, were happy and that David was not abusive.

15.48. ICS notes indicate arrangements for a legal planning meeting were started the same day with the view of starting the Public Law Outline (PLO) process (see glossary). It is recorded that this development was because the social worker escalated her assessment of risk due to Jean and her mother's failure at the ICPC to accept that the children were at risk from David, as well as the imminent move to Town B which was closer to David's family. The social worker produced a danger statement which included:

> "(the children) may have seen and heard volatile arguments between their mother, their birth fathers and now her new partner."

15.49. On 13th December, a representative of Town A and Town B housing departments met with Jean and the mutual exchange tenant. When the mutual exchange tenant was asked to leave so the housing departments and Jean could speak privately, Jean intercepted that she wanted the other tenant there, the other tenant knew David well and was aware of the situation. The discussion concluded with the exchange still going ahead on 18th December as neither party wanted to delay the move.

15.50. On 14th December 2017, David Baker was refused charge due to lack of evidence.

15.51. Jean met with the CMHT on 15th December 2017 as planned. She attended this initial assessment appointment with her grandmother. Jean reported that she had been struggling with her mental health since the age of 12, and this was the age when she started experiencing suicidal ideations. Jean said she had mood swings including manic episodes with erratic and impulsive behaviour. During these manic periods, which often lasted for months, her sleep was minimal, and she reported making poor decisions. At the time of the assessment Jean was feeling depressed, in low mood, lacked motivation and had been socially isolating herself. Jean noted she had been binge drinking at the weekend, which she described as self-medication and said that she had been "starting fights with males", instigated when she was intoxicated and socialising. She explained her move to Town B was

for “escapism”. Jean disclosed she had tried to take her own life approximately ten times over the past year. She reported as experiencing suicidal thoughts the day before the assessment and had previously experienced intrusive thoughts of jumping off a bridge but identified her children as protective factors. She said she struggled to manage her daily activities when she was feeling depressed, but her children motivated her to cope. She explained her family were currently involved with social care. During the assessment Jean also disclosed she was sexually abused by a family friend at the age of 12 and the case had not got to court due to lack of evidence. Jean explained she was unemployed as she found sustaining employment difficult due to her mental health. She disclosed she had been in a relationship with a man who was abusive for eight years, but her current relationship was supportive. The Mental State Examination (see glossary) found that she was well kempt and casually dressed, maintained good eye contact throughout the assessment, was emotional at times but remained calm and pleasant. She was articulate and speech sounded slightly pressured. Jean was not assessed as being at risk of exploitation, abuse or neglect and her overall risk was assessed as medium. A decision was made to arrange for an outpatient appointment with the Consultant Psychiatrist to explore a diagnosis and treatment plan.

15.52. On 18th December, the GP was advised that the children were made subjects of a Child Protection Plan due to emotional abuse. The GP also received a letter from the CMHT with the outcome of the initial assessment at the psychiatry clinic three days earlier, as detailed above.

15.53. On the same day, the IDVA called Jean, who advised her that the mutual exchange was completing that morning. The IDVA advised Jean that she would be transferred to an IDVA in Town B and her case would be heard at the Town B MARAC. Jean updated the IDVA about her psychiatric assessment appointment three days earlier and told her that she had another appointment booked for the new year. She stated that she was keen to continue support from the CMHT and still wished to attend the Freedom Programme. She said again she wished to resume her relationship with David and that her children were not displaying any effects of experiencing domestic abuse. The IDVA explained some children behave as “perfect” children to keep themselves safe, so it is hard to identify how a child is affected by living with an abuser. Jean asked the IDVA if the social worker could force her to sign an agreement not to see David, as she believed it

was unfair to David who should be involved in the plan. The IDVA stated she would advocate Jean's wishes - for David to be involved in the plan - with the social worker and reminded her it is the children's safety which is paramount. The IDVA became aware of a male voice in the background which became louder and seemed angry and Jean confirmed David was in fact present. The IDVA recorded she heard Jean trying to pacify David, and so advised she would call back when David was not present. She ended the call and sent a text to Jean to confirm she would speak to the social worker regarding Jean's suggestion that David should be involved in the child protection plan.

15.54. The IDVA then updated the social worker of the details of the call and advised the social worker that bail conditions had ended. The social worker advised the IDVA she would be asking Jean to sign an agreement not to have contact with David, she was aware of the move to Town B happening that day and she requested the commencement of legal proceedings. The IDVA passed on Jean's request to have David involved in the child protection plan, which the social worker declined and stated that she hoped the social worker in Town B would also decline this suggestion as she thought it would prove dangerous for the children. The IDVA updated the social worker about Jean's CMHT engagement, her wish to attend the Freedom Programme and that the IDVA would request a MARAC2MARAC transfer for Jean (see glossary). Jean would be closed to the current IDVA due to changing location but would be offered an IDVA who covered Town B. The IDVA then undertook the task of advising the MARAC coordinator of the transfer and referred the case to her counterpart in Town B.

15.55. On 22nd December 2017, the social worker called to arrange a visit to see the children and Jean following the ICPC. A male voice and the voices of the children were heard in the background. Jean called her back 15 minutes later and confirmed the voice had been David's as his bail conditions were dropped. This was fed back to the team manager who contacted Jean to remind her of the child protection plan and the need for the children not to have contact with David even if bail conditions were lifted. There is a note that Jean changed her account of the earlier conversation with the social worker, however there are no further details of this. The manager recorded the following "'I am concerned that Jean does not accept the need for the safeguarding arrangements and will be permitting the children to spend time with David. Legal Planning meeting to be held."

15.56. On 27th December 2017, Kent Police received a call from Roy Davis concerned that he had not seen Child A since 14th December, the child's phone was inactive, and he would like the police to check on the child's welfare. This was passed to ICS Out of Hours Team (OOH) team. The next day a social worker called Roy Davis to discuss, and he explained that Jean was not complying with contact arrangements over the Christmas period. He believed Jean and both children were living together with David Baker at a temporary address in County B. An unannounced visit to the temporary accommodation was undertaken by two social workers the next day, where they spoke with Jean, her mother, and the children. It is not noted whether David was present at the property. It is noted that Jean had a faded black eye but when asked she denied this was a fresh bruise. Child B confirmed they had seen David.

15.57. Following a discussion with ICS on 28th December, Kent police were made aware of the fact that Jean and the Children were residing temporarily in County B and therefore passed the welfare check request to County B Police. It is noted that County B Police had no knowledge of the family residing in their area. There had not been capacity to undertake this check on 28th December and ahead of a check being carried out on 29th December, patrols spoke with Kent ICS who confirmed their OOH team had undertaken the check, no concerns were identified and therefore Kent police did not undertake the check.

15.58. On 30th December 2017, Jean contacted Single Point of Access (SPoA) stating she was feeling low – a member of the CMHT returned her call one hour later. Jean was tearful and told them she was upset about the pressure from ICS who believed she was in an abusive relationship which she denied. She stated she felt she was pushing people away and was only sleeping for four hours per night. She indicated she was not currently on any medication and was experiencing suicide ideation, however, did not feel actively suicidal and described her children and partner as safety factors. Support was given over the phone and a request faxed to the CMHT for a duty worker to follow up with Jean.

15.59. On 2nd January 2018, Jean reported to the CMHT that she had attempted suicide the previous day making cuts to her wrists. David found Jean and medical attention had not been sought. It transpired David had discovered previous attempts in October and November and no medical attention was sought. A call was returned to Jean to check her wellbeing and she reported as feeling very ill

but was better than she had been over the last couple of weeks. She reiterated she was stressed by the involvement of ICS with her family, and she was not finding social workers very helpful or supportive towards her. She explained she was currently staying at her mother's home in County B where she had been for the last week. She denied any thoughts, plans or intent to harm herself and said she had tried to cut her wrists the day before but that her partner stopped her. She said this was not intended as a way of ending her life, but of relieving pressure and gaining control of her life. Jean is reported as having pressure of speech (see glossary) and described having lots of energy and said she could not sit still. She requested a medication review, asking for something to calm her down and help her to sleep. An urgent appointment was booked for a medication review for the next day.

15.60. On 3rd January 2018, Jean attended the medication review, following which a letter was sent to the GP, outlining information from the meeting. Jean shared her fears of abandonment which led to her rejecting people before they can abandon her. She saw pressure from social workers as increasing her distress which led to an increase in her alcohol intake. It is recorded "(Jean) and her partner stated that even when she is not drunk, she gets into arguments" which indicates David had accompanied Jean to her appointment. It is noted in the KMPT case files that the psychiatrist had given Jean the option of being seen alone and she expressed she wanted David with her. Jean explained she self-harmed by cutting, due to feelings of emptiness, she had taken an overdose the previous month and was continuing to have suicidal thoughts. Jean confirmed that when she reported child sexual abuse to her mother she was not believed and had run away from home a couple of times, which was when she started to drink and misuse drugs. She stated she had achieved alcohol sobriety in 2014 for ten months following intervention from AA (taken to mean Alcoholics Anonymous). She also reported a familial history of mental health issues that led to suicide in some family members. She denied psychotic symptoms. A mental health diagnosis of Emotionally Unstable Personality Disorder (EUPD) was made, along with probable Bi-Polar Disorder and a Mental and Behavioural Disorder due to alcohol abuse. She was deemed as low risk of harm to self and others. Jean commenced on a medication used to treat Bi-Polar Disorder and was to be referred to a STEPPS programme (See Glossary) which is used to treat Borderline Personality Disorder, and the Consultant Psychiatrist planned to keep the GP informed of her progress.

15.61. On 4th January, the social worker received confirmation from County B ICS archives that Jean was known to them as a child. The social worker requested Jean's social care files from County B.

15.62. On 5th January, the social worker made a phone call to KMPT to request an update on Jean's engagement with CMHT. They were updated that Jean had attempted suicide on ten occasions, the most recent being four days before, on 1st January 2018. The social worker was informed that Jean had not sought medical attention through fear of her children being removed from her care and that she contacted KMPT on 30th December 2017 asking for help as she felt under pressure from ICS. The social worker was updated on the diagnosis of Emotionally Unstable Personality Disorder for which Jean was prescribed mood stabilising medication. In turn, the social worker updated KMPT of the criminal history of Jean's current partner, detailed the domestic abuse in previous relationships and that Jean had been denying her current partner was abusive despite the social work team having evidence of his abuse. The KMPT duty worker recorded they had "relayed some pertinent information to (the social worker) re CMHT's recent contact with Jean regarding risk to self (which KMPT) did not appreciate previously. The social worker has asked that mental health team update her after contacts with Jean."

15.63. Following this call the social worker recorded her concern regarding Jean not sharing information about her debt and suicide ideation/attempts with ICS, and that the CMHT should not think that it was positive that Jean referred to her children as protective factors. She concluded Jean's complex mental health condition increased the risk to the children, that Jean was in "complete denial of the concerns" and was using contact with the CMHT to "cover up the abuse."

15.64. The social worker had supervision with her line manager on the same day where it was decided that a Legal Planning Meeting would be held along with a multi-agency core group. The case was to be transferred to Town B upon the family's move. The social worker recorded her concerns that Jean's reports of self-harming, suicide attempts and getting into fights when drunk was a cover up for domestic abuse. The social worker recorded "all factors of the toxic trio are present, increasing risk for the children."

15.65. On 8th January 2018, the Children and Family Assessment was completed, and the social worker requested a Legal Planning Meeting (see Glossary).

15.66. On 11th January 2018 contact was made between the Town A and Town B IDVAs. They discussed Jean and David's continuing relationship and how this would make safe contact with Jean very difficult.

15.67. Also on 11th January, the legal planning meeting was held where it was agreed that the threshold for pre-proceedings had been met. It is recorded Child A provided further information, stating they were worried about their mother as David was abusive. They told the social worker that their mother and grandmother had told them not to say anything, and David had stayed with them over Christmas. It was agreed that an initial pre-proceedings meeting would be held on 26th January 2018, with Jean attending a separate meeting to the children's biological fathers.

15.68. On 12th January 2018, Town A IDVA contacted Town B IDVA to update that ICS were following the legal proceedings route due to emotional neglect, and the details of the social worker were available on their shared case management system. It appears the IDVA service thought Jean had completed the planned move. Town A IDVA updated she had last spoken to Jean just before Christmas, Jean was still in a relationship with David and would be likely to share information with him. The IDVA suggested Jean's family were supportive of her relationship with David, who would "often come across hard done by (like nothing was) his fault." The Town A IDVA explained that Jean had moved to Town B to be closer to David's family, that Jean is always with David and puts her phone on loudspeaker when professionals call so it is difficult to speak safely with her. The Town B IDVA contacted the social worker, leaving a message for her call back so they could liaise.

15.69. On 13th January 2018, Roy Davis made a call to the ICS OOH and alleged Jean was currently intoxicated, using drugs, was distressed and was with the children. Roy repeatedly argued that the children would state everything was fine if contacted. The OOH Team contacted Jean and noted she sounded sober, they spoke with Child A who stated they were fine and wanted to stay with their mother. The OOH social worker spoke with Jean who stated Roy Davis was "making her life a misery". The OOHs social worker also contacted Jean's mother who was on her way to visit Jean along with Jean's brother.

