Domestic Homicide Review

Leanne

2019

Overview Report

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Commissioned by:

Kent Community Safety Partnership

Medway Community Safety Partnership

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Version 5

Leanne was not just a name or a victim, she was a special unique lady who we miss every day, in everything we do she made our lives better.

Leanne was a very much-loved Mum, Sister, Aunt and Friend. Who touched so many with her words, wisdom and just being there to help us all.

She loved to help people, to make them smile to do whatever she could.

She was selfless and never put herself first, she was strong and brave and did the very best she could in all aspects of her life.

Leanne trusted the system and it failed her, and because of this we lost not only her that night but a brother, nephew and cousin.

Leanne's death has left a huge void in all our lives and the pain is immense, the silence greets us every day when it should be her laughter and chatter.

Leanne deserved so much more than this.

She was intelligent, warm, loving, kind and funny.

She was our Leanne, our bright star who we love and miss beyond words.

Leanne's sister

On behalf of the Domestic Homicide Review panel, its members, contributing organisations and myself as the panel chair and the author of this report, I would like to express our condolences to Leanne's family for their loss, and to express my gratitude and respect for the dignified manner in which they have assisted this review.

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1. INTRODUCTION

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Leanne, a resident of Town A, before her death in October 2019. On that day, Leanne was at home with her two sons, David, and Paul, and her niece, Ellie. While in the kitchen with her son David, Leanne received a fatal stab wound. Following a struggle with his brother Paul, David fled from the scene. He subsequently contacted the police and was arrested nearby.

1.2 This DHR examines the involvement that organisations had with Leanne (a white British woman in her 50s) and David (a white British man in his 20s), between 23 June 2015 and the date of Leanne's death in October 2019.

1.3 The key reasons for conducting a DHR are to:

a) establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are, both within and between organisations, how and within what timescales they will be acted on, and what is expected to change;
c) apply these lessons to service responses, including changes to policies and procedures as appropriate;
d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children through improved intra- and inter-organisation working;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

1.4 In accordance with Section 9 of the Domestic Violence, Crime, and Victims Act 2004, a Kent and Medway DHR Core Panel meeting was held on 5 November 2019. It agreed that the criteria for a DHR had been met, and this review would be conducted using the DHR methodology. The chair of the Kent Community Safety Partnership ratified that agreement, and the Home Office was informed.

1.5 This report has been anonymised and the personal names contained within it are pseudonyms, except for those of DHR panel members. Pseudonyms were discussed with the family, and following a period of reflection, the family provided pseudonyms with which they were comfortable.

2. CONFIDENTIALITY

2.1 The findings of this DHR are confidential. Information is available only to the participating officers/professionals and their line managers until after the DHR has been approved by the Home Office Quality Assurance Panel and published. Dissemination is addressed in Section 11. As recommended by statutory guidance, pseudonyms have been used, and precise dates have been obscured to protect the identities of those involved.

2.2 Details of the deceased and perpetrator:

Name (Pseudonyms)	**Gender**	**Relation to deceased**	**Ethnicity**
Leanne	Female	*The deceased*	White British
David	Male	*Son of the deceased, and perpetrator*	White British

2.3 The following individuals/family members were known to the review panel and have been given the following pseudonyms to protect their identity:

Pseudonym	**Relation to the deceased**	**Relation to the perpetrator**
Paul	Son	Brother
Sarah	Sister	Aunt
Ellie	Niece	Cousin
Doris	Sister-in-law	Aunt

3. TERMS OF REFERENCE

3.1 The full terms of reference are included in **Appendix A**. This review aims to identify the learning from Leanne and David's case, and for action to be taken in response to that learning, with a view to preventing homicides and ensuring that individuals and families are better supported.

3.2 The review panel was comprised of agencies from Kent and Medway, as that was where both Leanne and David were living at the time of the homicide.

3.3 The review panel first met on 16 January 2020 to consider draft terms of reference, the scope of the DHR and those organisations whose involvement would be examined. At this first meeting, the review panel shared information about agency contacts with David and with Leanne, and as a result, established the review period to be 23 June 2015 (when David and Leanne moved to the county) to the date of the homicide.

3.4 Key lines of enquiry: The review panel considered both generic issues, as set out in the statutory guidance, and identified and considered the following specific issues:

- Agencies were asked to consider the time before Leanne and David moved to the county from London (June 2015) and to consider any history/handover of information relevant to this DHR from those London agencies.
- Review of the housing history of David and Leanne during the period of this DHR and any impact on either of them.
- Exploration and identification of a mental health specialist or consultant to sit on the panel later in the process.
- Focus on the prescribed medication taken by David, including the rationale for his prescriptions.
- Exploration of David's substance misuse and consequent impact upon him and his treatment.
- Analysis of the communication, procedures, and discussions that took place within and between agencies.
- Analysis of the cooperation between different agencies involved with David and/or Leanne and the wider family.

- Analysis of the opportunities for agencies to identify and assess domestic abuse risk.
- Analysis of agency responses to any identification of domestic abuse issues.
- Analysis of the policies and procedures available to the agencies involved in domestic abuse issues.

4. TIMESCALES

4.1 This review began on 5 November 2019 and was concluded on 19 October 2021. The timeframe includes significant delays during 2020 due to the coronavirus pandemic. Both the national and local restrictions put in place, as well as the need to reduce demand on health and emergency services represented on the panel, required flexibility. The family was kept informed throughout. Further corrections/amendments were made to the overview report in December 2021 following discussions between the chair, health and social work panel members. Further work was undertaken between January and July 2022; to complete the executive summary, to ensure the documents were proofread, and to ensure the extensive action plan was fully populated by all agencies prior to Home Office submission.

5. METHODOLOGY

5.1 The detailed information on which this report is based was provided in independent management reports (IMRs) completed by each organisation that had significant involvement with Leanne and/or David. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

5.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a senior manager of that organisation before being submitted to the DHR panel. Neither the IMR authors nor the senior managers had any involvement with Leanne or David during the period covered by the review.

5.3 In addition to IMRs, three organisations provided summary reports of their minimal involvement with Leanne and David.

6. INVOLVEMENT OF FAMILY MEMBERS AND FRIENDS

6.1 The review panel considered who should be involved in the DHR process. In February 2020, the Independent Chair wrote to Paul explaining the purpose of the DHR, its process, and providing the family with the relevant Home Office DHR leaflet. The Independent Chair met with the family on 27 February 2020. The police investigation was ongoing, and a police Family Liaison Officer (FLO) accompanied the Independent Chair to the meeting. Paul and Ellie were witnesses, and consequently, discussions focused entirely on the DHR process. At this meeting, it was agreed that the family would continue to meet with the Independent Chair and contribute to the review. A Crown Court trial was pending, and as a result, the perpetrator was not discussed, as it would have been inappropriate to do so prior to the conclusion of the Police Crown Court trial. The terms of reference were shared with them to assist with the scope of the review.

6.2 The Independent Chair continued to meet with the family throughout the DHR process, at which progress was discussed. These meetings provided an opportunity for the family to contribute to the process, providing valuable insights from both the victim's and family's perspective, an example being the difficulties they had experienced in gaining 'out-of-hours' mental health support for the perpetrator. At a meeting with the family on 16 December 2020, advocacy support services, specifically those of Advocacy After Fatal Domestic Abuse (AAFDA), were discussed. The benefits of AAFDA were explained at that meeting and at further meetings with the family, but unfortunately, they were never taken up by them.

6.3 The draft of the overview report was shared with the family on 23 August 2021. They were given time to read the report and were encouraged to provide feedback and questions they wished to raise with the panel.

6.4 On 29 September 2021, the family was invited to meet with the panel at a local, neutral venue. They discussed questions that the family had identified for Kent and Medway Partnership Trust (KMPT), Kent and Medway Clinical Commissioning Group (CCG), and Medway Adult Services, along with the recommendations. Following the meeting, the Independent Chair met with the

family to seek feedback regarding their inclusion in the DHR process, in the spirit of making improvements for future families. The family confirmed that opportunities to contribute and the level of support provided to them, including the choice of venue, were appropriate and sufficient for their needs. The feedback provided was open, honest, and favourable. They held the belief that their requirements for updates and progress reports were best served by the Independent Chair, as opposed to an FLO. They felt that they had sufficient time to review the draft report in detail and found the panel members welcoming and supportive of their attendance at the panel meeting. They felt confident enough to challenge them if they were required to do so and had made the decision not to seek advocacy support, as they felt they did not need it. They preferred face-to-face attendance at the meeting, as opposed to a video link. The perpetrator was not interviewed during this process. The family informed the Independent Chair that the perpetrator was in a poor state of mental health and was proving challenging to those charged with his care. They did not believe that he was in a state where he would be able to provide meaningful support for the DHR process. In addition, there was a degree of family objection that he should be included in the process, and the Independent Chair decided to respect their views.