15.70. On 15th January 2018, the family's social worker received an email from Paul Williams supporting the views of Roy Davis and alleged Jean "brainwashes" Child A about what the child can and cannot say to professionals. On the same day, a follow up call was received from Roy Davis asserting Jean was coercing Child A and that he was concerned the social worker was believing a "manipulated (child) and a drug and drink dependant mother." The social worker duly responded to both fathers clarifying the situation and assuring that all views were being taken into consideration.

15.71. On 17th January 2018, Jean's case was heard at the Town B MARAC. This was a "mention only" (See Glossary) as a transfer into the area. At this point the family had not yet moved to Town B.

15.72. Also on 17th January 2018, Jean was handed the "letter before proceedings" (See Glossary). The five key concerns are summarised here:

- The social worker is very worried that you have a history of engaging in on-going domestic abuse relationships including your relationship with (both of your children's) fathers. We are worried that despite abuse being evident you have tried to maintain these relationships or then entered into a new relationship which becomes abusive.
- The social worker is extremely worried that you are now in an abusive relationship with David Baker. The most recent referral to Specialist Children Services in November 2017 has highlighted that you were very badly beaten up whilst intoxicated, and you sustained significant injuries to your face and body. Professionals working with your family believe that the perpetrator of this attack is your partner David Baker, although since sobering up and thinking about your situation you have categorically denied that it was David. The social worker is extremely worried that you are not taking the necessary steps to safeguard the children from seeing and hearing domestic abuse, parental substance misuse and mental health issues. This means that the children are at risk of suffering on-going emotional and physical harm.
- Concerns that you are misusing alcohol and drugs, and this is having an impact on the care given to (your children). It is reported that you become aggressive and volatile when under the influence of substances.

- Concerns are being raised that your mental health is having an impact on your capacity to parent (your children).
- Concerns have been raised regarding the wider family network.

15.73. A child protection visit was carried out on the same day with no concerns identified. Jean confirmed the family were living with David and the social worker recorded this honesty as a positive step. Jean continued to refuse to sign an agreement not to see David, she was advised to seek legal advice and confirmed she had already done so.

15.74. On 19th January 2018, the social worker contacted CMHT to raise a concern that the children were being seen as "protective factors" for Jean.

15.75. A core group meeting was held on 22nd January 2018. Neither Jean nor Roy Davis attended the meeting. There was no representative from the CMHT therefore the social worker updated on Jean's mental health, voicing her concerns that Jean was "fragile", she was self-medicating with alcohol but did not consider herself to have a current problem with alcohol. The school updated that Child A was doing well at school but did not like talking about their home life. It is recorded "work with IDVA had ended as Jean is still in a relationship with David and information had been passed to Town B IDVA team to inform MARAC." The social worker stated she would continue to make planned and unannounced visits to the family. It was decided the case would be transferred to a social worker in Town B once the family completed their move. It was recorded that a pre-proceedings meeting was arranged for 26th January 2018 and the next Child Protection conference was booked for 6th March 2018, so there would be no further meetings unless an incident occurred which required an emergency core group meeting.

15.76. On 22nd January 2018, there is a record of the school nurse attempting to contact Jean.

15.77. On 23rd January 2018, the Town B IDVA spoke about Jean's case during case management with a senior IDVA where it was decided the case would be closed to the IDVA service due to a lack of engagement and a lack of opportunity to safely contact Jean. On the same day, the Town B health visiting team attempted to make contact with the Town A health visiting team in order to share information and request a hand over – there was no response.

15.78. On 24th January 2019, the social worker contacted the Town B ICS team to seek clarification that the family would be transferred at the pre-proceedings meeting booked for 26th January 2018. It was fed back to the social worker that the case would not be transferred at the meeting, as the family had not physically moved to Town B and were staying temporarily in County B, it was argued that it would be difficult to implement a child protection plan and PLO effectively. Town B ICS Team agreed to pick up the case once the move to Town B was completed.

15.79. The pre-proceedings (see Glossary) meeting for Roy Davis and Paul Williams took place on 26th January 2018 where written agreements were signed. It is recorded that the meeting "went well." Jean's meeting was rearranged for 12th February 2018 to accommodate her solicitor.

15.80. It was agreed pre-proceedings would be progressed, along with a rapid initial assessment of both biological fathers to consider their parenting capacity if escalation to care proceedings was required.

15.81. On 29th January 2018, the social worker called Jean, who confirmed the family would be fully moved to Town B the following week as their four weeks of leniency granted by Town B Housing Team would have ended and her tenancy could be challenged. Jean stated that she was remaining living with David at a temporary address during this time "regardless of the safeguarding agreement".

15.82. On 30th January 2018, Jean contacted her GP for a telephone medication assessment – she confirmed that she was feeling better on this medication and a new prescription was prepared for her.

15.83. On 8th February 2018, the social worker contacted KMPT and was advised Jean did not have an allocated CMHT worker and therefore the social worker spoke to the person on duty to enquire whether Jean had capacity to attend a child protection meeting. The duty worker advised they could not comment as they had not met Jean, and there had not been an assessment on Jean's capacity to be able to attend and contribute to a meeting regarding the care of her children, however, that in the first instance capacity is always presumed. The social worker advised there was a pre-proceedings meeting planned for 12th February, and she would contact CMHT if there were capacity issues raised during the meeting by Jean's legal representation.

15.84. The pre-proceedings meeting due to take place on 12th February 2018 was cancelled as Jean and her solicitor were unable to attend. An alternative date was offered for 23rd February 2018.

15.85. On 16th February 2018, Jean's social worker unsuccessfully attempted to conduct a child protection visit. A call was made to Jean, who was unhappy that her new address was shared via the core group minutes and accused the social worker of being a liar. David could be heard in the background shouting at Jean and telling her to hang up. Jean was advised to register with a GP and CMHT in Town B, which would support her assertion that she had now moved. Jean then called the ICS office in Town B and advised the new social worker that she would no longer speak to the social worker from Town A.

15.86. A few days later the social worker completed statutory visits with Child A and Child B. Neither child spoke about their home life apart from confirming they had slept at David's accommodation the night before.

15.87. On the same day, a parenting assessment was undertaken in respect of Paul Williams with a positive outcome. It was decided and recorded that if Child B was removed under police protection due to domestic abuse in their mother's home, they would go into the care of their father.

15.88. On the following day, Jean was involved in an incident which ended her life.

15.89. In May 2019, the Kent Coroner returned a verdict of misadventure.

16. Analysis

16.1 Overview

16.1.1. From the information made available, it is clear Jean Carter struggled with mental health issues from a young age. Her poor mental health may be linked to the domestic abuse present in her childhood, she spent time in local authority foster care and the trauma related to a sexual assault inflicted upon her by a family friend. It would appear the trauma from these events went unidentified, and therefore untreated, and was exacerbated by a continuous stream of violence and abuse by intimate partners throughout her adult life.

16.1.2. Jean's perception of ICS may have been tainted by her own childhood when she spent time in care. She vocalised her fear of ICS involvement and losing the care of her children on numerous occasions to her IDVA, the CMHT and to her GP. Jean's experiences of the Criminal Justice System may also be linked to the trauma of reporting sexual abuse and seeing no one held to account; an experience which was also reflected in her experiences of police involvement when she was with Roy and again with Paul.

16.1.3. Jean's distrust of professionals may also be a consequence of EUPD, which she was diagnosed with just before her tragic death. People diagnosed with EUPD find it difficult to form relationships and to trust others.

16.1.4. Jean's life was punctuated by male violence. She received "warnings" from ICS about the behaviour of her partners. Towards the end of her life these men became involved with the ICS process, in a way which Jean may have perceived as supporting a plan to remove the children from her care.

16.1.5. Jean's EUPD diagnosis came only a matter of weeks before her death. Practitioners therefore did not have the time or space to begin any meaningful work with Jean before she died. The treatment of EUPD requires long term and intensive interventions, which should include the forming of optimistic and trusting relationships.[41]

16.1.6. Whilst agencies may have followed the policies and processes in place at the time, there were missed opportunities for professionals to be more professionally curious about domestic abuse incidents. There also appears to have been a lack of understanding of Jean's experiences and how they may have led her to normalise violence and abuse within intimate relations, distrust of authorities and being viewed as "choosing" her relationship with David over her children. This lack of understanding of Jean's life experiences, along with a wider lack of knowledge of the complex effects of both domestic abuse and EUPD, and a resulting lack of trauma informed response to her needs, culminate and thread through the relationships Jean had with each of the agencies. These responses will be analysed in the next section, this will be followed by an analysis of the common themes emerging from the review.

[41] NICE, "Borderline personality disorder: the NICE guideline on treatment and management" *National Clinical Practice Guideline Number 78* The British Psychological Society and the Royal College of Psychiatrists (2009)

16.2 Kent Integrated Children's Services / Early Help and Preventative Services

16.2.1. There is an inextricable link between mothers and their children. Even if professionals did not agree with Jean's choices, in order to protect her, and therefore her children, they needed to understand her experiences, how these experiences moulded her motivations and made her behave in the way she did. The ICS IMR Writer recorded that:

> "aside from a more joined up approach with mental health professionals, ICS were unable to identify anything which could have changed their relationship with Jean. The Social Worker was determined and committed to safeguarding the children but Jean's resistance to work with Kent Integrated Children's Services made it difficult to build a meaningful relationship."

16.2.2. However, it could be argued that if the social workers had a better understanding of how Jean's traumatic experiences as a child, and of abuse in her previous relationships, may have shaped her expectations of what constitutes a healthy intimate relationship; also how this abuse affected her mental health – and particularly her EUPD, reduced her confidence, self-esteem and negated her sense of self; and in turn, how David's violent, coercive and controlling behaviour would feed off these vulnerabilities and render Jean as either incapable of identifying the risks she and her children faced, or certainly incapable of doing anything about these risks; they could have approached Jean with an empathy which may have broken down the barriers to her asking for help.

16.2.3. The Safe and Together Model, which is currently active throughout Scotland and within ten Local Authorities across England,[42] is an approach to child welfare which:

> 'provides a robust foundation upon which practitioners from statutory and non-statutory backgrounds can work

[42]Bocioaga, A *Evidence on the Safe and Together Approach* (December 2019) Available <safe_and_together_summary.pdf (iriss.org.uk)> Accessed 8th January 2020

collaboratively and reach consensus about how best to ensure the safety and wellbeing of children living with domestic family violence.'[43]

16.2.4. The model's three principles are; to keep children safe and together with their non-abusive parent, for practitioners to partner with the non-offending parent as a default position, and to interview with the perpetrator to encourage engagement and accountability. The Safe and Together Model provides a suite of tools, including ongoing training for practitioners to understand the complexities of domestic abuse, which ensure all practitioners start from the premise that the behaviour of the perpetrator is the foundational source of the risk and safety concerns for the children, not the adult survivors, or their behaviour. The model reduces the use of victim blaming language and potentially encourages the survivor to engage with practitioners. If this model, or a similar victim centred model was available to social workers in Jean's case, the details of this child protection case may have been different.

16.2.5. The assault upon Jean in November 2017 was assessed as high risk. There were 14 previous domestic abuse incidents recorded over the years, involving Jean as the victim, at the hands of her previous partners, and four other concerns raised with ICS. None of the incidents, or referrals, were deemed as meeting the threshold for child protection procedures to be instigated and the majority of these resulted in Jean receiving advice that further reports of domestic abuse would lead to social care involvement with her family.

16.2.6. In January 2014, Jean was cited in social worker's notes as being "aware of the consequences" of her then partner Paul Williams drinking and becoming aggressive again. Presumably, these consequences would have been the involvement of ICS. A week later she admitted to a mental health worker that she had told the social worker all was well, when in fact it was not – this was during Paul's assessment appointment which had to be halted due to him being intoxicated. At this point responsibility for controlling her partner's behaviour

[43] Humphreys C, Healey L and Mandel D (2018) Case reading as a practice and training intervention in domestic violence and child protection. Australian Social Work, 71, 3, 277–291. Available<Case Reading as a Practice and Training Intervention in Domestic Violence and Child Protection: Australian Social Work: Vol 71, No 3 (tandfonline.com)> Accessed 8th January 2020

rested upon Jean. This expectation upon mothers to control the abusive behaviours of fathers is well documented. Felicity Kaganas argues that:

> "Clearly, the risks inherent in being assessed and monitored, and the responsibility of behaving in a way that withstands scrutiny, do not rest on both parents equally. Nor do the burdens of co-operating with the professionals."[44]

16.2.7. Social workers and other professionals expect to deal predominantly with mothers during the child protection process,[45] and indeed during the process mothers are expected to "cope despite extremely trying circumstances."[46]

16.2.8. When social workers and other professionals deal with domestic abuse situations by focusing on the parenting of the non-offending mother, they:

> "operationalise erroneous and dangerous assumptions: that a woman has some control over her partner's violence; that reporting the violence or leaving the perpetrator will reduce violence; that victimised mothers receive swift and supportive responses from the criminal justice system if they choose to report…"[47]

16.2.9. At the time of the abusive incidents, perpetrated upon Jean first by Roy and then by Paul, the circumstances of each individual event were not deemed to reach safeguarding thresholds, however, collectively these incidents were later used to build a picture of a safeguarding concern - presumably the concern being that Jean was unable to "choose" safe men - whilst the men whose behaviour led to the ICS involvement were not deemed to be a safeguarding concern any longer. This may have signalled to Jean that she was the problem. She may have perceived the behaviour of her ex-partners was not held to

[44] Kaganas F, "Child Protection, Gender and Rights" in Wallbank, J, Choudhry, S and Herring, J (eds) Rights, Gender and Family Law (2010) p.66
[45] Ferguson, H *Protecting Children in Time* (2004) p.3
[46] Krane, J and Davies, L "Mothering and Child Protection Practice: Rethinking Risk Assessment" Child and Family Social Work 5 (2000) p.42
[47] Strega, S and Janzen, C "Asking the Impossible of Mothers: Child Protection Systems and Intimate Partner Violence" in Strega, s et al *Failure to Protect: Moving Beyond Gendered Responses* (2013) p.57

account – whilst her ability to parent was now being held to account - the fact of which may have alienated her from engaging in the child protection process.

16.2.10. The Domestic Abuse Act 2021 recognises children as direct victims of domestic abuse.[48] Had the incidents of domestic abuse perpetrated by Roy - and later by Paul - occurred today, the law would call for the children to be recognised as victims of their (step) fathers' behaviours.

16.2.11. A study by Stanley et al. examined DHRs to identify the effects on children situated within a family where a domestic homicide had occurred. In this study it was found that fathers were largely "invisible" to professionals, and this led to the victim being required to take responsibility for the child's safety.[49]

16.2.12. On 18th December 2017, Jean asked for David to be part of the agreement and the social worker turned this down – however unlikely it was for David to have engaged with a multiagency meeting, this may have been an opportunity to challenge David in a constructive way and may have eventually led to engagement from Jean who would have been able to witness his behaviour in the multi-agency setting.

16.2.13. On 14th December 2017, following the CPS decision to refuse a charge on David, a social worker telephoned Jean, and David was heard in the background – this led to a manager calling Jean to remind her David was not to have any contact with the children. The manager recorded her concern that Jean was allowing contact between David and the children. This assumes Jean had a choice in the matter and assumes she had control over David's behaviour which she did not.

16.2.14. Professionals who visited Jean's home described it as clean and tidy with no physical damage that might have suggested domestic abuse had taken place. However, when the social worker pointed out the bruises on her face, Jean denied they were fresh injuries. No alcohol was present to indicate Jean had been drinking heavily or using drugs, and there was no evidence of any injury to the children when they were seen at home or in school and nursery. School

[48] S 3.3

[49] Stanley, N, Chantler, K and Robbins, R "Children and Domestic Homicide" The British Journal of Social Work (2018) pp.1-18

and nursery reported that although the children did not speak very much about home, they were settled and happy and their attendance record was good. Although it is unclear whether the children witnessed their mother being physically harmed, during direct work with professionals the children explained that they had witnessed the aftermath of violence, for example injuries to Jean and damage to their home. It was decided at the legal planning meeting not to immediately issue court care proceedings as the Local Authority is committed to using pre-proceedings to work with families in order to avoid the need of going to Court.

16.2.15. As someone who grew up with male violence surrounding her and as an adult had continued to experience male violence, Jean may have believed her situation with David was the norm. Jean's mother told the review's author that David was good to Jean, compared with Paul and Roy who had been violent, and continued to control Jean after her relationships with them ended. This is despite the serious assault upon Jean by David. It would seem both Jean and her mother did not identify David as abusive, instead they identified him as safer than the previous partners because he was less violent.

16.2.16. When Jean was handed the letter before proceedings on 17th January, this may have been a pivotal point for her in terms of her mental wellbeing. She was very vocal about the children being the only reason for her carrying on. KMPT notes state that during her assessment Jean expressed she experienced intrusive thoughts of jumping off a bridge and experienced suicidal thoughts the day before the assessment, but it was thinking about her children that meant she did not do this. During the KMPT IMR preparation, the KMPT social worker was asked about her record keeping that noted Jean's children as "protective factors", she noted Jean had stated the reason for seeking help was because of her children and that she saw them as the reason why she needed to "make things better." Although there was a valid cause for concern raised by the social worker - that children should not bear the burden of being a parent's protective factor - the letter before proceedings could have been identified as a flash point for Jean where she saw her fear of losing the care of her children come true. Had this flash point been identified, with her diagnosis of EUPD being understood and her experiences of coercive control being acknowledged, she could have been re-offered further support at the time she was given the letter before proceedings, for example this could have been an opportunity for a joint

visit with the IDVA and a mental health worker to have a frank discussion about her options.

16.2.17. Jean may have been made aware of the fact that the biological fathers' pre-proceedings meeting went ahead on 26th January in her absence; and parenting assessments were undertaken to explore if the fathers could care for the children, if it were deemed necessary to remove them from Jean's care. At this point, Jean may have felt she was losing further control of the situation.

16.2.18. A 'Signs of Safety'[50] approach was used by ICS for risk assessment and to identify safety and strength within the family. Supervision, both formal and informal, was utilised to reflect on the concerns and there were clear 'worry statements' and 'safety goals' recorded on file. The Team Manager had been consulted appropriately. There were definable action points in the child protection plan but many required Jean to work with the Social Worker and other safeguarding agencies. Agency procedures had been followed and within timescale, but this did not result in a purposeful relationship developing between Jean and the allocated social worker. It is of note that Jean had only been seen once without another member of the family being present, however, this is in line with the Signs of Safety model's best practice which requires practitioners to involve family/friends in meetings, in order to support transparency and empower family/friends to support with safety planning.

16.2.19. In January 2018, the social worker received calls and emails from Roy and Paul alleging that Jean was "brainwashing" Child A with respect to what they should and shouldn't say to professionals, the fathers also raised concerns that the social worker was believing a "manipulated (child) and a drug and drink dependant mother." The social worker duly responded to both fathers clarifying the situation and assuring that all views were being taken into consideration.

16.2.20. The social worker's skilful management of the children's father's expectations, whilst not allowing them to become collusive due to their own wishes and feelings, was good practice and enabled a different perspective to be shared.

[50] Since 2015, Kent Children's Specialist Services has practiced a 'Signs of Safety' model. 'Signs of Safety' is a strengths-based approach that provides a consistent framework for practice throughout Children's Kent Integrated Children's Services from Early Help through to a child becoming looked after, including the format for child protection conferences. Risk is assessed using the 'Signs of Safety' format.

Whilst it is important to involve fathers - especially fathers who do not live with their children - in assessing risk and the planning process, it is important not to lose focus on the needs and views of the children. Burton and Thoburn warn of the dangers of workers being pulled into 'collusive situations that can result in the loss of focus on the child'. [51]

16.2.21. Despite Jean's reluctance to engage, the social worker was both persistent and creative in working with the children who, when on their own, were able to provide some information about their lives at home. There were examples of good practice such as ensuring Child A had a safe person to contact if they were worried or felt under threat. The social worker also liaised closely with the children's fathers and arranged a planning meeting so that information was shared, their views listened to, and their expectations managed. Although it is good practice to engage fathers, absent and otherwise, in child protection planning, the involvement of the ex-partners who had also abused her may have created a further barrier to engagement for Jean. Jean's mother explained to the review author that both of Jean's ex-partners had a vendetta against Jean because she was no-longer under their control since meeting David. This may or may not have been the case, but a good understanding of how the involvement of the abusive ex-partners may have been perceived by Jean, how in turn it may have further eradicated her trust in the child protection system, may have allowed more creative attempts to also engage Jean actively in the process.

16.2.22. Opportunities to creatively engage Jean in the child protection process may have included a joint visit by the social worker and the IDVA to Jean. This may have given the social worker a chance to build a rapport and monopolise upon the engagement which the IDVA managed with Jean. The social worker could have also arranged a meeting with the CMHT and Jean to learn more about her new diagnosis of EUPD and particularly what the impact of this disorder may have on Jean's ability to parent and her engagement with services. There may have also been a role for Adult Social Care services in supporting Jean, and this could have been explored by the social worker. The need for Children and

[51] Burton, S. (2009) Safeguarding briefing 3: The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information? And Thoburn, J. (2009) Safeguarding briefing 1: Effective interventions for complex families where there are concerns about, or evidence of, a child suffering significant harm

Family social workers to share safeguarding information with other services, including making referrals for adult services, is also reflected in a recently published DHR.[52]

16.2.23. The ICS team followed their domestic abuse policy and procedures in accordance with Kent Safeguarding Children Board[53]. There was evidence of good practice in the social worker sharing information and concerns with other agencies such as Police, IDVA, and attempts were made to share concerns with the Community Mental Health Team.

16.2.24. Both the social worker and Team Manager have been keen to learn from this experience and have already implemented new ways of working in the team such as recognising the importance of having the right conversations with parents who are resistant to engaging.[54]

16.2.25. The child protection process was further complicated by the delay in the family's move to Town B. There was a period of time where the family moved from the home in Town A and were staying at a temporary location in County B whilst the property in Town B was being decorated. There was good practice identified where the Town A social worker commenced the transfer process to the ICS team at Town B ahead of the move, to ensure a smooth transition. This was due to the level of risk identified by the Town A social worker.

16.2.26. During the period where the family were residing in the temporary location the Town A social worker made trips across the County, and outside of their geographical area, this was good practice. The Town A team manager commented that during this time "it felt like it was only social services that were willing to cross boundaries and that other agencies were backing away". It is to the credit of the Town A ICS team that they continued to travel to meet the family wherever they were residing. The Team Manager also explained that although caseloads were high in the team at that time, the risks surrounding Jean and her children were responded to appropriately by dedicating two social workers to each visit, regardless of travel time.

[52] Connie (2018)

[53] This Board preceded the current Kent Safeguarding Children Multi-Agency Partnership (KSCMP) which was introduced following the revised Working Together to Safeguard Children Statutory Guidance in 2018.

[54] Shaheed, F "Engaging resistant, challenging and complex families." *Research in Practice Strategic Briefing* (2012) RiP Prompt Briefing V3 — [Orange].indd (lrsb.org.uk)

16.3 Kent Police

16.3.1. Whilst she was a teenager, Jean was known to a police force outside of Kent, as a missing person, a victim of neglect and a person at risk of domestic abuse from her mother's partners.

16.3.2. During 2007-2008 she was known to Kent Police as a victim of domestic abuse at the hands of her then partner Roy Davis.

16.3.3. The second reported incident perpetrated by Roy Davis in May 2008 was assessed as 'high risk', however, three months later officers attended and assessed a further incident as 'standard risk'. These incidents appear to have been dealt with as single incidents, as they presented themselves rather than in the wider context. Evan Stark argues that coercive control is not a single incident, but a course of conduct which permeates all parts of a victim's life,[55] and as such incidents of violence should be investigated within this wider context of day-to-day intimate terrorism.

16.3.4. These incidents perpetrated by Roy Davis occurred in 2007, prior to the introduction of the MARAC and the CRU. Had these arrangements been in operation in 2007 the couple would have been subject to a more comprehensive risk assessment and a greater exchange of information would doubtless have taken place between agencies. The risk assessments would have been more robust, and the 'standard' classification may have been upgraded. The CRU would have been contacted immediately for safeguarding advice due to the presence of a child, and a domestic abuse triage discussion would be triggered to ensure all referrals, information sharing, and safeguarding options had been explored. A more coordinated response to Jean as a victim of domestic abuse, earlier on in her life may have given her more confidence in the ability of police to respond to domestic abuse and may have raised her status as a victim within her own mind.

16.3.5. Jean next came in to contact with Kent Police following a number of domestic abuse incidents perpetrated upon her by a new partner Paul Williams.

[55] Stark, E *Coercive Control: How Men Entrap Women in Personal Life* (2009) p.15

16.3.6. Until January 2014 police were always called by a third party and Jean was reluctant to engage with police. In January 2014, Jean called Kent Police reporting that since 2009 she had been abused by Paul. On this occasion Jean was supportive of positive police involvement, and Paul was arrested, however the CPS declined to proceed with a prosecution due to a lack of evidence. This may have further impacted upon Jean's perception of the police ability to protect her from intimate partner violence.