7. CONTRIBUTING ORGANISATIONS

7.1 Each of the following organisations contributed to the review.

Agency/ Contributor	Nature of Contribution
Medway Council Adult Services	IMR
Kent Police	IMR
Kent and Medway Partnership Trust	IMR
Medway Foundation NHS Trust	IMR
Kent and Medway CCG	IMR
Kent Fire and Rescue Service	IMR
Medway Community Health	Short Report

Choices (Domestic Abuse Service)	Short Report
South East Coast Ambulance Service	Short Report

8. REVIEW PANEL MEMBERS

8.1 The review panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Leanne and/or David, including the domestic abuse service, Choices. It also included a senior member of Kent County Council's Community Safety Unit, and a consultant psychiatrist from KMPT was invited to join the panel considering the significant mental health aspect of this review.

8.2 The members of the panel were:

Agency	**Name**	**Job Title**
Independent Chair	Sean Beautridge	Independent Chair
Medway Council Adult Services	Jane Easton	Operational Safeguarding Lead for Adult Services
Kent Police	Neil Kimber	Detective Inspector
Kent and Medway Partnership Trust	Alison Deakin	Head of Safeguarding
Medway Foundation NHS Trust	Bridget Fordham	Head of Safeguarding
Kent and Medway CCG	Kirsty Edgson	Designated Nurse for Safeguarding Children
Kent Fire and Rescue Service	Rebecca Chittenden	Safeguarding Manager
Choices (DA Service)	Deborah Cartwright	Chief Executive Officer
South East Coast Ambulance Trust	Jenny Churchyard	Safeguarding Practitioner
KCC Community Safety Unit	Kathleen Dardry	Community Safety Practice Development Officer

Agency	Name	Job Title
Kent and Medway Partnership Trust	Dr Abdulazeez Towobola	Consultant Psychiatrist

8.3 The panel members hold senior positions in their organisations and have not had contact or involvement with David or Leanne. The panel met on four occasions during the DHR. The terms of reference were set on 16 January 2020. IMR writers were briefed on 20 February 2020, but the initially agreed deadline for IMRs was extended significantly due to the demands placed on agencies during the pandemic. The IMR review meeting was held on 12 November 2020, followed by a meeting to discuss the first draft of this report on 21 April 2021. A final meeting was held on 29 September 2021, where the family met the panel and had the opportunity to raise specific questions after having read the draft overview report.

9. INDEPENDENT CHAIR AND AUTHOR

9.1 The Independent Chair, who is also the author of this overview report, is a retired senior police officer who served with Kent Police, retiring in October 2016. He has no current association with any of the organisations represented on the panel. He has experience and knowledge of domestic abuse issues and legislation and an understanding of the roles and responsibilities of those involved in the multi-organisational approach to dealing with domestic abuse. As the head of the Kent Police College, the Independent Chair was responsible for delivering training to the Kent Police. This included the formulation and delivery of domestic abuse training with an emphasis on victim and witness care, as well as investigative training. As the Deputy Divisional Commander for East Kent, the chair worked in direct partnership with frontline service providers, such as the Crown Prosecution Service, victim and witness services, and the courts to ensure that the needs of victims and witnesses were met and that the best quality evidence was presented. Latterly, the chair was the head of strategic partnerships at Kent Police, allowing him to work directly with strategic partners on a range of issues, including improved service delivery concerning domestic abuse. Upon retiring from the police force, the chair has worked as a volunteer case worker for the Soldiers, Sailors, Airmen, and Families (SSAFA) charity, identifying domestic abuse in several forms and consequently taking

positive action. His work with SSAFA included forging closer links between the charity and Kent Police, leading to improved awareness by officers of the challenges faced by service users and improved signposting towards the charity and the support it can provide.

9.2 The Independent Chair has a background in conducting reviews, investigations, inquiries, and inspections. He has carried out senior-level investigations and presented at courts and tribunals. He has completed online training on DHRs, including additional modules on chairing reviews and producing overview reports. Since his appointment, the Independent Chair has been a regular attendee and contributor at DHR 'lessons learnt' seminars. In addition, he has attended DHR webinar online learning events.

10. OTHER REVIEWS/INVESTIGATIONS

10.1 Kent and Medway Partnership Trust (KMPT) have carried out a root cause analysis (RCA) of this matter. Information was taken from the RCA and validated by an IMR writer. Cross-referencing with the relevant information within the chronology of the RCA has taken place.

10.2 The NHS (South) head of investigations for mental health homicides reviewed the final draft of the overview report before submission to the Home Office. A separate mental health homicide review was not to be pursued.

11. PUBLICATION

11.1 This overview report will be published on the websites of the Kent and Medway Community Safety Partnerships.

11.2. Family members will be provided with the website addresses and offered hard copies of the report.

11.3 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, among others.
b. The Kent and Medway Safeguarding Adults Board.

c. The Kent Safeguarding Children multi-agency partnership.
d. Additional agencies and professionals identified who would benefit from having the learning shared with them.

12. EQUALITY AND DIVERSITY

12.1 The chair and the review panel considered the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation during the review process.

12.2 Equality and diversity issues were included in the terms of reference and were also discussed explicitly at each review panel meeting. At the first meeting of the review panel, based on the information available from an initial scoping exercise, the following protected characteristics were identified as requiring specific consideration: disability (David suffered from mental health problems and was diagnosed with paranoid schizophrenia), sex (Leanne was female, David is male), and age (Leanne was in her 50s).

12.3 Questions as to the impact on David's mental health resulting from the incorrect administration of medication were apparent. This was further reinforced by similar concerns raised by the family. Attempts were made to identify a specialist/expert who could be part of the review and share their expertise. This included seeking the guidance of a psychiatrist to determine the impact of prescribed medication upon David and, conversely, the impact caused by any reductions in antipsychotic medication during the period of this DHR and the weeks immediately leading up to Leanne's death. A consultant psychiatrist attended the panel meeting held on 29 September 2021 to assist in answering these questions and in doing so, ratifying the recommendations made as a consequence of this DHR.

12.4 Sex should always require special consideration. A recent analysis of domestic homicide reviews reveals gendered victimisation across both intimate partner and familial homicides, with females representing most victims and males representing most perpetrators. Evidence which informed the UK

Government's 'Tackling violence against women and girls strategy'[1] also shows this pattern of gendered victimisation and perpetration. This characteristic is therefore relevant in this case: the victim of the homicide was female, and the perpetrator of the homicide was male.

12.5 Age is also relevant as studies have shown that victims in cases of adult family domestic homicide are more likely to be older than the perpetrator[2, 3].

13 BACKGROUND INFORMATION

13.1 Leanne was in her 50s at the time of her death. She was the eldest sister and has been described by her family as a very gentle and selfless woman. Upon leaving school, Leanne commenced a career in banking, a job which eventually took her to London. She was career-focused and enjoyed her profession, and it was an important part of her life.

13.2 In 1981, Leanne met her life partner, Michael. They had two sons together: David and Paul. Life was good for the family until 2002, when Michael suddenly died of a heart attack while only in his 40s. David was still at primary school, and Paul was five years younger. The family remained in London.

13.3 David has been described as becoming a child with challenging behaviour following the death of his father. He identified himself as the new head of the family, yet despite this, problems arose at school. His behaviour deteriorated and became troublesome. Bad behaviour, including drug abuse, led to an escalation in sanctions rising from detentions to exclusions to temporary and, finally, permanent exclusion.

13.4 Leanne continued to work at the bank to support her family, assisted by child minders. David's behaviour continued to deteriorate. Further drug-taking including cocaine, petty crimes, and involvement with the police followed. Home life progressively worsened, with bullying, coercive, and controlling behaviour directed towards Leanne and Paul. Oppressive and violent behaviour towards

[1] Tackling violence against women and girls strategy (accessible version) - GOV.UK (www.gov.uk)
[2] https://domestichomicide-halt.co.uk/wp-content/uploads/2021/11/MMU2621-Briefing-paper-Adult-Family-Domestic-Homicide_V5.pdf
[3] https://www.vkpp.org.uk/assets/Files/AFH-Spotlight-Briefing-Jan-2022-AC.pdf

Leanne has been described. The agencies became involved, and at one point, supported housing was arranged for David in Catford. However, despite his bullying and his violent behaviour towards her, David was emotionally dependent upon his mother, and he remained with the family.

13.5 In 2015, seeking family and social support, Leanne moved her family back to Kent, moving in with Leanne's elderly mother. For a short while, things were better. Leanne joined a darts team and went to quiz nights, and she benefitted from the proximity of a loving extended family. Sadly, this was a brief period as David's mental health issues continued, as did his drug abuse and violent behaviour towards Leanne. Professional agencies continued to be involved with the family until Leanne's death.

14 CHRONOLOGY

14.1. David was referred to the Kent and Medway Primary Trust (KMPT) by the South London and Maudsley Trust (SLAM) in June 2015. The referral stated that he had a diagnosis of mania with psychotic symptoms and drug-induced psychosis. The referral included details of his first admission to hospital in March 2009, which was precipitated by his being arrested by the police for criminal damage to cars.

14.2. In July 2015, David was taken to the Medway Emergency Department (ED) by Leanne, as he was presenting with relapsing psychotic symptoms. According to Leanne, David had frequently been using cannabis, and he was self-harming. She reported that he had been verbally abusive and aggressive, and that she feared for her safety if he returned home with her. On that occasion, David reported to the ED staff that he felt unwell after he stopped taking his medication, and he requested that he resume taking it. David was detained under Section 136 of the Mental Health Act and subsequently admitted informally to a private hospital for ten days.