16.3.7. In March 2014, Jean again reported an assault by Paul Williams who was subsequently charged. Jean later refused to support any prosecution against him, and the case was withdrawn. Had this incident occurred in more recent years there may have been more of a drive to proceed without Jean's evidence where possible. Evidence led prosecutions can be sought by the CPS where there is no evidence directly adduced from the complainant. A prosecution must be in the public interest; for example, if a prosecution is likely to protect the victim from further abuse. Complainant hearsay, for example evidence taken from a body worn camera, information from 999 calls, bad character and witness hearsay can be used to build a case without the direct involvement of a victim. In 2018 Steven Saunders was the first person to be jailed for coercive and controlling behaviour without the support of his victim through the process.[56]

16.3.8. Between the commencement of Jean and David Baker's relationship in July 2017 and to the point of her death in early 2018, Kent Police had limited involvement with Jean or David. More information in relation to David Baker and to Jean's two previous partners came to light as a result of the criminal investigation into her death. As an example, this investigation identified an assault in October 2017 when David Baker allegedly 'smashed Jean's mobile phone into her face' resulting in her sustaining two black eyes. Friends also told police that the relationship became intimate and serious very quickly and that David Baker was controlling her from the outset. Research has identified a number of warning signs which can be indicative of a prelude to domestic abuse and domestic homicide e.g. early co-habitation, early commitment,

[56] See < Prison sentence following "victimless prosecution" for controlling and coercive behaviour | Criminal Law Blog | Kingsley Napley> Accessed 8th January 2020

jealousy at an early stage, drug, alcohol and mental health issues, suicide threats and the isolation of children.[57]

16.3.9. Following the attack on Jean in November there was good practice identified, where officers from the Vulnerability Investigation Team (VIT - See Glossary) VIT team viewed eight hours of footage from a body worn camera, filmed from the scene of the attack and throughout the time that officers stayed with Jean whilst she was attended to in hospital. Officers spent this time trying to engage Jean in a conversation about her assailant. She continued to refuse to give up the identity of her attacker during a conversation with the Gypsy Liaison Officer who also spoke with Jean. On 22nd November, Jean drove David to the police station to be dealt with, and whilst he was spoken to, officers took a further opportunity to speak to Jean about the incident, again asking her to divulge the name of her assailant. Throughout the discussions with officers Jean insisted that the assailant was not David, but another man, and that she had deserved the violence.

16.3.10. There was good practice identified in the consideration of an evidence led prosecution (See Glossary) against David, however Jean had clearly stated that the assailant wasn't David which undermined any evidence to charge.

16.3.11. David Baker was released on bail with a condition that he should not have any contact with Jean or her children.[58] This was good practice in that it was designed to safeguard Jean and her children and provided her with time to consider her status as a victim of domestic abuse.

16.3.12. The VIT team discussed the case with CRU and an "adult at risk" referral (See Glossary) was considered for Jean; however it was decided that other agencies would be engaged via the child protection process and also via the MARAC. This could have been a missed opportunity to engage an agency who would have approached Jean from an adult safeguarding perspective.

[57] Monckton-Smith, J *In Control: Dangerous Relationships and How they End in Murder* (2021) p.61

[58] In April 2017, there was a change in legislation in relation to bail and from this point it was rare for arrested persons to be the subject of bail following their 'release under investigation'. This subsequently gave no protection to victims. The use of conditional bail can only be considered after consent of an Inspector and can only be granted for a maximum of 28 days. An extension can only be approved by a Superintendent.

16.3.13. The IMR writer discussed the use of a Domestic Violence Protection Notice and Order (DVPN/DVPO)[59] with the Investigating Officer, who stated that the consensus had been that Jean's denial that David was a perpetrator of domestic abuse, meant obtaining a DVPN would have been problematic. Conditional bail was utilised which, under the circumstances, was viewed as providing the same protection that a DVPN/DVPO would have achieved. This could have been a missed opportunity. As guidance on DVPN/DVPOs clearly states that:

> 'the success of any such process will be reliant on the partnership work with other agencies and organisations including those that contribute to Multi-Agency Risk Assessment Conferences (MARACs) and service providers for Independent Domestic Violence Advocates (IDVAs) or other, similar services.'[60]

16.3.14. The use of a DVPN/DVPO, alongside engagement with specialist services would have sent Jean a message that her situation was serious, that the police were using all available resources to protect her, even if she did not recognise the risk, and a more immediate coordinated response would have been possible. As it was, the MARAC was not held until 3 weeks after the incident.

16.3.15. Although a DVPN is not suitable or relevant whilst bail conditions are in place, a DVPN could have been served on David when he was refused charge – a DVPO could have followed, with a visit to Jean alongside the IDVA to explain the process. This may not have encouraged Jean to engage, however it could have illustrated to her that the police powers had improved since her relationship with Roy and Paul and may have encouraged her to confide in the IDVA about her fear of David.

[59] Crime and Security Act 2010 s.23-33

[60] See < Domestic Violence Protection Notices (DVPNs) and Domestic Violence Protection Orders (DVPOs) guidance - GOV.UK (www.gov.uk)> Accessed 8th January 2020

16.4 Multi-Agency Risk Assessment Conference (MARAC)

16.4.1. The purpose of the MARAC is to bring together the agencies and professionals who may have insights into a survivors' life, with the objective of reducing risk and re-victimisation.[61]

16.4.2. Jean's case was heard at the Town A MARAC on 7th December 2017, following the serious assault upon her in mid-November. The allocated social worker did not attend this meeting which is recognised as a missed opportunity to share and learn information about Jean and her family. At the time, it was accepted practice for a management level representative to attend the MARAC on behalf of all the cases being heard. This practice has now changed, with allocated social workers being invited to MARAC and attending wherever possible. Jean's GP practice was asked for a report to inform the meeting of Jean's physical and mental health – this was not provided and left a gap in the attendees' understanding of Jean's mental health issues.

16.4.3. At this meeting housing representatives from Town A advised that a mutual property exchange had previously been agreed, but to assist with safeguarding they would delay the move. This action was designed to give Jean some 'breathing space'; to allow her time to consider her position in terms of risk and her relationship with David Baker. This was seen as an innovative approach to this difficult situation. Had this case not been subject to MARAC it is highly unlikely that Town A or Town B housing teams would have been aware of the risk involved in the property exchange.

16.4.4. Also, during this MARAC, consideration was given to sharing details of David's violent history with Jean. MARAC attendees agreed that this process would be unsuccessful owing to her denials and lack of engagement. It was considered that David Baker's violent past would be disclosed during the upcoming conference. It was recorded that Jean would then 'have no option but to hear of (David's) propensity for violence.' The reasoning behind the decision not to utilise the "Right to Know"[62] Process within the Domestic Violence Disclosure Scheme (DVDS) is misleading, as Jean's denials of the abuse should not be a

[61] Robinson, A L "Reducing Repeat Victimisation Among High-Risk Victims of Domestic Violence: The Benefits of a Coordinated Cardiff, Wales" Violence Against Women 12 (8) (2006) pp.761-788
[62] Home Office *Domestic Violence Disclosure Scheme Guidance* (2016) p.15

reason not to share this information. Marian Duggan has raised questions regarding situations where professionals have historic information about a victim's (or potential victim's) partner's violent history and choose not to disclose this information.[63] It could be argued that it should have been left up to Jean to decide how to respond to information about previous violence, and saving this information for a multi-agency conference, where her family, ex-partners and a variety of professionals are all present, instead of speaking to her individually in a secure setting, would have affected how Jean would have received this information.

16.4.5. On 17th January 2018 Jean's case was included in the 'mention only' list at the Town B MARAC as a transfer into the area (see Glossary). Although we now know that Jean had not moved to Town B at this point.

16.4.6. It does not seem that the full capabilities of the MARAC process were utilised for Jean. There was a lack of attendance from key professionals, a lack of information shared about a key part of her life, and apart from the action taken by the housing team to delay Jean's move to Town B, there seemed to be a lack of proactive decision making and action planning coming from either MARAC meeting.

16.4.7. It could be argued that on this occasion the MARAC did not fulfil its purpose. Recent DHRs have also identified weaknesses in MARAC provision and have called for a review of the process in Kent and Medway.

16.5 Town A and Town B IDVA Services

16.5.1. Kent County Council's Integrated Domestic Abuse Service (KIDAS) delivers the Independent Domestic Violence Advisor (IDVA) and outreach service in and around Town A in partnership with a local domestic abuse provider.

16.5.2. On 17th November, the Town A IDVA service received a MARAC referral for Jean. The presence of the victim is not permitted at the MARAC meeting[64] and

[63] Duggan, M 'Victim hierarchies in the domestic violence disclosure scheme' *International Review of Victimology* (24) 2 (2018)

[64] Kent Police Kent and Medway Multi Agency Risk Assessment Conference (MARAC) Operating Protocol and Guidelines (2013) p.6

so IDVAs "speak up for victims"[65] with the intention of ensuring their wishes and feelings are taken into consideration amongst the decisions that are made by the representatives of the police, social services, health and education departments.[66] The IDVA should be an "effective advocate"[67] at the centre of the MARAC proceedings, representing the views of the victim in her absence.

16.5.3. During Town A IDVA's frequent engagement with Jean, she continued to insist that David was not the perpetrator of the assault, although discrepancies in her accounts were recognised. As part of the safety planning, the IDVA encouraged Jean to accept aids such as a panic alarm, which she said could be useful if the person who Jean said *was* her assailant returned to the house.

16.5.4. The panic alarm was fitted on 27th November and the following day Jean disconnected it and called the investigating officer in tears stating she was not the victim of domestic abuse and did not need the alarm. There could have been an opportunity at this point for the IDVA to challenge this with Jean.

16.5.5. On 7th December 2017, the Town A IDVA attended the MARAC and represented Jean's wishes to stay in a relationship with David. The IDVA also expressed her own concerns that Jean's children could be at risk. On 13th December 2017, the Town A IDVA also attended the ICPC.

16.5.6. Throughout the month-long period that Town A IDVA supported Jean, she liaised and updated agencies regularly including the police officer and social worker involved in the case. There was a missed opportunity for joint visits and meetings involving both the social worker and the IDVA. These meetings would have allowed the social worker to challenge Jean's perception of the situation, whilst the IDVA was in attendance to offer Jean support but also advocate for Jean, utilising her knowledge of the dynamics, nuances and effects of coercive control, for the benefit of both the social worker and Jean.

16.5.7. Jean's case was transferred to the Town B IDVA service, and on 15th January 2018 the Town B IDVA contacted Jean and heard a male voice in the background. Jean stated she was not in an abusive relationship and declined

[65] Harne, L and Radford, J Tackling Domestic Violence: Theories, Policies and Practice (2008)
[66] Kent Police above n 27 pp.5-6
[67] *Ibid* p.10

support from the IDVA. The Town B IDVA contacted ICS about this conversation, but was not informed that Jean was yet to move to Town B. During the Town B IDVA's case management on 23rd January 2018 it was decided that the case would be closed to the Town B IDVA due to Jean declining support. This decision was in line with case management protocol; however, the decision was made without all the relevant information about Jean's situation.

16.5.8. As with other agencies, in her contact with the IDVA service Jean did not appear to recognise the risk that David posed to herself and her children. This could be due to her normalising the abuse, as discussed above. However, it is usual for someone who is being subjected to coercive and controlling behaviour to normalise this behaviour – this is assisted by the perpetrator minimising his behaviour, often blaming the victim, the children or other external factors rather than admit that his behaviour is abusive.[68] The victim's perception of abuse being normal, or of it being her fault, is further exacerbated when professionals frame her as the problem, either because she has failed to stop the abuse, end the relationship, support prosecution, or if she abuses drugs or alcohol. This feeds into the abuser's standpoint that the behaviour is not his fault, and he is the injured party.

16.5.9. Normalising abuse is also a protective factor for a victim which allows them to live each day despite the risk of harm they are facing.[69] It is widely documented that the riskiest time for a victim of abuse, and their children, is the point of separation. As Campbell et al argue:

> "it is problematic to construct a women's decision to stay with a violent partner as child endangerment because perpetrators often threaten, and in some cases do, kill women and children precisely because women leave or indicate their intention to do so."[70]

[68] Wiliamson E "Living in the World of the Domestic Violence Perpetrator: Negotiating the Unreality of Coercive Control" *Violence Against Women* 16 (12) (2010) pp.1412-1423
[69] Herman, J *Trauma and Recovery* (2001) p.83
[70] Campbell, J et al "Risk Factors for Femicide in Abusive Relationships; Results from a Multi-Site Case Control Study" *American Journal of Public Health* (93) 7 (2003)

16.5.10. During the IMR writer's interview with Town A IDVA she maintained that to ensure Jean engaged with the IDVA service she chose not to question her normalising of David's behaviour, but to focus on safety for her and her children. Town A IDVA understood that Jean was in a relationship with an abusive and coercively controlling man and was in fear of reprisals. However, in order to successfully advocate for Jean, she would need to encourage the social worker to also understand the complex and pervasive manner of coercive control. There is evidence that this was attempted during a phone call between the IDVA and the social worker, however the social worker responded that it did not matter why Jean was failing to see the risk, what mattered was the fact that the children were faced with risk. It does not seem that the IDVA challenged this on Jean's behalf, and did not broach this with the social worker, or any other partner agencies - either individually or within a multi-agency meeting, again.

16.6 Kent and Medway NHS and Social Care Partnership Trust (KMPT)

16.6.1. KMPT provides a number of different mental health services to people living in Kent and Medway. These services are provided through community-based teams, outpatient clinics and inpatient units.

16.6.2. CMHTs provide assessments and interventions for individuals experiencing mental health problems. Referrals to CMHTs can be made either through a SPoA for urgent assessments, or in non-urgent cases directly to locality teams. In the future the service pathway plan will be for SPoA to capture and triage all referrals made to KMPT. Once a referral has been screened and assessment needs identified, CMHT practitioners carry out an initial assessment.

16.6.3. KMPT were informed by Jean herself that she had been the victim of domestic abuse in her past relationships, but she did not disclose any abuse from David.

16.6.4. The assessments undertaken by Town A CMHT clearly ascertained Jean's wishes, feelings, and views. Practitioners appeared to undertake the assessments sensitively and sought to understand Jean's view of the support she needed. However, Jean presented KMPT with only partial information about her life.

16.6.5. In January 2014 there had been a missed opportunity for the CMHT to share with ICS that whilst speaking to a community mental health worker during Paul's assessment, Jean had confided in them that she hadn't been accurate when stating that "all was well" in her relationship with Paul.

16.6.6. During involvement with CMHT from 2017, Jean declined to be seen independently for the two assessments, wanting her grandmother to be present on one occasion and David on the other. This could be due to the influence of David, or other family members, or could be evidence of her fear and distrust of professionals, which is possibly a symptom of her EUPD diagnosis. Either way, it would have made it difficult for practitioners, who would have been wanting her to feel at ease during sessions.

16.6.7. The first opportunity KMPT had to make an assessment came when the Town A CMHT received the initial referral from her GP. The referral was made on 27th November, screened on 29th November and Jean was seen on 15th December. The referral indicated issues with domestic abuse but was not explicit as to who the perpetrator of the abuse was. The referral was first screened for appropriateness and then triaged for assessment by a senior member of the clinical team and a Consultant Psychiatrist. This is routine practice when referrals are made directly to a CMHT. It was decided that the referral could be triaged for routine assessment which meant an assessment had to occur within 28 days, however, in Jean's case contact for an appointment and assessment was made promptly.

16.6.8. The next key opportunities for decision making came in both the Initial Choice Assessment and in the medication review appointment. Both of these appointments presented an opportunity for the assessing clinicians to have consulted with other agencies to find out information relating to risk. This opportunity was not taken because there appeared to be a reliance on this information sharing/gathering being the responsibility of the Care Coordinator, for which Jean was on a waiting list to be allocated. The systems and processes within the Town A CMHT have since changed but at the time it was usual practice that such on-going assessment, including gathering and sharing of information with other agencies, fell to the allocated worker unless the risk was deemed immediate. The lack of allocated worker in Jean's case delayed

any liaison with other agencies and meant that relevant risk information known by other agencies was not gathered by KMPT in a timely way.

16.6.9. At the initial assessment Jean was not asked the reasons for the GP referral or about her contact with ICS. Had these questions been asked potential indicators of abuse could have been explored and Jean's account of events probed, and if necessary, challenged. The GP referral also mentioned Jean's fear of ICS and her children being removed from her care, had KMPT probed this further they may have built a better picture of the situation and could have also been involved in the child protection process.

16.6.10. All actions and risk management plans were based upon the information received directly from Jean. Whilst these plans appropriately supported the mental health needs which Jean herself presented - the delay of including other agencies in information gathering resulted in the risk management plan not being fully understood within the context of Jean's situation.

16.6.11. Whilst listening to a patient's wishes, feelings and views is a vital part of any assessment, mental health practitioners should also triangulate risk information from other agencies where contradictory information is given. The lack of clarification between the referral and Jean's report meant practitioners underestimated the risk of domestic abuse, or how agency involvement have impacted on her mental state and her parenting ability. Triangulation of the information provided on the referral form and the information provided by Jean, with ICS, IDVA and/or Police would have provided a clearer picture for all.

16.6.12. Jean told CMHT that David Baker had been on holiday when he was alleged to have assaulted her. She also repeatedly said that he was supportive of her, which was very much the impression created when David accompanied Jean to the second appointment. Jean said that on several occasions David had prevented her from hurting herself.

16.6.13. KMPT did not have contact with ICS until 5th January 2018, when the family's social worker contacted them to update on David's history of violence and drug offences, the police's suspicions about his involvement in the attack on Jean in November, and the reason for the child protection involvement. When contact was made there was evidence that the duty worker in Town A CMHT did

comply with KMPT's domestic violence and abuse protocols and evidenced the sharing of pertinent information in relation to Jean's mental state with the ICS social worker. Although this information was given, KMPT did not follow up to enquire as to how these risks and concerns were being managed. This could have been an opportunity for triangulation of information.

16.6.14. CMHT failure to send a representative to the core group on 22nd January is a cause for concern. Jean had recently been diagnosed with EUPD, and the absence of a mental health specialist at the core group meant that the diagnosis was not considered as a factor contributing to Jean's experiences as a victim, her inability to recognise the risk of harm from David, or her refusal to engage with ICS.

16.6.15. Information was correctly recorded by mental health practitioners, although the risk assessments did not include information about domestic abuse or that Jean's children were subjects of a child protection plan. The section on the recording template indicating children in a client's network, was left blank. The recording template is an established part of the KMPT safeguarding children and young person's policy, and this omission highlights an issue with practitioners not thinking of the whole family when completing assessments.

16.6.16. Jean shared that she was fearful of her children being removed from her care, and that this fear had previously prevented her from seeking help and support when she had harmed herself. It was therefore very important that staff in KMPT understood the child protection process and plans and were actively involved in conferences and significant meetings. This did not happen and consideration of what impact the outcome of these meetings may have had on Jean's mental state was not considered by mental health practitioners. This was especially important as Jean had said on a number of occasions that she viewed her children as 'a reason to keep herself safe'.

16.6.17. Town A CMHT's training for safeguarding children was significantly below target and locum staff were not included in the training matrix. The lack of monitoring of training completed by locum staff meant there was no clear evidence of whether they had been introduced to local priorities and resources.

16.6.18. The negative aspects of KMPT involvement in this case stem from the lack of a collaborative approach with ICS and a failure to triangulate information presented, which in turn resulted in missed opportunities to develop a more holistic and risk orientated understanding of Jean's situation and mental state. The referral and allocation process have now been addressed under the Choice and Partnership Approach (CAPA) model, and means patients no longer experience periods where they are not allocated a named worker whilst awaiting care coordination. This system now ensures any immediate actions are undertaken more promptly; which includes contacting other agencies for information sharing and gathering purposes.

16.7 Town A Clinical Commissioning Group

16.7.1. The review is focused on the GP group practice (GPM) which Jean and her children were registered with from the beginning of January 2017.

16.7.2. Throughout the timeframe of the review, Jean was seen on fifteen occasions at the surgery by five different GPs and sometimes by Practice nurses; she also had ten telephone consultations throughout the review period.

16.7.3. Child A was seen at GPM once, and was the subject of three telephone consultations, one of which was between a GP and the maternal grandmother. Child B was seen on five occasions at the surgery.

16.7.4. In November 2017 GPM requested that Jean complete a PHQ-9 questionnaire, which objectifies the level of depression severity, and a GAD-7 questionnaire, which objectifies anxiety levels. Both questionnaires scored in the severe range. As a procedural requirement, GPM referred Jean to the CMHT and Think Action who provide support and a range of interventions including talking therapy for depression and anxiety.

16.7.5. Subsequently Jean was contacted by Think Action[71] but she declined their support informing them that she had been referred to another service instead. It

[71] From 27th January 2020 Think Action have been named We Are With You - Home - We Are With You – this company encompasses Think Action, Addaction and Young Addaction – providing mental health, drug and alcohol advice and support

is unclear if this account was factual as there is no evidence in GP records of any other referrals to adjunct support services for depression and anxiety.

16.7.6. The GP demonstrated good practice by undertaking relevant mental health assessment scales, referring to CMHT for a psychiatric assessment, and also referring to a counselling service. CMHT contacted Jean within two days of the referral, and she turned down the counselling service when they contacted her. It is unclear whether Jean was advised of the two different referrals, and so it is not possible to determine whether she turned down the counselling because she thought that CMHT contact was sufficient for her needs.

16.7.7. The GP was the only service to see Jean alone – however she remained steadfast in reporting to GPs that any violent assaults had involved the partner with whom she had an 8-year relationship, and a man with whom she had a casual encounter. These men were unnamed in the GP records and there was no attempt made to identify who they were.

16.7.8. GPM received a detailed letter from the hospital where Jean was treated following the assault upon her on 15th November. The letter described the patient as being assaulted by her boyfriend who was allegedly intoxicated with alcohol. The letter stated this assault took place at her home and the police had been informed. The letter described Jean as being punched several times, thrown to the floor and kicked and that she fainted for a few seconds when her assailant tried to throttle her.

16.7.9. GPM had opportunities to discuss the assault with Jean but discussions at this stage were focussed on Jean's mental health. There are no records which suggest the surgery discussed what led up to the assault, the assault itself, Jean's physical/mental state, or what occurred following her discharge home, in particular if the assailant was present at her home address. This was a missed opportunity to reduce the risk of harm or neglect to Jean and her children and to ascertain if she was aware of what to do to raise concerns about her safety and wellbeing.

16.7.10. The contact on 27th November 2017 was crucial in that it provided a unique opportunity to discuss with Jean whether she felt safe and to consider her ability to protect her children from harm. A complete review of Jean's records would have identified her strengths, challenges and any family adversity.

Piecing this information together could have added greater insight and understanding about potential impacts on the children.

16.7.11. There was no suggestion in records that Jean lacked capacity, but she was highly vulnerable and should have been identified as a risk to herself. It was therefore important for her to be aware that if she felt her decision making was being affected in any way by undue influence or duress within the home, she could access help. It would have been important to help her to understand the risks to herself and to the children by remaining within a coercive relationship. It would also have afforded GPM the opportunity to signpost her to appropriate services.

16.7.12. Information about domestic abuse was not included in the records of Child A or B. Had this information been so recorded it would have alerted the staff at GPM that they may also be potential victims of domestic abuse. This was both a missed opportunity and a failure to uphold internal and national policy requirements regarding information sharing.

16.7.13. GPM has a specific requirement in their Adult Protection Protocol and the Domestic Abuse Policy relating to record keeping. The documents state:

- Domestic abuse is to be recorded in the patient's record.
- Records should be kept for evidential purposes.
- The practice computer systems should be used to identify those patients and families with risk factors or concerns using locally agreed Read Codes.
- The Practice Medical Secretarial Team are responsible for managing alerts and Safeguarding Adult information and correspondence which is supposed to be held together in one health record.

16.7.14. The practice safeguarding lead, named on the GPM domestic abuse policy, was a GP who no longer worked in the practice and therefore the Policy required updating. The Adult Safeguarding Policy also required updating as some contact details were incorrect.

16.7.15. It could be argued that both the GPs and Practice Nurses should have been more curious, and respectfully uncertain about Jean's social circumstances by applying critical evaluation to any information received whilst maintaining an

open mind. ‘Safe uncertainty’ would have focused on safety, taking account of her changing information, whilst acknowledging that certainty may not be achievable. Had the professionals ‘thought outside of the box’ and beyond their usual professional role, this would have facilitated the consideration of the family’s circumstances holistically.

16.7.16. GPM practice records indicate that there was a good interaction with Jean when ascertaining her wishes and feelings. This was especially seen in relation to her mental health medication and queries about the need for a mental health diagnosis. Appropriate and timely referrals were made regarding Jean’s physical and mental health and the practice was diligent in following these up.

16.7.17. There was good practice identified where GPM made follow up calls to Jean after she was seen at the local Minor Injuries Unit (MIU) for a wrist contusion, and a week after the assault in November 2017. This illustrates good information sharing from other health settings, as well as a proactive follow up when the information was received.

16.7.18. A large amount of information was recorded about Jean’s alcohol and drug use and misuse after she had achieved a period of sobriety. There was no evidence that a referral to drug and alcohol services was being considered, nor signposting to agencies or support services should Jean have wanted to reduce or cease her consumption.

16.7.19. Jean had some insight and knew that her life was complex and chaotic. She lacked control when navigating her life and at times she was disinhibited and aggressive. There is no clarity in GP records if anyone sought to comprehend what she understood about the trauma and adverse impact this situation could or may have had on her children.

16.7.20. On 15th December ICS made GPM aware of their involvement with the family, this prompted the GP to attempt contact with Jean. They called three times and left answerphone messages. On 18th December GPM was made aware of the child protection plan and the date of the ICPC. Despite the attempted contact, GPM did not manage to discuss ICS involvement with Jean.

16.8 Kent Community Health NHS Foundation Trust (KCHFT)

16.8.1. The KCHFT supply a range of community health care services across Kent including health visitors and school nurses, which are roles relevant to this case in as much as they affected Jean's children.

16.8.2. Jean was known to the KCHFT from 2nd December 2014, but the first contact of significance came in September 2017 when she was seen by the Clinical Health Service where she divulged a history of domestic abuse in a previous relationship with a named individual. She explained that she was now in a relationship with David Baker.

16.8.3. The history of Jean's past abuse was unknown to those professionals dealing with the current case as these details were not included on her electronic record – this may have been due to the archiving of paper records. Such information is now scanned and uploaded on to the KCHFT electronic database.

16.8.4. The lack of historic information impacted on the accuracy of assessment, and other than at the CP Conference, KCHFT professionals only discussed domestic abuse on one occasion with Jean - this was with the Clinical Health Service in relation to past relationships. As part of their contact with parents and children, KCHFT practitioners should be encouraged to discuss relationship issues and, where relevant, this should include domestic abuse.

16.8.5. Handovers between KCHFT services did not take place. There is no evidence within the records that the School Nurse or Health Visitor contacted one another - or liaised with mental health services or Jean's GP to share information which may have encouraged further/multiagency contacts. This was a failure to follow guidelines and safeguarding processes.