14.3. KMPT records dated 2 July 2015 state that in the past David had his hands around his mother's neck. She described David as controlling, impulsive, and difficult to cope with. David was not complying with his treatment.

14.4. On 12 July 2015, David was transferred to a different mental health facility, and while there, staff reported an incident where he had been aggressive without provocation, his behaviour being described as intimidating and intrusive. It was noted that David had behavioural issues.

14.5. David was discharged on 22 July 2015 on antipsychotic medication by depot injection. Depot injections of antipsychotics are used to improve historically low adherence in patients suffering with mental ill-health, such as schizophrenia. Various products may be administered or implanted by either a doctor or a nurse; some are designed to be administered by the patients themselves (usually oral medications). David's was to be administered by a nurse.

14.6. On 24 July 2015, the crisis resolution home treatment team (CRHTT) conducted a clinical review. It was documented that David's mother struggled when he was unwell, and that a carer's assessment was to be offered to her.

14.7. On 8 August 2015, KMPT records note that David had left home with a knife. He attended the ED by ambulance this time. He was unaccompanied. He presented with suicidal thoughts and thoughts of hurting himself and others (including CRHTT staff). David's past medical history was documented as having paranoid schizophrenia. The liaison psychiatry service liaised with the crisis team, who reported their concerns about David following a failed home visit earlier that day. David presented as agitated and threatening to harm the crisis team staff. A plan was made for the psychiatric liaison nurse to complete a mental health assessment and to update the ED staff. There were indications that his mental health had deteriorated, and the family had raised concerns. He was readmitted to a mental health hospital for eight days, and while there, he would state that Leanne was not his mother. He presented as suspicious, seeking constant reassurance from those around him.

14.8. David attended the ED again on 18 August 2015, accompanied by Leanne. He presented with abdominal pain and informed ED staff that he had swallowed a lithium battery 2-3 weeks previously. David was streamed to the same-day treatment centre. It is unclear from records whether the context of David swallowing a lithium battery was explored.

14.9. David first came to the attention of Kent Police in August 2015 after he made threats with a knife during a telephone call with the police. This resulted in a mental health assessment. He was not actually in possession of a knife, and so was not detained by the police.

14.10. Once detained on 12 July under a 136 police section, David was then taken to the Place of Safety A. Following this, he agreed to an informal admission and was admitted to Hospital A (this was not a KMPT facility). David's mental health care came under the remit of the Kent and Medway Partnership Trust (KMPT).

14.11. Police were called to Leanne's home on 10 September 2015, first by David, who did not want to accompany the mental health workers, and then by mental health services, as David became threatening. Police assessed it as a domestic abuse incident, as David had been making threats to cause damage to Leanne's property. Police assessed the incident as a standard risk (after a domestic abuse, stalking, and harassment (DASH) assessment), as threats were directed towards property. Leanne did not want to support prosecution. This was the first incident of domestic abuse recorded by Kent Police.

14.12. The first recorded contact by Adult Social Care (ASC) with David was on 10 September 2015, when a request was made to the Medway Approved Mental Health Professional (AMHP) team for an assessment under the Mental Health Act (MHA). The assessment resulted in David being detained at Littlebrook Hospital, Dartford. The AMHP from Medway Council contacted Leanne and forwarded details of the Carers First service to her.

14.13. David had a further re-admission to a mental health ward on 11 September 2015 under Section 2 of the MHA, later converted to Section 3 of the Act. During this admission, his depot injection was changed from aripiprazole to clopixol. He was discharged at the beginning of November 2015. It does not appear that risks to Leanne were considered. The risk assessment and discharge letter indicated that this risk was considered and deemed low (given documented previous aggression and violence against his mother and delusion that she was not his mother) after he showed improvement following two weeks of Section 17 extended home leave from hospital during October, and his mother and crisis and home treatment team confirmed improvement.

14.14. Leanne's fear, and the fact that she was struggling to cope, were evident. A risk assessment does not appear to have taken place. (Addressed earlier, this risk is dynamic and would be expected to change based on the patient's mental state; risk management would depend on the likelihood, severity, and imminence of current risks.) It would be a further ten months before a multi-agency risk assessment conference (MARAC) referral was made by Kent Police.

14.15. On 5 October 2015 (during David's Section 17 home leave), a further request was made to the Medway AMHP team, as David had been readmitted to hospital. An AMHP was allocated, and contact was made with Leanne to seek her views on detaining David under Section 3 of the MHA; however, records indicate that David agreed to an informal admission to a mental health ward.

14.16. In October 2015, the police were contacted by the hospital where David had been detained, as he was missing. David eventually returned of his own volition.

14.17. In November 2015, David was arrested and cautioned for committing criminal damage to Leanne's property. David's auntie acted as an appropriate adult while David was in custody. The criminal justice liaison and diversion service (CJLADS) visited David in his cell on 20 November 2015. Police planned to review him when an appropriate adult arrived. The CJLADS team e-mailed the community mental health nurse to request a review. The mental health crisis team was spoken to by officers, but they were unable to deal with David at that time. The reasons for this are unknown.

14.18. On 24 November 2015, one of the practice nurses at Leanne's general practitioner (GP) surgery noted that Leanne had hazardous drinking levels; however, the reasons behind these levels were not discussed.

14.19. In December 2015, David was noncompliant with his depot injection regime. It is noted that throughout 2015, David's mental health fluctuated, and Leanne made several reports stating that she was struggling at times and presenting as tearful.

14.20. From July 2015 to December 2015, David presented to clinicians with symptoms of deteriorating mental health and a history of violence towards

Leanne. Concerning and criminal behaviour in the form of possession of an offensive weapon, coercive and controlling behaviour, and assault were all revealed. His noncompliance with his depot medication exacerbated an already high-risk situation.

14.21. In January 2016, David called 111, complaining of back pain following a football game.

14.22. On 10 February 2016, David attended a Medway Community Health (MCH) orthopaedic practitioner for pain following trauma to his index finger from punching a window six months earlier. David demonstrated an understanding of the treatment and gave no cause to consider his capacity under the Mental Capacity Act 2005. No further treatment was prescribed. David self-reported his mental health condition during the assessment. The orthopaedic practitioner was aware of David's diagnosis of schizophrenia from the GP referral letter. Social history was taken, and it was documented that David lived with his mother. There was nothing indicated that this was cause for concern.

14.23. On 7 July 2016, David attended the ED accompanied by Leanne. He reported that he had stopped taking his medication in January 2016 and that he had been 'feeling different' inside for about seven months. He was reviewed by an ED doctor, who reported that David was anxious and did not like leaving the house. David also reported that he had felt annoyed with himself for about five months. Additionally, David felt restless. Blood tests were taken, and he was discharged home with an advice sheet. Unfortunately, not all the ED records could be read by the IMR writer, as the handwriting is illegible. There was no documentation from the psychiatric liaison team.

14.24. On 3 September 2016, David attended the ED accompanied by the police. It is recorded that David was known to be a paranoid schizophrenic and that he had not been taking his medication for a week. David had thought he was being followed, and so he had called the police. A care plan was commenced, and David was assessed by a psychiatric liaison and mental health nurse.

14.25. During the assessment, David reported low concordance with medication for the last week, and that the medication had given him a headache. David reported that he had been deteriorating since he sustained an injury in

November 2015, for which he believed he had not been accurately diagnosed or treated. He explained that he had seen someone privately who advised him that he might have fractured ribs or a fractured sternum, which would possibly need physiotherapy. Nothing corresponding to this can be found in David's medical records. Additionally, David reported that he felt that his family was not his and that he had been adopted, and as a result, he wanted a DNA test. David also stated that he had not been sleeping yet still had 'so much energy' and 'nowhere to channel it'.

14.26. During the same assessment, it was documented that David was aggressive towards his mother. David reported that he had placed his hands around her neck. Unfortunately, due to the illegibility of the handwriting, it was not possible to read all the content of the report; however, the words 'and a tap on her head' are legible. It is documented that 'David is minimising the assault'. It can further be made out that 'Mother contacted Crisis Resolution Home Treatment Team (CRHTT), who advised her to contact the police, and the police had attended the property.'.

14.27. Additional disclosures by David during this assessment revealed fleeting thoughts of wanting to harm himself or those who had harmed him in the past; however, he stated that he would not act upon these thoughts. David denied regular misuse of cannabis, alcohol, or any other drugs. He refused admission at that time and requested a home visit. Later, David absconded from the ED prior to a safeguarding care plan being completed.

14.28. It is unclear from ED records whether David returned to Leanne's house. ED staff assumed that it was most likely that he did so based on the fact that Leanne is named as next of kin and their addresses are the same on ED documentation. Based upon the facts known as a result of his attendance at the ED that day, this could have placed Leanne at further risk of harm.

14.29. In September 2016, David was admitted to a mental health ward. This followed disclosure by Leanne that David had become aggressive towards her and had grabbed her throat for no apparent reason. David showed irritability, believing Leanne was not his real mother, a common theme when he was unwell. This was a missed opportunity to offer support to Leanne.

14.30. In October 2016, the police had contact with David on two separate occasions. The first was a concern call from David, in which he alleged that he was the victim of rape and gave a different name to the police. The attending officers spoke with Leanne, who disclosed David's controlling behaviours. The incident was assessed as a medium risk using DASH, and he was arrested. The police considered mental health support and contacted the crisis resolution homecare treatment team (CRHTT), which offered an initial assessment at this stage. However, the police thought it was safer to arrest. While in custody, the police made contact with the AMPH service to request an MHA assessment. However, due to other assessments pending, it was advised that this would have to be passed to the day shift, as there was no second AMPH. The following day, 10 October, the AMPH service referred David to the CJLADS team due to concerns for his mental health. David was seen in the cell, and the CJLADS team advised the police that he required a full MHA assessment. CJLADS contacted the AMPH team. The AMPH team advised the CJLADS team that an MHA assessment was booked. However, David then agreed to an informal admission. He was released on conditional bail under the care of his aunt while a bed was being found. A bed was then found on 14 October. David was discharged on 19 October and returned to his mother's home. A risk assessment at this time noted no psychosis.

14.31. On 23 October 2016, David assaulted Leanne. Leanne had requested David's admission, as she feared harm to others. It was believed that David was not taking his medication. The police reported to the community mental health team (CMHT) that they would eventually arrest David for questioning. On 24 October David was seen by the Medway CRHT team. On 26 October David was arrested by the police. On 28 October David was seen by CJLADS. David was referred to ASC in order to assist him with moving out of his mother's home.

14.32. Following David's release on bail, Leanne informed the police that she did not wish to support a prosecution, and that she was seeking a restraining order. The crisis team was now supporting David, and as a result, no further action was taken. About this time, mid-October, Leanne moved in with her mother.

14.33. Leanne was referred to MARAC by Kent Police on 24 October 2016, and the referral was received into Choices on 25 October 2016. Choices provide

specialist domestic abuse services to adults and young people in West Kent and Medway.

14.34. The MARAC referral is for those victims who are deemed as being high risk, scoring 14 or above on the DASH risk assessment tool, or based on professional judgement. The police DASH risk assessment noted Leanne's risk as being scored at 9, and her referral was based upon professional judgement.

14.35. Choices attempted to contact Leanne on 26 October 2016 without success. On 28 October 2016, Choices' independent domestic violence adviser (IDVA) telephoned and made contact with Leanne. She spoke about David confirming his diagnosis of paranoid schizophrenia and bipolar disorder. The IDVA stated that David was using cannabis and cocaine, the cannabis use having started in 2007. The transition to cocaine started in 2009 while they were living in Lewisham, causing him to go into a manic state. Leanne stated that David was considered a danger to himself and others, and that he would jump on car roofs. Leanne informed the IDVA that she suffered from high blood pressure and slight emotional depression, but that she was not on medication. She was fearful that he would hurt her again, as she was unable to predict David's behaviour. She stated that the abuse was getting worse and more physical, and that he did not care that he was doing this in front of other people. The IDVA stated that David had begun putting his hands out, gesturing that he was going to squeeze her breasts. When she told him that it was not appropriate, he began poking her in the side. In addition, Leanne stated that David was financially controlling and made unreasonable demands of her, such as making her fill his water bottle and plug in his laptop. Leanne stated that her greatest priority was that David would be accommodated elsewhere, and that she wanted to be able to get back to her own home.

14.36. On the same day, the IDVA contacted both Medway Council Adult Services and KMPT's CMHT. The IDVA disclosed that Leanne had expressed that she felt let down by the police and mental health services, and she expressed concerns that David was not taking his medication and was demonstrating sexualised behaviour towards her, resulting in Leanne leaving her house for her own safety. The IDVA was told that CMHT would be reopening David's case. The IDVA correctly suggested the need for close partnership working; as the situation was unpredictable, the CMHT member agreed. A professionals' meeting should

have been convened to explore further support interventions, but unfortunately, this did not happen. An adult safeguarding concern was considered for Leanne, but the view was that the primary need was for David. A referral for an assessment of need was made for David, and it was determined that David had social care needs and required supported housing.

14.37. Regular contact from the IDVA was maintained with Leanne between 25 October 2016 and 9 January 2017. Of note was a contact made on 15 November 2016 during which Leanne disclosed that David had been to his maternal grandmother's house feeling down and wanting his medication. Leanne was unsure as to what MH services were being offered to him. Leanne informed the IDVA that she had suggested to David that he speak to the Samaritans but was worried that giving David advice would make David cross with her. She added that David informed her that cannabis made him feel better. It was agreed that the IDVA could contact ASC on Leanne's behalf.

14.38. On 28 October 2016, the IDVA contacted the mental health team advocating on Leanne's behalf and expressing Leanne's concerns as to what help David was getting, as it only appeared to be centred around his medication. The IDVA made it quite clear that Leanne needed to speak with someone from the mental health team and was informed that the community psychiatric nurse (CPN) would be asked to call Leanne.

14.39. At the beginning of November 2016, Kent Police were contacted by Yorkshire Police as they had received a call from David, claiming to be a different person and the victim of kidnap and abuse by travellers. Yorkshire Police raised concerns that David was suffering from mental health concerns. Kent Police referred the matter to the crisis team, who stated that they would contact David.

14.40. On 3 November 2016, a MARAC was held. An overview was provided by Choices following their direct contact with Leanne. Within this overview, a history of David's mental health issues from 2009 was presented. Mental health issues, such as schizophrenia and bipolar disorder, compounded by illegal substance misuse, were described. A history of violence by David towards Leanne was described, including headbutting, grabbing her throat and slapping her, as was his controlling behaviour. Leanne's fear of David was evident in the report, along with her lack of faith in mental health services. She felt she was

not being listened to by them. No safeguarding plan or carers assessment was considered for Leanne at MARAC. Only one action ensued: to 'chase' the ASC referrals via an e-mail.

14.41. On 10 November 2016, a social worker and social care officer visited David at his mother's house, where he had been living alone for the previous four weeks. Leanne was present at the meeting. An assessment of his social care needs was completed, and it was determined that he needed alternative housing to remove him from the home so as to mitigate the risk to his mother. It was further determined that he might require supported accommodation due to his lack of independent living skills.

14.42. A further visit by the previous attending social worker and social care officer was made, the outcome of which was discussed with David's community mental health worker. Due to David's presentation, a request was made to review his antipsychotic medication. Both the social care assessment and risk profile completed by the attending social worker detailed signs of relapse, action to take, and protective factors. An indication of deteriorating mental health was raised with David's mental health social worker. Leanne continued to stay with her mother rather than in her own home.

14.43. Following this, the attending social worker made two attempts to progress housing with David. The first occasion was on 30 November 2016, during which David would not engage with the social worker, stating that he did not need supported housing. This was reported to the mental health social worker, along with the concern of possible relapse in his mental health. On 1 December 2016, the same social worker telephoned David and noted that he sounded aggressive while still maintaining that he did not require supported housing. A plan was made for a social worker to arrange a visit with David.

14.44. In November 2016, David was referred to Turning Point, a Medway-based substance misuse service. However, David appeared to have difficulty engaging with this service and abstaining from substance misuse.

14.45. Following the visit to David on 10 November 2016, a referral for a carer's assessment for Leanne was made by the attending social worker. Subsequently, Leanne was contacted by telephone by a social care officer.

Leanne replied that she had access to support from her family, and she was aware of support groups should she need them. The referral for Leanne was closed.

14.46. On 2 December 2016, David assaulted his mother. Police attended, and David was detained under Section 136 of the MHA. Leanne was spoken to by officers, but she declined to support a prosecution, so the matter was not pursued. However, the police deemed the matter high risk, and a second MARAC referral was made. David was subsequently detained under Section 2 of the MHA.

14.47. David remained detained under Section 2 (converted to Section 3) of the MHA. He would later be transferred to a KMPT rehabilitation facility in March 2017.

14.48. On 8 December 2016, the IDVA spoke with Leanne, who informed the IDVA that David, while detained at a mental hospital, had posted a Facebook video in which he stated that he was being poisoned by the doctors. He had ripped a letterbox off because he thought it was a bomb. She had been to see David in hospital, but he became antagonistic, so she would not be visiting him again. She was adamant that she did not want David at her home. She was going to be moving back into her home, and the police would be providing her with an alarm. She declined Sanctuary, a housing and care provider. The IDVA advised that she would be speaking to the hospital to discuss her safety. The IDVA phoned the mental health team, to whom her concerns were raised.

14.49. The IDVA contacted the CPN on 13 December. The IDVA had contacted the MARAC coordinator to ask the doctor from the mental health hospital to attend the MARAC. In the discussion with the CPN on that date, it was agreed it would be better for the CPN to attend.

14.50. The IDVA contacted Leanne to update her, and she was informed by Leanne that she had spoken to David on the telephone. He was angry at Leanne for not allowing him back into her home, stating that while he liked the house, he did not like her. The IDVA informed Leanne that she would share this with the professionals as soon as they got back to her. This was a good transfer of support. During the following conversation with the CPN, the IDVA expressed her professional view as to the risks David posed to Leanne. The CPN asked whether Leanne would have David back home when discharged and was

reminded of Leanne's stance on this, which was that she did not want David back in her home.