16.8.6. At the time of the original review, KCHFT had two very clear and updated Domestic Abuse Policies and a Safeguarding Operational Manual. All KCHFT staff had access to safeguarding advice and supervision, however it must be acknowledged that staffing levels do impact on time available to read policies and to contact the safeguarding team.

16.8.7. Policies and guidance in place at the time would have highlighted the need for robust handovers, and the importance of seeking advice and information sharing regarding concerns and issues linked to safeguarding. Guidance includes the need for safeguarding concerns to be discussed with managers, and with the KCHFT safeguarding team. There was a health visitor/GP communication policy in place at the time.

16.8.8. Improved handovers, with better communication and information sharing is now in place – this is supported by a system of management review and oversight of cases at six weekly staff 1:1s.

16.8.9. Following learning from this, and other DHRs, there is now better management oversight, safeguarding, domestic abuse and risk assessment training in place. There are briefings available on the weekly staff bulletin which cover new policies and guidance. Team meeting attendance is monitored, and new policies are shared at these meetings.

16.8.10. Use of the safeguarding consultation process has increased across the services, which is evidenced from internal audits.

16.9 East Kent University Foundation Hospital Trust

16.9.1. There was only one relevant episode involving EKUFHT during the time parameters of this review and that related to Jean's attendance at the hospital in Town A, following the assault on 15th November 2017. At the time of writing the IMR it had not been possible to interview the treating doctor and to date information relating to this hospital attendance has been compiled from records only.

16.9.2. During the time of the review period the hospital was extremely busy. Adult Safeguarding is regularly taught in the department and classes had been attended in 2017 by Accident and Emergency Consultants. A new electronic patient record was in place as was a MARAC flagging system. EKUFHT had been accepted on a domestic abuse pilot scheme because the organisation was already aware of the high level of domestic abuse in the area. At the time Jean attended the Accident and Emergency Department this scheme was in the process of being set up and the Domestic Violence Advocate had not started in post.

16.9.3. The Hospital Independent Domestic Violence Advisor (HIDVA) service was introduced in Kent in April 2018. The HIDVA service provides a link between the hospital and community services, ensuring that patients accessing the service in a clinical environment have the onward support they need when they leave the hospital. The HIDVA Service Annual Report[72] from 2019/2020 reports that 620 patients had benefited from the support and advice of a HIDVA between April 2018 and March 2020. Of those referred to a HIDVA within the hospital setting, only 4% declined advice or support.

16.9.4. It is recorded that after she left the hospital, Jean changed the narrative around who had assaulted her. If the HIDVA Service had been in place when Jean was admitted following the assault in November, this point of crisis may have provided the opportunity to engage her in discussion about the assault before she was externally influenced to change her version of events.

16.9.5. The treating doctor recorded Jean's injuries on her electronic record and sent a letter to Jean's GP detailing her injuries – this letter is detailed above at 16.7.8.

16.9.6. The records indicate that an adult safeguarding service was consulted but this was documented later that evening after Jean had left the hospital; it is not clear who was consulted as this was after the usual services had closed for the day. There is nothing recorded to indicate what, if anything, happened because of such a consultation.

16.9.7. Due to the paucity of the clinical record keeping it is unclear what took place to protect Jean from future abuse. Records state that police were known to be involved which may have influenced the actions of the doctor. There appears to be no evidence of any action to safeguard the patient other than to let the GP know she had been assaulted. It is possible that Jean did not give consent for an onward referral, however this is not recorded. There is no evidence Jean lacked mental capacity so any refusal for an onward referral would need to be considered, however, due to the attempt of strangulation recorded on the letter to the GP, this would have been sufficient to have reported this matter under the Kent and Medway Information Sharing Protocol (see Glossary).

[72] Westlake, R *Hospital Independent Domestic Violence Advisor (HIDVA) Service Annual Report 2019-2020* Kent County Council

16.10 Town A and Town B Borough Councils

16.10.1. Jean had applied to exchange her council owned property in Town A with an existing tenant in Town B. She advised that she wanted to move to this area due to 'previous domestic abuse, to be closer to family, childcare issues and the prospect of better job opportunities.'

16.10.2. The Housing Officer in Town B followed all processes according to the Housing Assignment Policy as it stood at that time. However, Jean had mentioned 'previous domestic abuse' on her application form in relation to the reasons for applying for the mutual exchange, and at the time there was no policy requirement to follow up on the nature of the domestic abuse, and this indicates a potential policy gap.

16.10.3. Jean could have been explicitly asked about the domestic abuse, who the alleged abuser was, the period the abuse took place and about her current situation in terms of risk. If the housing team had a standard risk assessment to be completed whenever there was mention of domestic abuse on a mutual exchange application – this would add another layer of assessment of the situations of victims of domestic abuse. Although in Jean's case, she was referring to historic domestic abuse from her ex-partner and presumably may not have disclosed David's behaviour to the Housing Officer – these questions, alongside the information shared at MARAC, would have enhanced the housing team's understanding of Jean's situation. A standard assessment for all mutual exchange applications which cite domestic abuse in any capacity, could also link to a range of measures available for the Housing Officer to support with, for example sanctuary measures, protective civil order, or indeed declining the move as it may not be deemed as safe.

16.10.4. As mentioned above, it is well documented that the point of separation is a danger flash point for victims of domestic abuse, and perpetrators often

continue harassment and threats to their ex-partners following separation.[73] Although it was felt by Town A Housing Team that the fact that Jean was moving away from the area where she experienced domestic abuse, indicated that Jean was removing herself from risk. Contrary to this, it could be viewed as dangerous for victims of domestic abuse to undertake a mutual exchange as the abuser need only ask the new tenant where they used to live in order to locate their ex-partner, if they intended to continue to harass them.

16.10.5. Jean's mother told the review author that David had paid the tenant in Town B to exchange with Jean. She also disclosed that she believed the purpose of the move was to isolate Jean from her family. Despite the efforts which were made by the housing team to draw Jean's attention to matters around her personal safety following the information shared at the Town A MARAC, there was no apparent consideration made for the safety of the tenant who was exchanging with Jean. Information regarding David's propensity for violence and intimidation was shared at the Town A MARAC, this information could have been shared with Town B housing team and this could have triggered some assessment of the tenant in Town B to determine whether they had been coerced or intimidated into moving. There was a meeting on 13th December with both Jean and the exchanging tenant – however this would have not been the forum for the tenant to raise a concern for the situation.

[73] See for example - Toews ML, Bermea AM. "I Was Naive in Thinking, 'I Divorced This Man, He Is Out of My Life'": A Qualitative Exploration of Post-Separation Power and Control Tactics Experienced by Women. *Journal of Interpersonal Violence*. 2017;32(14):2166-2189. doi:10.1177/0886260515591278; Stephanie Holt, Domestic Violence and the Paradox of Post-Separation Mothering, *The British Journal of Social Work*, Volume 47, Issue 7, October 2017, Pages 2049–2067, https://doi.org/10.1093/bjsw/bcw162; Katz, E et al "When Coercive Control Continues to Harm Children: Post-Separation Fathering, Stalking and Domestic Violence" *Child Abuse Review* (29) 4 (July/August 2020) pp.310-324

17. Conclusions

17.1 Trauma Informed Practice

17.1.1. Adverse childhood experiences (ACEs) are traumatic events occurring in early years; these events include neglect, violence between or perpetrated by parents or caregivers, alcohol or substance misuse within the home, and peer, community or collective violence, and which are associated with the development of health harming behaviours, physical and mental ill health in adulthood.

17.1.2. In order to respond to adults presenting with vulnerabilities and complexities linked to early years trauma, professionals must "show understanding" and "help explore through (their) work the question 'what happened to you and what may help you?'.[74]

17.1.3. The British Association of Social Workers (BASW)[75] have recently called for social workers to approach working with survivors in the context of their abuse, including holding perpetrators to account, whilst also ensuring that interventions remain child focused – and in the child's best interest. They argue that this approach will reduce practices which shame, penalise, and hold abused mothers solely responsible for their children's welfare.[76]

> "The impact of living with domestic abuse is traumatic. Often, there are long-lasting outcomes for mental and physical wellbeing. Trauma-informed practice for social work is not about therapy and treatment, but about doing no further harm. It is about creating a safe environment, building trust, promoting collaboration and sharing power to be empowering and help a survivor regain confidence in their own ability to move forward and create a safe, nurturing home for their child or children."[77]

[74] SPACE matters - Kent County Council
[75] www.basw.co.uk | The professional association for social work and social workers
[76] BASW *England Domestic Abuse Practice Guidance: for Children and Family Social Workers* (March 2021) p.7 Available: Layout 1 (basw.co.uk)
[77] *Ibid* p.30

17.1.4. All services responding to victims of abuse, and early years trauma should adopt a trauma informed approach, this requires "an organisational transformation model that improves awareness of trauma and it's impacts, supports services to consider and put in place appropriate support, and prevents re-traumatising those accessing or working in services."[78]

17.1.5. Trauma informed practice includes the ability to identify signs and symptoms of trauma, utilising a strengths-based model which empowers service users to collaborate in the design and delivery of their support – and asks, "what happened to you" instead of "what's wrong with you".[79]

17.1.6. For people living with a mental health diagnosis, trauma informed approaches mean that:

> "it can be extremely empowering and healing to explore and recognise that many or even all of their symptoms are linked to chronic traumatic experiences in childhood rather than innate 'defects' or 'disorders'."[80]

17.1.7. There appeared to be a lack of trauma informed practice deployed by most of the professionals responding to Jean's needs.

17.1.8. From the information available about Jean's life experiences, it is clear she experienced trauma in childhood, through her teens and into adulthood – predominantly in the form of male sexual abuse and violence.

17.1.9. NAPAC[81] argue that responses to survivors of sexual abuse, which do not utilise a trauma informed approach can lead to:
"disbelief, coercion, manipulation, restriction of movement, shaming, belittling and many other behaviours and dynamics that are reminiscent of the original abuse"[82]

[78] RELATE-framework.pdf (kent.gov.uk)
[79] See Trauma-informed practice: what it is and why NAPAC supports it | NAPAC Accessed 29th April 2021
[80] See Trauma-informed practice: what it is and why NAPAC supports it | NAPAC Accessed 29th April 2021
[81] NAPAC | Supporting Recovery From Childhood Abuse
[82] Trauma-informed practice: what it is and why NAPAC supports it | NAPAC Accessed 29th April 2021

17.1.10. For those professionals approaching people affected by trauma without an understanding of the long-lasting effects of trauma:

> "'non-engagement (can be) seen as a refusal of services, not a common symptom of mental health, trauma and complex needs, when sometimes attending appointments can feel overwhelming and frightening'.[83]

17.1.11. During the time Jean was in the care of the Local Authority there was reportedly police involvement due to an allegation of sexual abuse against Jean, which did not result in a prosecution. It is possible that this experience of the criminal justice system (CJS) influenced her disengagement with subsequent CJS processes.

17.1.12. Women and girls' charity AVA provide three key messages for those supporting victims of abuse. First that Professionals should work in a way that understands trauma, its impact on the body and focus on interactions that maximise both physical and emotional safety. Second is that when women use substances it is often as a coping strategy to manage their experiences. They ask that professionals work in a way that acknowledges what women have done to survive and not to blame the women but rather listen to them and believe them. And finally, that professionals must understand behaviour as a form of communication and consider what is going on under the surface for women, take the time to be professionally curious, and focus on building trusting relationships with women that acknowledge their strengths and capabilities.[84]

17.1.13. A vital element of practising in a trauma informed way is to understand the experiences and challenges the mother is facing. Although most of the professionals involved with Jean and her children were able to identify domestic abuse as an issue, they appeared to lack an understanding of the effects of domestic abuse and coercive control, which undermine the autonomy

[83] Sharpen, J *Jumping through hoops: How are coordinated responses to multiple disadvantage meeting the needs of women?* (2018) Available Jumping-Through-Hoops_report_FINAL_SINGLE-PAGES.pdf (avaproject.org.uk) Accessed 29th April 2021

[84] AVA Project *Breaking Down the Barriers: Findings of The National Commission on Domestic and Sexual Violence and Multiple Disadvantage* (2019) Available: Breaking-down-the-Barriers-full-report-.pdf (avaproject.org.uk) Accessed 30th April 2021

of a victim rending it difficult to simply leave their abuser.[85] This led to an absence of empathy for Jean which reduced their ability to identify the risk that Jean posed to herself.

17.1.14. Alongside Jean's experience of trauma as a child - and possibly due to this trauma – and her experiences of male violence as an adult, was her diagnosis of EUPD. Although this diagnosis was made less than two months before her death, professionals did not appear to adjust their plans or approaches to Jean once they were informed that she was living with a personality disorder. This may have been due to a lack of understanding of the condition, alongside a lack of clarification from mental health professionals to support social workers and IDVAs understanding of EUPD; along with a lack of triangulation of the pieces of information they each held.