14.51. The doctor from the psychiatric hospital spoke to the IDVA, and the IDVA shared her concerns with the doctor, stating that it was vital for both Leanne and the IDVA to be informed as to when David was to be discharged from hospital. The doctor informed the IDVA that there was to be a meeting regarding David the following day, and that the IDVA's concerns would be shared at the meeting. The IDVA asked that the doctor attend the MARAC but was told that it would be better if the CPN attended.

14.52. A second MARAC was convened regarding Leanne and was held on 15 December 2016. A senior social worker attended as the ASC representative. Rehousing David was discussed, as was Leanne's belief that David was on the wrong medication. Leanne's concerns that mental health professionals were not listening to her were raised. It was clear that Leanne was still afraid of David. The senior social worker representing ASC highlighted actions that were being proposed for David, as he had never lived on his own. It was recognised that David might be considered for housing because of his cannabis use. It was agreed that rehousing and supported accommodation were the most suitable options for him, given his mental health history, current presentation, and functioning levels. ASC would be applying for one of the supported accommodation schemes locally.

14.53. At the MARAC meeting on 15 December 2016, no actions were raised.

14.54. On 9 January 2017, Kent Fire and Rescue Service (KFRS) received a referral for Leanne from Choices. The referral was made due to Leanne being a high-risk victim of domestic abuse. Leanne's son, David, was identified as the perpetrator, and described as having significant mental health problems and 'targeting' Leanne at her property. At the time of the referral, David had been sectioned and detained at a mental health hospital under the MHA. It was not known when he would be discharged from the hospital, but safety needs were required before his release.

14.55. On 10 January 2017, KFRS called Leanne to book an appointment for a safe and well visit, which was arranged for 18 January 2017. The visit took place,

during which Leanne disclosed that she was at risk from David, who, since December 2016, had been sectioned and detained at a secure mental health unit. Leanne disclosed that David had attacked her on several occasions and that she was afraid of him returning to her house following his release from the hospital.

14.56. The safe and well visit identified some electrical safety matters. Advice was given regarding escape routes, closing doors at night, and general electrical and fire safety. Leanne agreed to discuss a personal attack alarm at the property with the police. It was noted that KFRS would e-mail the police liaison officer at the secure mental health unit about Leanne's situation once permission from a KFRS team leader was granted. It was further noted that Choices had now closed their case.

14.57. On 20 January 2017, the KFRS safe and well officer e-mailed the KFRS team leaders asking for permission to e-mail the police liaison officer at the mental health facility where David was detained to ask for an update regarding their intention to release David. On 23 January 2017, a KFRS team leader replied, instructing not to proceed with contacting the police liaison officer until approval was received from a KFRS information officer.

14.58. The information officer has since been spoken to and has no recollection of Leanne's case. There is no record of a decision to contact the police liaison officer being made.

14.59. On 31 January 2017, the KFRS safe and well officer contacted Leanne, updating her that KFRS could not contact the police liaison officer regarding David's discharge. Leanne stated that she understood and thanked KFRS for their assistance.

14.60. Case records show that on 5 January 2017, David was detained under Section 3 of the MHA. Subsequently, he was supported through a Care Programme Approach. His behaviour remained challenging. A funded mental health rehabilitation bed was provided, and on 16 May 2017, a referral was made for supported housing. David attended his first session of independent living learning, but then excused himself on the following four occasions.

14.61. David remained detained within the mental health care system for much of 2017; however, not without incident. In February 2017, he was found to be in possession of a knife with which he approached a member of staff, with the knife held towards his own neck. It was later determined that David thought he was in a prisoner of war camp.

14.62. On 27 February 2017, a care programme approach (CPA) meeting took place, attended by Leanne. At that meeting, Leanne disclosed two further incidents in which David had assaulted her. On one occasion, he had slapped Leanne around the face when she had asked him to leave. On another occasion, Leanne had woken up to find David standing over her, followed by him attempting to strangle her. Leanne informed the meeting that should David ever move back into her house, she would need a panic button fitted.

14.63. In October 2017, David was discharged under a community treatment order (CTO) towards supported accommodation. CTOs were introduced into legislation for England and Wales by the MHA (2007). They can be applied to a patient who is already subject to a section under the MHA, by a clinician responsible for the patient, to enable supervised treatment. A person under a CTO can be returned to hospital for treatment, and conditions can be added. While a CTO lasts for six months, it can be renewed by the clinician.

14.64. Despite Leanne's earlier disclosure and David's known history towards her, no risk assessment or carer support appears to have taken place at that time. Records indicate that, following his discharge, David frequently visited his mother. Additionally, he attended the depot clinic regularly and received 60 mg of depixol every three weeks.

14.65. When he was discharged, David moved to supported accommodation. Between 26 September 2017 and 29 January 2018, a support plan commenced, led by ASC. On 30 January 2018, David's case was transferred to the long-term support team of Medway Council Adult Services. The file was transferred to Locality 2 as an 'unallocated case'.

14.66. Medway ASC works to an unallocated model for casework. This means that when a worker (social worker, occupational therapist, etc.) is actively working

with the service user around an assessment, review, enablement, Section 42 safeguarding, and risk management, then a named worker is allocated. When a service user, in receipt of a service provided by ASC, is in a situation that becomes stable, they will not have an allocated worker. The electronic recording system flags up when a review is due; this is usually annually but can be set for a shorter period. From a recent safeguarding adult review, service users who are detained in hospitals under the MHA and were previously known to ASC will have an allocated worker. The service is currently working towards a blended model of unallocated and allocated casework. Service users with an entitlement to Section 117 aftercare services that are not in receipt of any service will be 'unallocated'.

14.67. On 28 March 2018, Leanne raised concerns to a supported accommodation provider regarding David's lack of motivation and heavy reliance upon her as well as his general attitude towards her. David's cocaine use had increased, and it was further identified that David was spending a lot of time at his mother's house. David was still subject to a community treatment order, and the question arose as to whether a further professionals' meeting should be held. This information was passed on to ASC, and a request was made for a review and social work input. The review was scheduled for June.

14.68. On 3 April 2018, staff from David's supported living accommodation provider e-mailed David's care coordinator at KMPT to relay concerns raised by Leanne. She had reported David's lack of motivation, his reliance on her, his general attitude towards her, as well as his financial troubles and use of cocaine. Leanne disclosed that she had become impatient with David and felt like she might need to cut all ties with him if things continued as they were. David had told Leanne that he did not like being alone at weekends, which was the reason why he was spending more time with her.

14.69. Internal e-mail communications followed, and a review by ASC was arranged for 4 June 2018. However, this did not happen, with the reason given that David was staying at his mother's house. Discussions took place between the allocated ASC worker and the relevant manager. And on 7 June 2018, the case was allocated to a social worker. There were further engagements with KMPT services through June and July. For example, though David did not attend his appointment on 12 July for his depot, he was contacted, and it was suggested

that this could be given on 13 July. David reported being too tired after watching football as the reason for not attending on 12 July. The clinic was very flexible and arranged for the depot to be given on 13 July, which David attended.

14.70. On 26 July 2018, Leanne attended the phlebotomy department for a blood test, and she was then discharged to MCH services.

14.71. On 30 July 2018, the allocated social worker visited David at his supported accommodation. He was sleeping at the time, so he was not spoken to. On 30 August 2018, a further visit was made, but David was not at the accommodation as he was at his mother's house. Three months later, another visit was attempted, but again David was not there.

14.72. In 2018, reports were made to the police involving David's harassment of a woman (Female A) whom he had met while detained in hospital. During one of these reports, David was shot with a pellet from a BB air weapon. In August 2018, allegations of indecent exposure by David toward Female A were made. However, the woman did not wish to pursue prosecution, and no further action was taken.

14.73. On 6 September 2018, David attended the ED by ambulance and was accompanied by the police. He presented with an injury to his head as a result of being shot with a pellet from an air weapon. ED records noted that past medical history was documented as schizophrenia affective disorder, and medication was listed as depot. David provided an account to ED staff that he had been shot at about 2 a.m. while in the street. He was discharged home. South East Coast Ambulance Service (SECAmb) documented that David had been visiting his girlfriend and a friend.

14.74. On 26 September 2018, David attended his GP presenting with paranoid ideas claiming that he had a metal detector in his head after being shot in the head by an air rifle. No discussion with the mental health team took place, and no risk assessment was undertaken. David was not seen again by the GP before Leanne's death.

14.75. In September 2018, a CPA review was conducted. This was attended by an approved mental health practitioner (AMHP) team lead, David, and Leanne.

David's consultant psychiatrist agreed to reduce David's depot injection to 50 mg of depixol every three weeks due to the side effects he was experiencing. This was further reduced to 50 mg every four weeks.

14.76. Significant events were taking place in David's life at that time, such as a lack of communication between him and his adult social worker, his drug misuse, and his ongoing harassment of Female A. It appears that professionals at the September CPA were unaware of these events.

14.77. In November 2018, David was arrested for common assault and carrying a bladed weapon, and he was recalled to the psychiatric intensive care unit (PICU) for two days. It is recorded that David had been 'mainly stable that year'.

14.78. On 10 December 2018, Medway NHS Foundation Trust received a referral letter from David's GP, as David had reported a lump in his left eyebrow following being shot by a pellet on 6 September. On 14 February 2019, he attended day surgery where a foreign body was removed from his left lateral brow.

14.79. In December 2018, David visited the home of Female A and used violence to secure his entry to the premises. He was arrested and charged with that offence and for assaulting the attending police officers. While in custody, no mental health assessment was undertaken, although the officer in the case was aware of David's previous mental health concerns. Risk assessments were completed; however, David was not identified as a vulnerable person or someone requiring a mental health assessment. David received a conditional discharge at court.

14.80. On 10 January 2019, David telephoned a health care assistant (HCA) in KMPT's CRHT asking for help. He disclosed that he did not seem able to take control of his drug use and that he lied to his mother and his care coordinator.

14.81. On 18 January 2019, the allocated social worker presented a handover to her team manager as she was leaving her post. It was reported that the supported housing staff had not raised any further concerns when the social worker visited in July, August, or December 2018.

14.82. On 21 February 2019, David attended MCH for the removal of sutures following the surgical extraction of a pellet from his left temple. A history of mental health

was noted in his records. David demonstrated an understanding of the treatment and gave no cause to consider his capacity under the Mental Capacity Act 2005.

14.83. The new social worker visited David on 7 March 2019. David was on his way out, but he informed the social worker that he was moving into his own flat the following day. Following two attempts to speak with David on the telephone, the social worker made a referral to the ASC community support outreach team (CSOT) to provide support for David in getting 'some essentials' for his new flat. David was staying at his mother's address. During June and July, the CSOT made efforts to support David's request, and in August, David declined further support from them.

14.84. In March 2019, a review of Leanne's GP notes was undertaken; however, no safeguarding concerns were identified. Leanne attended the GP practice infrequently. The reference to abuse found in the notes is not recorded as being explored further, and there are no documented follow-ups regarding this.

14.85. In early April 2019, David reported to the police that he had been assaulted by strangers in the street.

14.86. On Sunday 7 April 2019, Leanne reported to a community resolution home treatment team (CRHT) nurse that David had been verbally abusive towards her and her niece, and that they had to call the police.

14.87. On 24 April 2019, it was noted by Medway CMHT that David had been banned from Paydens Pharmacy and was now using Boots Pharmacy.

14.88. On 25 April 2019, the supported accommodation worker reported to the care coordinator that David's behaviour was a concern, believing this to be related to his medication.

14.89. On 27 April 2019, police were called to Leanne's house as David had been banging on the front door and being verbally abusive. It transpired that David had been out all day, and upon his return home, found himself to be locked out. DASH risk was assessed as medium. No police action was taken.

14.90. On 11 June 2019, the care coordinator discussed David's case at a multi-disciplinary team (MDT) meeting. It was agreed that the care coordinator would meet David at his next depot clinic appointment to assess his mental state and risk. The MDT meeting failed to identify that the risk assessment had not been updated for a while. There were no attempts made to visit David or recognise the fact that he remained on a CTO. There was an overreliance on the planned depot clinic meeting and not enough scrutiny of David's history or his records.

14.91. David attended the depot clinic on 19 June 2019. He was looking well. He reported that he had expected his depot dose to have been reduced, which it had, from 40 mg to 30 mg. The CPN looked for David after his injection; however, he had left. The depot staff reported that David had been stable in mood, and no risks were identified by the clinic at that time.

14.92. On 5 July 2019, David called the CPN and asked whether his medication would be reduced, as agreed, before his next injection. David sounded calm and pleasant. David was advised that a medication review would be booked in; however, David asked for it to be reduced before this date, on 24 July. The CPN reported that she would request this.

14.93. On 6 July 2019, David was reported by Leanne to the police as behaving aggressively and refusing to leave her home. Officers attended and found him sitting on the sofa. He was compliant when spoken to. When asked to leave, David did so willingly. He told the officers that his mother favoured his brother and that she did not want him (David) in the house. He discussed his mental health issues with the officers and informed them that, while he had medication, he did not take it all the time. During discussions with Leanne, she told the attending officers that she wanted David gone and nothing further to be done. David was taken home and advised to seek help from his GP. A DASH assessment was graded as medium risk.

14.94. Also on 6 July 2019, Female A contacted the police to report that David had visited her father's house. She was upset that David knew where her father lived. She had been alerted by neighbours, and having checked CCTV, confirmed it to be David. Female A was also concerned because David was on conditional bail following his arrest for an offence of violence to secure entry to her home in December 2018 (see paragraph 14.78).

14.95. On 9 July 2019, the Medway CMHT doctor agreed to David's request to reduce flupentixol decanoate medication to 20 mg every four weeks.

14.96. On 17 July 2019, David attended the depot clinic, where it was noted that he presented as unpredictable and irritable and that 'every word he used was the "F" word'. It was further noted that David was 'very suspicious', and he was slightly elated. This was the first 20 mg dose of flupentixol decanoate.

14.97. On 23 July 2019, police received a report that David had assaulted a woman, Female B. She had stayed the night with David and then refused to leave the following morning. He forcibly removed her, which led to her falling down some stairs and receiving injuries. At the time, she did not want to pursue a prosecution, but later contacted the police, informing them that she had changed her mind. She stated that it was not an intimate relationship.

14.98. A few days after David's visit to her father's address, the police visited Female A. The decision was made that David could no longer be prosecuted, as he had just been dealt with at court. It was also decided that David could no longer be dealt with for a possible breach of bail. The incident was closed, and safety advice was given.

14.99. In August 2019, Female A contacted the police again to report harassment by David. She stated that he would ring the doorbell two or three times a week in the middle of the night. She informed the police that she had never been in a relationship with David. She did not want to support a prosecution. Officers recorded the incidents as harassment and provided Female A with safeguarding advice.

14.100. After David met with CSOT on 13 August 2019, David's case was moved to 'unallocated' as no active service was being provided by ASC, and as David was subject to a CPA and CTO, mental health services were the lead agency for monitoring him. There was one further contact relating to David, from the community health team on 1 October 2019 to the community resource centre, as David required some activities to provide structure to his day. On 4 October 2019, David's case was allocated to a social care officer.

14.101. On 14 August 2019, David was seen in the depot clinic, where he received his 20 mg dose of medication by injection. It was documented that he presented as ‘looking rather unpredictable’ and ‘suspicious’. It was further noted that his mood remained slightly elated.

14.102. Three hours after David’s attendance at the depot clinic, the care coordinator received a call from Leanne disclosing what appeared to be escalating symptoms. David exhibited paranoia and felt that he was being watched by others when out in public. He was making delusional statements, saying that he was ‘going to explode at someone’. Leanne also reported that a fast-food restaurant had recently refused to serve David due to his aggressive behaviour. Leanne expressed that she did not want David to be admitted back to an acute ward, and it was agreed that the CPN would arrange for him to be seen by a doctor.

14.103. On 16 August 2019, David attended a follow-up appointment. He presented as slightly hyper-vigilant, finding it difficult to maintain eye contact. He was fidgety and unable to keep still. David reported poor sleep and only eating one meal per day. A CPA review was undertaken, which noted that David remained stable on 40 mg flupentixol decanoate every four weeks; however, since the reduction to 20 mg, he was experiencing a relapse. It was decided to return to the higher dose. However, his medication chart was not reviewed. As a result, over the next two months, David had a lower depot dose than required on two occasions (11 September and 9 October). The prescription chart was not amended, and the care coordinator did not monitor David in line with CTO policy.

14.104. On 9 September 2019, the CPN made contact with ASC to request increasing support for David. The social worker advised that David was closed to his social worker on 6 September, as he had refused support. The CPN advised the social worker that David would need reallocation for 147 support. The duty worker agreed to request allocation.

14.105. On 11 September 2019, David attended the depot clinic and was looking very well; his mood was stable and pleasant. The depot was to be reviewed, as David thought this was the last depot injection. 20 mg was given.

14.106. On 15 September 2019, Female A rang Kent Police in the early hours of the morning, stating that David was outside ringing on her doorbell and those of her neighbours. She added that he was 'touching himself', although not exposing himself.

14.107. David was allocated to a social care officer on 4 October 2019.

14.108. On 9 October, David attended the depot clinic as planned. He was irritable following needing to wait a few minutes. He apologised before leaving the clinic. David told the staff he had nothing planned after his appointment; he wanted to go home and play his game. 20 mg was given. David did not attend his CTO renewal appointment on this day the 9th October, and the AMPH had also not attended; however, there is no evidence that they were invited. It was noted that David was given 20 mg; however, his required dose had previously been increased to 40 mg.

14.109. In October 2019, the police were contacted by the ambulance service, stating they were attending a knife attack incident. Upon arrival, they discovered Leanne dead at the scene.

15 OVERVIEW

15.1 During the period examined by this DHR (23 June 2015 to Leanne's death in October 2019) agencies working in support of both Leanne and David were aware that David had significant mental health issues, having been diagnosed with paranoid schizophrenia and bipolar disorder. His mental health history dating back to his childhood in London was known, along with his incursions into minor criminality that included the use of illicit drugs, namely cannabis and cocaine.

15.2 The continued impact of David's mental health upon Leanne was known and well documented. Injuries sustained by her because of assault by David, her fear of him, and his controlling behaviour were also known. This was widely reported to agencies and recorded by them and expressed very clearly by Leanne, as was the fact that she often had to remain away from her home for her own safety.