17.1.15. NICE guidelines on treating patients with personality disorders include the:

> "Need to explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable, and build a trusting relationship, work in an open, engaging and non-judgemental manner and be consistent and reliable."[86]

17.1.16. Rose Buckland argues that this rhetoric should function across all services when responding to the needs of mothers faced with mental ill health, and specifically personality disorders.[87] She warns how the multi-organisational context of mental health and child protection arenas, can couple with the complexities of information sharing and collaboration which exists across health and social care settings and lead to "professional dangerousness" – where "professionals can behave in a way which either colludes with or increases the dangerous dynamics of the abusing family members."[88]

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[85] BASW *England Domestic Abuse Practice Guidance: for Children and Family Social Workers* (March 2021) p.10-11

[86] NICE, "Borderline personality disorder: the NICE guideline on treatment and management" *National Clinical Practice Guideline Number 78* The British Psychological Society and the Royal College of Psychiatrists (2009) P.380

[87] Buckland, R "Working with Josie: Swimming Against the Tide" *Critical and Radical Social Work* 7 (1) (2019) p.122

[88] Morrison, T *The Emotional Effect of Child Protection on the Worker* Practice 4 (4) (1990) p262

17.1.17. No one will ever know what happened at the scene of Jean's death. The Kent Coroner found that Jean died following an act she took voluntarily. As introduced above, in summing up, the coroner stated that he could not be satisfied that Jean had intended to take her life but found that her judgement was affected by the level of alcohol and drugs in her system. He also cited the domestic abuse, current and historic. He found that she may not have intended the outcome of her action to be death.

17.1.18. As with suicide, Jean died because of her own actions, and in the absence of available research into the links between domestic abuse, and/or EUPD and death by misadventure the author has therefore highlighted the relevant aspects of the available research linking the experiences of domestic abuse and suicidality.

17.1.19. There is a raft of research available linking the experiences of domestic abuse and suicidality. This research includes failure to identify risk of suicide when risk assessing harm from domestic abuse.[89] Kent County Council's Suicide Prevention Team have recently undertaken research, aiming to identify the link between suicidality and domestic abuse. They found that 63% of domestic abuse victims had feeling of suicidality. Although the Coroner returned a verdict of death by misadventure, Jean had told mental health practitioners and her GP that she had thoughts of suicide, including jumping off a motorway bridge. However, she did not disclose these thoughts to social workers, and in this way, none of the agencies had the full picture of Jean's current circumstances or state of mind. Jean's mother told the review author she also did not know Jean's state of mind at the time of her death.

17.1.20. At the time of her death, Jean was under the influence of alcohol and cocaine, an alternative narrative to the circumstances of her death is that the action which led to her death was due to an impulsiveness and lack of consideration of consequences which is often seen in people with EUPD,[90] mixed with the disinhibiting effects of drug and alcohol use.

[89] Munro, V and Aitken, R "From Hoping to Help: Identifying and Responding to Suicidality Amongst Victims of Domestic Abuse" *International Journal of Victimology* (26) 1 (2020)
[90] NHS Highland *Personality Disorder; Integrated Care Pathway* (July 2015) p.10

17.1.21. Despite the uncertainty of the circumstances surrounding Jean's death, there is no doubt that her life at the time of her death – and arguably a good proportion of her life overall – was shaped by domestic abuse. Jean may not have directly been killed by a third party, but her death was unexplained. In 2017 Professor Jane Monckton-Smith began blogging about unexplained deaths which she termed as hidden homicides.[91] Professor Monckton-Smith argues the statistic of two women killed, by a partner or former partner, every week is an underestimation. Jean may not have been directly murdered by her partner, however the abuse she had been experiencing since her teens certainly factored in the circumstances of her death.

17.1.22. MP Jess Phillips has called for a national count of women who die suddenly, or in unexplained circumstances, and who are known to have been victims of domestic abuse.[92]

17.1.23. Victims face multiple barriers to reporting domestic abuse; these have been discussed throughout this review, for example fear of reprisals from the abuser, fear of children being removed from the victim's care, the victim's inability to identify the risk they face due to normalising the abusive behaviour, risk of homelessness, debt, and other practical factors – all of these are further exacerbated when the victim is suffering from poor mental health.[93] Domestic abuse perpetrators use mental health as a tool to control, questioning the memory of experiences of abuse, placing the blame for their behaviour on the victim's mental health and over time this worsens the victim's mental health. Yet systems surrounding Jean were better established to identify - and professionals were certainly more focused on - the potential risk of harm from David than from the risk of Jean dying due to her own actions. Despite Jean telling professionals that was her intention.

[91] HIDDEN HOMICIDE – FORENSIC CRIMINOLOGY (janems.blog)
[92] Jess Phillips MP: We count what we care about - Tortoise (tortoisemedia.com)
[93] Rose, D et al "Barriers and Facilitators of Disclosures of Domestic Violence by Mental Health Service Users" *The British Journal of Psychiatry: The Journal of Mental Science* (198) 3 (2011) pp.189-94

17.2 Multi-Agency Mechanisms

17.2.1. Following the incident on 15th November Kent Police immediately made a referral to Integrated Children's Service, which was processed through the Central Referral Unit. A Strategy Meeting was held and there then followed two Multi-Agency Risk Assessment meetings and an Initial Child Protection Conference – all attended by several relevant agencies. This use of these multi-agency mechanisms is identified as good practice.

17.2.2. However, following these initial meetings there appeared to be missed opportunities to utilise multi-agency working to its full potential. There seemed to always be at least one agency missing from meetings. Those with the greatest knowledge of Jean's mental and physical health issues were not present, or involved, at either a MARAC or at the ICPC. This was unfortunate as Jean's situation was profoundly influenced by her mental health, together with her consumption of alcohol and drugs.

17.2.3. The purpose of multi-agency forums is to share all the small pieces of information each agency holds, to allow a clearer picture of the victim, family, perpetrator, as well as contextual information; all of which allows a more accurate assessment of risk of harm and provides the basis for more robust safety planning.

17.2.4. Introduced across England and Wales in 2006 as part of a Coordinated Community Response[94] to domestic abuse, the MARAC was designed to take the responsibility for high-risk cases away from just one or two agencies.[95] A multi-agency response to domestic abuse is vital because:

> "No single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety."[96]

[94] What is a CCR? — Standing Together
[95] Coordinated Action Against Domestic Abuse *MARAC Chair – toolkit for MARAC* Somerset (2009) p.1
[96] Sharp-Jeffs, N and Kelly, L *Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together* (2016) p.6

17.2.5. This periodic meeting is held to discuss victims of abuse who are faced with a high risk of death or serious injury.[97]

> "A MARAC meeting consists of representatives of both statutory and non-statutory organisations who are actively supporting those at high risk of domestic abuse. Representatives discuss and analyse the ongoing risk to the safety and wellbeing of both adult survivors, and children, and actions are agreed with a view to safeguarding them."[98]

17.2.6. Research in 2007 illustrated that victims were better able to live in safety, without violence, following their inclusion in the MARAC.[99]

17.2.7. Pivotal to the MARAC process working successfully is the role of the Independent Domestic Violence Advocate, who in the victim's absence represents their wishes and feelings, and advocates for them as a victim of abuse.[100]

17.2.8. The MARAC process includes the allocating of actions for agencies, in this way the work of the MARAC is intended to extend beyond the meeting.

17.2.9. The actions from the initial meeting where Jean's case was discussed produced the following:

- IDVA to update victim about the MARAC within one week.
- DVDS were considered but decided against as the CP conference will be opportunity to share David's criminal history.
- Housing – to confirm with MARAC Coordinator once she has definitely moved to Town B.
- For MARAC Coordinator to share the confirmed move with ICS and complete a MARAC to MARAC.

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[97] Robinson, A *Domestic Violence MARACs (Multi Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation* (2004)
[98] BASW *England Domestic Abuse Practice Guidance: for Children and Family Social Workers* (March 2021) p.30-31
[99] Robinson, A and Tregidga, J "The Perceptions of High-Risk Victims of Domestic Violence to a Coordinated Community Response in Cardiff, Wales" *Violence Against Women* 13 (11) (2007) pp.1130 - 1148
[100] Robinson, A *Independent Domestic Violence Advisors: A Multisite Process Evaluation* (2009)

17.2.10. There could have been a much more proactive use of the MARAC mechanism to make robust actions, to encourage engagement with Jean and promote joint working with agencies not yet working together.

17.2.11. For example, the social worker told the IMR writer that she had a good relationship with the IDVA, and they spoke and texted frequently to plan how best to manage contact with Jean. This relationship could have been expanded upon to include meetings taking place between the IDVA, the social worker and Jean. An action from the MARAC could have included a joint visit to Jean.

17.2.12. There could have been an action for a referral into Adult Social Care to support Jean with the toxic-trio complexities of mental health, alcohol use and domestic abuse that she faced.

17.2.13. On 18th December Jean told the IDVA that she was moving to Town B that day. As per the MARAC actions, the IDVA made a MARAC-to-MARAC referral – this is a process where a victim with a live MARAC case open moves to a different area. Jean's case was then added to the next MARAC listing at Town B MARAC as a "mention only" case.

17.2.14. The "Mention only" process was introduced in Kent following a sharp increase in repeat MARAC cases. The process was intended to streamline the meetings, where a case which was returning to MARAC within a 6-month period was not discussed at length – the understanding being that the details of the case were already known to the MARAC attendees. This process has recently ceased as it was felt by MARAC Coordinators that it was not in the best interest of victims, and invariably the cases required further discussion despite being listed as mention only.

17.2.15. The MARAC-to-MARAC process was incorrectly used in Jean's case, as she had not physically moved to Town B when the transfer was made. The MARAC guidelines state that there should not be two MARACs running in two places for the same victim. The MARAC which "owns" the case should be the one sited where the victim resides. In this case, Jean was residing outside of the County, so technically the transfer should have been to the MARAC in County B.

17.2.16. The IDVA made the MARAC-to-MARAC referral in good faith, when Jean stated that the move to Town B was going ahead. There is a reliance on each area's MARAC to run the process in line with the national best practice guidelines. This is because the MARAC process is not written into legislation and is not a statutory process. Coordinators are able to utilise a National Database which is managed by Safe Lives – this records the movement of MARAC cases across England and Wales. (See Glossary).

17.2.17. It could be argued that MARAC as a process was not fully utilised in Jean's case. The actions appeared to be standard, and lacklustre. As a high-risk case involving a lack of engagement with the victim, and a perpetrator with a long criminal history, the MARAC process could have been utilised to create actions which would not have been possible from any other source.

17.2.18. A positive action from the MARAC was the delay of the mutual exchange which would not have been possible if it had not been a MARAC action. This is an example of a proactive action which utilises the power of the MARAC process.

17.3 Challenge and Triangulation of Information

17.3.1. As mentioned above, the IDVA role is pivotal to the MARAC process as she represents the wishes and feelings of the victim and advocates for her in her absence. One of the important elements of advocacy is challenge. Domestic abuse, coercive control, and the trauma that it causes are complex concepts and often involve nuanced behaviours, from victims and perpetrators, which those outside of the field of domestic abuse sometimes struggle to identify or understand. As also mentioned above, professionals are able to identify the presence of domestic abuse, and social workers especially are well trained around the effects of domestic abuse on children. However, many professionals remain unsure of the difficulties in leaving an abuser[101], the multi-layered experiences which reduce a victim's confidence, financial stability, and social standing, and in cases like Jean's intersect with enduring mental health issues. It is up to the IDVA within the MARAC, and other multi-agency forums, to respectfully challenge thinking that can be construed (by others, and

[101] Stahly, G. B *Battered women: Why don't they just leave?* In J. C. Chrisler, C. Golden, & P. D. Rozee (Eds.), *Lectures on the psychology of women* (2008)

specifically by the victim) as victim-blaming and encourage a trauma informed approach to responding to victims.

17.3.2. The presence of the IDVA at the MARAC is "intrinsic"[102] to the overall process of multi-agency working. The presence of the victim is not permitted at the MARAC meeting[103] and so the IDVAs "speak up for victims"[104] with the intention of ensuring their wishes and feelings are taken into consideration amongst the decisions that are made by the representatives of the police, social services, health and education departments.[105] The IDVA should be an "effective advocate"[106] at the centre of the MARAC proceedings, representing the views of the victim in her absence.

17.3.3. There is no evidence of robust challenge from the IDVA at the meeting – although minutes from MARACs are not comprehensive so this may have been missed. The IDVA presented Jean's wishes and feelings, to continue a relationship with David, and included her own concerns about the safety of the children. It is recorded in the IDVAs own notes that she explained "why victims minimise".

17.3.4. The social worker's danger statement of 6th December 2017 uses language which appears to situate the blame for the risk to the children upon Jean, implying the violence was mutual, consensual and that Jean was culpable for the potential risk of harm to the children. This language used may have further alienated Jean from asking for help. She would have already been self-identifying as responsible for the violence and abuse. This language will exacerbate this viewpoint and could lead to Jean feeling that she is safer to stick with David who is likely to have been vocally self-identifying as being victimised by the social worker and the wider systems. This danger statement was accepted at the ICPC held on 13th December, where the IDVA was in attendance. This would have been an opportunity for the IDVA to challenge the lack of trauma informed practice, and the use of language which situated the blame for the risk to the children with Jean. However, there is no evidence that

[102] Home Office, above n 67
[103] Kent Police *Kent and Medway Multi Agency Risk Assessment Conference (MARAC) Operating Protocol and Guidelines* (2013) p.6
[104] Harne, L and Radford, J *Tackling Domestic Violence: Theories, Policies and Practice* (2008)
[105] Kent Police above n 89 pp.5-6
[106] *Ibid* p.10

any challenge occurred. The ICPC could have been a good opportunity for the IDVA to advocate for Jean, which may have encouraged Jean's engagement with the specialist domestic abuse service – however there is no evidence that this happened.