15.3 Not only did David's mental health remain a challenge both for him and for Leanne, but it impacted others. Harassment of another woman which turned into assault, violence to secure entry, indecent exposure, and possession of an offensive weapon (a knife) in a public place, was known to some, but not all, the agencies. It was known that his continued taking of cannabis and cocaine not only had a serious detrimental effect on David's mental health, but also exposed his vulnerability to others, including drug dealers. His continued drug abuse exacerbated an already toxic and charged situation, making him an increasing threat to those around him, especially Leanne. His history of conduct problems in childhood and adolescence, as well as ongoing antisocial behaviours leading up to the death of his mother, even when he was deemed "stable" as many incidents were unknown to mental health professionals, would perhaps be enough for professionals to consider other diagnoses or support.

15.4 Lack of supervision of a newly qualified care coordinator was a tangible factor in what unfolded. Lack of contact with David, lack of assessment and coordination of responses, and failures in the administration of antipsychotic drugs all combined to lead to what has been described as an avoidable death.

16 ANALYSIS

16.1. The IMRs and submitted reports have been carefully considered to ascertain whether each agency's contact with both David and Leanne was appropriate and whether they acted in accordance with their policies and in compliance with legislation and statutory obligations. Where they have not done so and where failings have been identified, the panel has deliberated upon the lessons that have been identified and the resulting recommendations that it is hoped will lead to improvement.

16.2. Domestic abuse is defined within the Domestic Abuse Act 2021[4] and includes any incident of abusive behaviour between those aged 16 or over who are personally connected.

16.3. Domestic abuse covers a range of types of abuse, including, but not limited to, psychological, physical, sexual, economical, or emotional abuse. Domestic

[4] Domestic Abuse Act 2021 (legislation.gov.uk)

abuse can be prosecuted under a range of offences, and the term is used to describe a range of controlling and coercive behaviours used by one person to maintain control over another with whom they are personally connected.

16.4. Domestic abuse is rarely a one-off incident, and it is the cumulative and interlinked types of abuse that have particularly damaging effects on victims.

16.5. It is evident from the information provided by Leanne to her family and the agencies that she was subjected by David to:

- Physical abuse, such as being slapped, punched, strangled, and hit on her head.
- Coercion, threats, and intimidation, which led to Leanne being excluded from her own home for significant periods of time.
- Suggestions of sexual assault when he gestured that he was going to squeeze her breasts.
- Emotional abuse, doubting her legitimacy as his mother, threatening her in front of her family, and using her for menial tasks.
- Economic abuse when he went shopping with her in a manner that controlled her spending and made demands upon her funds for his own upkeep.

16.6. The various forms of violence and abuse operated together over a sustained period, which was underpinned by coercive control that restricted Leanne's freedom and life choices and left her in an almost permanent state of fear and anxiety.

16.7. It is important to consider Leanne's experience of domestic abuse and how, for example, her sex (being a woman) impacted the abuse that she suffered. David frequently demonstrated an overreliance on Leanne as a mother, exposing her to continued harm. This appears to have been not only acquiesced to by the respective agencies, but also accepted by them.

16.8. David has been described as becoming a child with challenging behaviour following the death of his father. This event may be recognised as an Adverse Childhood Experience (ACE). ACEs are highly stressful, and potentially traumatic, events or situations. The Centres for Disease Control and Prevention

(CDC) in the United States note that ACEs have a tremendous impact on future violence victimisation and perpetration, and lifelong health and opportunity[5].

16.9. Abuse towards Leanne began when David was an adolescent, and research into the causes and consequences of adolescent-to-parent violence and abuse (APVA) has been conducted. The Home Office paper 'Information guide: violence and abuse (APVA)' Information guide: adolescent-to-parent violence (basw.co.uk) sets out guidance regarding reporting APVA and the many challenges involved. The research has identified a great deal of learning under the headings.

- General advice for practitioners
- How to respond: Healthcare
- How to Respond: Education
- How to respond: Social care
- How to respond: Housing
- How to respond: Police
- How to respond: Youth justice.

16.10. Economic abuse[6] is an aspect of coercive control – a pattern of controlling, threatening, and degrading behaviour that restricts a victim's freedom.

16.11. Making financial decisions, reducing, and directing her spending decisions are forms of economic abuse experienced by Leanne and do not appear to have been identified as the controlling and criminal behaviour that it was. This continued to allow David to keep a hold on his mother. It is important to remind professionals across the broad spectrum of services of the need for education and vigilance on this matter.

16.12. **Recommendation 1.** *Economic abuse are not consistently considered by agencies as controlling and coercive behaviour. Training on this subject should be delivered to all agencies contributing to this DHR.*

16.13. On more than one occasion, Leanne expressed dissatisfaction with the level of support she was receiving, and that she felt that she was not being listened to

[5] https://www.cdc.gov/violenceprevention/aces/fastfact.html
[6] Surviving Economic Abuse: Transforming responses to economic abuse

by professionals. This same view is shared by her family. The information provided by the IDVA goes some way towards corroborating this from a professional viewpoint, not that corroboration is required.

16.14. Schizophrenia is a psychiatric disorder characterised by continuous or relapsing episodes of psychosis. Psychosis is a condition of the mind that results in difficulties in determining what is real and what is not real. Symptoms may include delusions and hallucinations, as well as agitation and aggression. There may be sleep problems, social withdrawal, lack of motivation, and difficulties carrying out daily tasks. Treatment may include antipsychotic medication, counselling, and social support. David's mental disorder also appeared to have a mood component (hence, the diagnosis of bipolar affective disorder) with periods of elation and high energy (mania) and periods of low mood and tearfulness (depression) with associated suicidal ideas and behaviour.

16.15. David's mental health is the single biggest contributor to this set of circumstances and, consequently, to Leanne's death. His mental health condition was diagnosed and managed through the care programme approach and community treatment order provided by mental health services. Ultimately, those treatments and the mental health care received by David failed. This needs scrutiny to understand why, and so that lessons can be learnt. These have been identified in the RCA done by KMPT.

16.16. Illicit drug taking in the form of cannabis and cocaine no doubt affected David's treatment with antipsychotic medication and mental health care. His history and use of illicit drugs were widely known, having been reported by Leanne and David himself at various times throughout this DHR period, and indeed beforehand, when the family lived in London. Accurate control of David's medication, a dual diagnosis pathway, and multi-agency support would have been essential in managing his mental health, drug misuse, and safeguarding him and those around him, especially Leanne and Female A.

16.17. In September 2016, David was admitted to a mental health ward. This followed disclosure by Leanne that David had become aggressive towards her and had grabbed her throat for no apparent reason. David showed irritability, believing Leanne was not his real mother, a common theme when he was unwell. This was a missed opportunity to offer support to Leanne.

16.18. On the occasions that Leanne attended the ED with David, he presented with mental health issues. Violence towards her was disclosed. No consideration appears to have been given by ED staff as to the risks posed to Leanne or her family. A carer assessment does not appear to have been considered. It was not recognised that David may have been subjecting Leanne to controlling and coercive behaviour.

16.19. **Recommendation 2:** *It is recommended that training be delivered to ED staff in relation to referring and discussing carer assessments and controlling and coercive behaviour and domestic abuse to adult parents.*

16.20. The 'Think Family' principles that form part of safeguarding adults and children training were not applied. There are now regular meetings between ED staff and psychiatric liaison staff to discuss their assessments verbally with the nurse in charge of the ED.

16.21. MFT now has a hospital independent domestic violence advisor (HIDVA). HIDVAs (provided by DA Service Oasis[7]) provide specialist domestic abuse support in a range of critical healthcare settings across Kent, and links to community support enabling effective discharge. Their aim is to reduce repeat visits to acute healthcare settings because of domestic abuse, reaching a wider range of those in need of support and those who may be suffering from complex unmet needs, such as mental health, alcohol, and drug dependency.

16.22. **Recommendation 3:** *Oasis to offer MFT and KMPT (Medway) domestic abuse and MARAC training to staff in A&E (ED) including liaison psychiatry service (LPS). MFT and KMPT to ensure A&E and LPS staff attend (jointly where possible) this training, offered and delivered by Oasis.*

16.23. At the time of Leanne's death, KMPT policy was clear in setting out expectations when domestic abuse is identified. The policy details the need to discuss support, completion of a DASH risk assessment, and, where the circumstances merit it, a referral to MARAC. There is no record of a DASH risk assessment being considered.

[7] In 2021 the DA services Choices and Oasis merged and are now known solely as Oasis.

16.24. Leanne expressed fear, and she disclosed aggression and hostility from David towards her. This should have triggered staff to consider methods of support and signposting or referral to MARAC to safeguard her. The CMHT operational policy, which was current at the time, outlined staff expectations regarding carer support, which was in line with the Care Act 2014. Those expectations were not met. (It is documented in his record that the ward staff was invited to a MARAC meeting for domestic violence against his mother in December 2016.)

16.25. Professional curiosity is vital in responding to incidents in which multiple risks and vulnerabilities may exist. Every practitioner must take responsibility for their role in safeguarding processes and understand, without exception, what their role is. This needs to be underpinned by supportive and consistent supervision and management, as previously highlighted in the Kent and Medway DHR (Joan 2015)[8]. Senior leaders can foster such cultures through their visible leadership.