17.3.5. Another area the IDVA could have challenged was the language used within the letter before proceedings which was given to Jean on 17th January 2018. It stated that Jean had a "history of engaging in ongoing domestic abuse relationships." It is important for any professional responding to – or supporting victims of – abuse, that relationships are not abusive, people are abusive. Although this may appear to be simply a case of semantics, this language negates David, Roy, Paul and their behaviours from the dialogue. Again, this situates the problem as Jean being in relationships with violent men, not the violence itself.

17.3.6. Triangulation refers to the use of multiple datasets and viewpoints to cast light upon a topic. The agencies did not work together in the multi-agency forums available, to triangulate the evidence which each of them held about Jean, the children and David.

17.3.7. As introduced above, multi-agency meetings provide a vehicle for sharing the small pieces of information which each agency holds, in order to build a full picture about a victim and their family.

17.3.8. KMPT could have utilised the multi-agency forums available, and specifically the core group, to raise questions about the domestic abuse mentioned on the GP referral. Triangulation of the information held by KMPT regarding Jean's suicidal ideation and attempts; with the information that ICS and Kent Police held about David's violent history and current suspicion of his control of Jean, would have facilitated a greater understanding of Jean's situation and would have allowed an element of challenge at subsequent meetings between Jean and KMPT.

17.3.9. The GP did not provide specific information about the domestic abuse on the referral, despite having this information directly from ICS. The GP did not attend, or send a report to the MARAC, despite being asked to do so by the MARAC Coordinator.

17.3.10. Apart from ICS, each agency had the information which Jean presented to them – which was based upon a narrative prepared for a reason – to shine a positive light upon David, and to retain the care of her children.

17.3.11. If the information held by all agencies had been triangulated – using a multi-agency mechanism already in place – the bigger picture could have been viewed by all, and agencies could have worked together on a plan suited to the family's needs.

18. Lessons to be Learnt

18.1. There is no dispute that agencies involved with Jean and her family followed their policies and the formal and informal protocols in place at the time. What appears to be lacking in the agency responses to Jean is a trauma informed approach, with such an approach improving empathy, understanding of her life-long experiences, alongside the sensitive challenging of Jean's perception of events and the challenge of other professionals' approaches to Jean's situation. There appeared to be a lack of understanding of other agencies' remits, priorities, and roles within a multi-agency response to a high-risk victim of domestic abuse who was presenting with complex needs and a reluctance to access specialist domestic abuse support.

18.2. It is evident throughout this review – and indeed in other reviews – that professionals are becoming more experienced in recognising domestic abuse. Social workers especially demonstrate an understanding of the effects of domestic abuse on children. However, there is a need for learning and development around the effects of domestic abuse and coercive control on adult victims, and in Jean's case, how EUPD particularly influenced this dynamic. Without this knowledge, professionals will identify that there is a problem, but will not be able to respond to the victim in a way which encourages engagement with services.

18.3. This review identified that the professionals "around" Jean and her children were all focused on a different aspect of the family's life, all approaching the situation from a different standpoint. Their focus was either on safeguarding the children, or bringing an assailant to justice, or reducing the risk of harm to Jean, or supporting

her physical, or mental health. In this way agencies largely worked in silo, despite there being multi-agency mechanisms available, agencies appeared to concentrate on their specific focus without deviating from their path. A victim's life does not exist in silo, the sections of their life intersect, and domestic abuse is all pervasive, interweaving throughout all parts of their life. Agencies' responses to domestic abuse victims should work in the same way, utilising the multi-agency mechanisms and information sharing protocols in place throughout the County.

18.4. One of the missed opportunities to engage with Jean occurred whilst she was receiving treating for injuries in hospital. The presence of a Hospital Independent Domestic Violence Advisor may have caught her ready to engage, directly after the attack and before David could coerce her into changing her version of events.

18.5. Good practice can be identified, where ICS, IDVA and police were in constant contact to share information. However, the IDVA missed opportunities to take this further, and stringently collaborate with other agencies to engage with Jean on a level which illustrated to her that professionals understood her plight; and that they could be relied upon to properly protect her from her prolific and violent partner. Professor Jane Monckton Smith argues that victims of domestic abuse are experts at consequence management, and their disengagement is often due to their lack of faith in professionals to manage the consequences of police, social care, or support services' involvement. To put it plainly, victims of domestic abuse need to have more confidence in the ability of police to protect them from the abuser than they are afraid of repercussions from the abuser.[107]

18.6. The MARAC process is intended to go some way to facilitate such planning, however, in this instance it can be argued that the MARAC process was not used to its full potential and actions arising from the MARAC fell short of the multi-agency collaboration needed to both understand and protect victims like Jean – who was struggling with her long term mental health, who was telling professionals that she was suicidal and was using alcohol to cope with the effects of a life time of abuse; whilst being faced with a high risk of harm from a coercively controlling partner with a history of violence. At the time of the MARAC-to-MARAC mention only of Jean at Town B MARAC, she had received her diagnosis of EUPD, however the "mention only" did not provide the opportunity for sharing of

[107] Monckton-Smith, J *In Control; Dangerous Relationships and How they End in Murder* (2021)

information about this diagnosis with professionals who would soon be responding to her needs, had she completed the move to Town B. The MARAC process could be enhanced by the attendance of professionals with most information about a family. For example, the allocated social worker or mental health worker attending could bring direct information about the family.

18.7. Victims of domestic abuse are often coerced during appointments, by the very presence of an abuser or another family member. Jean was never seen alone, and this could have been addressed with her. Linked to the recommendation to encourage challenge, where agencies do not have policies to insist on meeting with patients or clients alone, this should be considered, and professionals should be urged to follow these policies. It is accepted that EUPD may have meant that for Jean attending appointments alone caused her distress, however, introducing the practice of always starting an appointment by seeing the patient alone for a short period, during which time the direct question of coercion can be posed to them, could provide the opportunity for a victim to disclose they are being coerced.

18.8. Jean was not allocated a mental health worker, which led to a lack of mental health knowledge at the core group. As Jean's experiences of abuse were compounded by her poor mental health, which was in turn exacerbated by her experiences of abuse – the lack of mental health expertise at the various meetings where she was discussed resulted in a missed opportunity to fully understand Jean and her life experiences. It is understood KMPT have adapted their model to a Choice and Partnership Approach, which means patients no longer experience a period without a named worker whilst awaiting care coordination and, therefore, any immediate actions required, such as sharing or gathering information, is undertaken promptly.

18.9. Whilst Jean was in local authority care there was a case regarding sexual abuse taken to court which did not result in a prosecution. It is possible that this experience of the criminal justice system (CJS) influenced her disengagement with subsequent CJS processes. The review panel suggested exploring a national recommendation surrounding the support for families who are looking to prosecute or have experienced abuse.

18.10. The panel are keen to share learning from this review in terms of the unexplained nature of Jean's death and would like to support the development of a central repository of such learning.

19. Recommendations

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

	Recommendation	**Organisation**
1.	The panel support recommendations emerging from other Kent Reviews which pertain to the evaluation of MARAC purpose and processes.	-
2.	Development of a secure professionals' virtual networking "Domestic Abuse Hub" within the Kent and Medway Domestic Abuse Website – to aid sharing of knowledge and referral pathways.	Kent CSP
3.	HIDVA service to be expanded to all Acute Trusts across Kent and Medway.	Kent & Medway CCG
4.	Domestic abuse training to include the effects of coercive control on victims.	KMSAB and KCC Learning and Development.
5.	A multi-agency learning event focusing on trauma informed practice, which raises awareness about responding to victims in a trauma informed way.	KCC Public Health
6.	Suicide prevention team to link in with (AAFDA) to join the conversation regarding unexplained deaths.	KCC Suicide prevention team
7.	Social landlords to include a section in their mutual exchange forms addressing the reason for a mutual exchange – if this	Kent Housing Group

	Recommendation	Organisation
	reason is due to domestic abuse landlords should follow their safeguarding procedures.	
8.	Investigate the possibility of a central repository for unexplained deaths linked to domestic abuse.	Home Office
9.	All agencies and commissioned services, to adopt trauma informed approaches and/or discussions within their staff supervision.	Kent Police, Education, K&M ICB, KMPT, Council A, Council B, KCC ICS, CENTRA, Rising Sun
10.	All agencies and commissioned services to have provision for a trauma informed training offer, which is accessible to all staff, and includes practices for their specific client group.	Kent Police, Education, K&M ICB, KMPT, Council A, Council B, KCC ICS, CENTRA, Rising Sun
11.	For agencies to have a lead person/or team, with knowledge of trauma informed practices.	Kent Police, Education, K&M ICB, KMPT, Council A, Council B, KCC ICS, CENTRA, Rising Sun

20. Appendices

Appendix A – Terms of Reference

Kent & Medway Domestic Homicide Review **

Victim – Jean Carter

Terms of Reference - Part 1

1. Background

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 24/04/2018. It confirmed that the criteria for a DHR had been met.

1.2 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 DHR 'Jean 2018'.

2. The Purpose of DHR

2.1 The purpose of this review was to:

i. establish what lessons can be learned from the domestic homicide of Jean Carter 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 DHR

3.1 This review established whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Jean Carter.

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

3.3 If domestic abuse was identified, this review focuses on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time. If domestic abuse was identified, the review examines the method used to identify risk and the action plan put in place to reduce that risk. This review also considers current legislation and good practice. The review examines 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) were submitted using the templates current at the time of completion.

4.2 This review is based upon IMRs provided by the agencies that were notified of, or had contact with, Jean Carter in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR was prepared by an appropriately skilled person who has not any direct involvement with Jean Carter 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 included a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMRs highlighted both good and poor practice, and made recommendations for the individual agency and, where relevant, for multi-agency working. The IMRs included issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency was required to complete an IMR which encompassed all information held about Jean Carter from 1st January 2017 to the date of her death. Information relating to David Baker was also included. Information relating to events which occurred before this time were also included if they are likely to assist the review process. In particular family members have stated that in the time preceding her involvement with Baker, the police and other agencies were called to incidents

involving Jean and her other partners particularly at her house in Town B. Jean's mother believes these incidents should be considered as if agencies acted upon them collectively, more could have been done to help her daughter.

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 were also identified.

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 Jean Carter and David Baker, 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 Jean Carter and David Baker (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Were Jean Carter and David Baker 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 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 Jean Carter and promote her welfare, or the way it identified, assessed and managed the risks posed by David Baker? 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 Jean Carter?

6. Document Control

6.1 The two parts of these Terms of Reference form one document, on which will be marked with 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 of Terms

CPP	Child Protection Plan
CRU	Central Referral Unit
CSP	Community Safety Partnership
CSWT	Children's Social Work Team
DAN	Domestic Abuse Notification
DASH	Domestic Abuse, Stalking and Honor-based Violence risk assessment model
EUPD	Emotionally Unstable Personality Disorder
GAD-7 questionnaire	A self-reported questionnaire used to diagnose generalized anxiety disorder
ICPC	Initial Child Protection Conference
IDVA	Independent Domestic Violence Advisor
KMPT	Kent and Medway NHS Social Care Partnership
MARAC	Multi-Agency Risk Assessment Conference
MARAC best practice and Data Set	Resources for MARAC meetings | Safelives Latest MARAC National Dataset | Safelives
MARAC mention only	A process followed in Kent and Medway where a victim was re-referred to MARAC more than once during a 6-month period, and where the situation had not substantially changed. The Chair would mention the victim and their family to determine whether the panel had further information to share. This practice is no longer in place and victims are discussed in full each time they are referred to MARAC.
ICS	Integrated Children's Service
VIT	Vulnerable Investigation Team See Force management statement 2019 (kent.police.uk)
S.47 investigations	Section 47 of the Children Act 1989 requires Local Authorities to carry out investigations under certain circumstances.
Pre-Proceedings	Pre-proceedings is a process to try and avoid issuing care proceedings and to ensure the child protection plan is best supported by advocacy from legal representatives. Pre-proceedings has a strong influence on preventing many families from going into care proceedings with only a small proportion entering proceedings.

Letter before proceedings	A letter sent to parent(s) and parties with parental responsibility to encourage the family to work with the Local Authority before proceedings are initiated.
PLO	PLO stands for 'Public Law Outline', a set of rules which tells social workers how to deal with these sorts of cases. The Public Law Outline rules say that when social workers are thinking that they may need to go to Court they should invite the parents to a meeting to discuss their concerns.
Pressure of speech	Pressure of speech is a tendency to speak rapidly and frenziedly. Pressured speech is motivated by an urgency that may not be apparent to the listener. The speech produced is difficult to interpret. Such speech may be too fast, erratic, irrelevant, or too tangential for the listener to understand.
STEPPS	Systems Training for Emotional Predictability and Problem Solving