16.26. **Recommendation 4:** *Timely, routine, and effective supervision is essential in supporting hard-working frontline professionals. KMPT expectations of supervisors, including time scales for completing assessments and reviews, should be formalised, mandated, and educated through aid memoirs, guidance manuals, training, and staff appraisals*.

16.27. Contact between the police and KMPT staff was limited despite David's behaviour towards Leanne. Timely ongoing discussions should have been held between KMPT and the police to discuss ongoing support and to inform KMPT's risk assessment and support plans in line with safeguarding adult policy. Safeguarding adult policy directs that, where safeguarding concerns are noted, care plans and risk assessments should be reviewed; this did not take place.

16.28. Throughout the period of this DHR, there are three documented notes with regards to carers' assessments on behalf of Leanne. On 24 July 2015, a KMPT doctor requested that a carer's assessment be offered to Leanne.

[8] Overview-report-Joan-November-2015.pdf (kent.gov.uk)

16.29. On 3 August 2017, a CPA review was held where an action was set for David's social services social worker to consider a carer's assessment for Leanne. During the discussion, Leanne stated that she already had contact details for Carers FIRST and that she would make contact once David was settled in his new supported living accommodation. There is no evidence of referrals having been made or further discussions with Leanne taking place, nor any follow-up action. The carer's assessment does not appear to have been revisited despite several indications that Leanne was struggling.

16.30. On 16 August 2016, an IDVA contacted CMHT and explained that Leanne did not feel enough was being done to help David move out of her home. The KMPT practitioner asked the IDVA to signpost Leanne to the carers' service. This was a key opportunity to have taken positive steps to review the need for action to be taken to support David away from Leanne's home, but it was missed.

16.31. Conversely, it can be argued that Leanne should not have required a carer's assessment, as she was a victim requiring protection and safeguarding. It can be concluded that her role as a carer was accepted by professionals because she was David's mother.

16.32. Choices provide specialist domestic abuse services to adults and young people in West Kent and Medway.

16.33. On 28 October 2016, Choices' independent domestic violence adviser (IDVA) telephoned and made contact with Leanne, who spoke about David, confirming his diagnosis of paranoid schizophrenia and bipolar disorder. She stated that David was using cannabis and cocaine, the cannabis use having started in 2007. The transition to cocaine started in 2009 while they were living in Lewisham, causing him to go into a manic state. Leanne stated that David was considered a danger to himself and others, and that he would jump on car roofs.

16.34. Leanne provided a further overview of how she had moved to Kent in 2015, describing several incidents since then, which included David grabbing her throat, pinching her throat, pinching her skin, hitting her over her head with his wrists and slapping her to the side of the head. She explained that these incidents had taken place over a three-week period and that she had reported them to the police.

16.35. At the time of the telephone call with the IDVA, David was on bail for those incidents and had been bailed to Leanne's sister's address, on the condition that he was not to contact Leanne. However, the police had contacted Leanne to inform her that her sister had explained to the police that she could no longer have David living with her. Leanne assumed that bail had been revoked, and she had spent time with David the previous weekend. They had been shopping together, during which he was unhappy, as he had to pay for his own food, and he questioned Leanne about where she spent her money.

16.36. On that same day, David attended his maternal grandmother's address, wanting to speak about their time living in London. Leanne refused, as she wanted to move on and not look back. He then wanted to look at photographs, which Leanne agreed to; however, this led to David becoming agitated and demanding a DNA test because Leanne looked different from him. It was later understood that police had released David because Leanne would not support a prosecution. During the discussion with the IDVA, Leanne stated that she felt let down by the police, saying that she might not tell the police anymore and that she would be unwilling to tell mental health professionals either. The police had told her that David 'was not of sound mind' and was mentally ill, and as such, they would not be able to do anything else with him.

16.37. **Recommendation 5***: It is recommended that Kent Police review this investigation to determine any lessons to be learnt regarding the use of bail conditions and the notification to the victim (Leanne) of those conditions and implications. In addition, Kent Police should examine the messaging to the victim of any changes in bail. Was Leanne notified in a timely and correct fashion? The notification to Leanne that the police could not do anything further because of David's mental health should be examined for any learning opportunities.*

16.38. Leanne informed the IDVA that she suffered from high blood pressure and slight emotional depression, but that she was not on medication. She was worried as she was unable to predict David's behaviour, fearing that he would hurt her again. She stated that the abuse was getting worse and more physical, and that he did not care that he was doing this in front of other people. She stated that David had begun putting his hands out, gesturing that he was going to squeeze

her breasts. When she told him that it was not appropriate, he began poking her in the side. In addition, Leanne stated that David was financially controlling and made unreasonable demands, such as wanting her to fill his water bottle and plug in his laptop. Leanne stated that her greatest priority was for David to be accommodated elsewhere, and that she wanted to be able to get back to her own home.

16.39. Safety planning was considered, and the following information was identified: the use of the 999 system, the call helpline, signposting to Rubicon counselling services, Leanne to investigate mental health support groups in the locality, an operational alert on Leanne's mother's address, David not to have keys to Leanne's mother's address, and for her to be accompanied should she need to remove anything from her own house.

16.40. On 28 October 2016, the IDVA contacted a CPN who signposted the IDVA to the mental health team social services, stating that the CPN had made a referral the previous day. The IDVA contacted mental health social care, raising her concerns, and was told that mental health social care would be reopening David's case. The IDVA correctly suggested the need for close partnership working as the situation was unpredictable; the mental health social worker agreed.

16.41. Regular contact from the IDVA was maintained with Leanne between 25 October 2016 and 9 January 2017. Of note was a contact made on 15 November 2016 during which Leanne disclosed that David had been to his maternal grandmother's house, feeling down and wanting his medication. Leanne was unsure as to what MH services were being offered to him. Leanne informed the IDVA that she had suggested to David that he speak to the Samaritans, but worried that giving David advice made him cross with her. She added that David informed her that cannabis made him feel better. It was agreed that the IDVA could contact MH social services on Leanne's behalf.

16.42. The IDVA contacted mental health social services, advocating on Leanne's behalf and conveying Leanne's concerns as to what help David was getting, as it only appeared to be centred on his medication. The IDVA made it quite clear that Leanne needed to be spoken to regarding her concerns and was informed that the CPN would be asked to call Leanne.

16.43. **Recommendation 6:** *The Choices report for this DHR makes it clear that mental health professionals would have better supported David had they paid closer attention to the information being provided to them from those closest to him, his mother and his family. Increasing behaviours, continued illicit drug misuse, and other lifestyle concerns could have shaped mental health service responses. It is recommended that mental health service managers explore this to determine whether it is an isolated event or systemic, and to take appropriate action if required.*

16.44. On 30 December 2016, the IDVA contacted Leanne to update her regarding the second MARAC. Leanne informed the IDVA that David had been sectioned and may have been in hospital for up to six months. The doctor from the hospital had phoned Leanne to enquire about her feelings, and Leanne felt that she was now being listened to.

16.45. The IDVA phoned the mental health team and spoke to the CPN, who informed the IDVA that David could be detained in hospital for more or less than six months. The CPN asked the IDVA whether David would be going home upon discharge from the hospital, and was advised by the IDVA that Leanne did not feel safe having David at her home.

16.46. Throughout this DHR period, Leanne expressed her fears and the challenges she experienced with David; however, despite this, there is little indication that continued support or assessment for her was made, as is required under the Care Act 2014 and CMHT policy. This DHR identifies concerns similar to those identified within the 2017 DHR 'Emily'[9] in which the carer's support, carer strain and risk were overlooked. The CMHT policy sets out clear support expectations for carers and the need to offer ongoing carer assessments. That policy was not followed.

16.47. **Recommendation 7:** *It is recommended that KMPT, when offering carer assessment referrals, document the outcome and review the decision when there is evidence of domestic abuse. KMPT staff should be surveyed to ascertain their understanding of the difference between carer support and*

[9] Domestic Homicide Reviews - Kent County Council

responding to domestic abuse, and the role of the nearest relative in relation to those subject to the MHA.

16.48. David killed his mother when he was an adult. However, his behaviour became challenging when he was a child ,after his father's death, and his abuse leading up to her death commenced when he was an adolescent. The relevance of Adverse Childhood Experiences (ACEs) and adolescent abuse towards parents is such that early recognition of signs and escalation may lead to better, earlier support for the young person and preventative guidance for victims. 'Who's In Charge' www.whosincharge.co.uk provide help and support for parents experiencing child-to-parent violence and abuse. They highlight to the parent victim that they are not alone and assert that 'abuse is never okay'. Valuable insights and advice are provided in an easy-to-follow guide that includes safety planning. Signposting to support networks is provided, as is a nine-week programme for parents which is run across the UK. Programme facilitators can be contacted at admin@whosincharge.co.uk

16.49. **Recommendation 8:** *It is recommended that each agency review staff training to include domestic abuse, where a parent is the victim of domestic abuse from their children, including adult children, to ensure that the best advice and signposting is known about and referred to.*

16.50. Social isolation, boredom, and a lack of meaningful engagement were features of David's life and were highlighted by both David and Leanne. David's mental health affected his ability to function in the community. There were clear gaps in support to address these issues. This resulted in an overreliance on his mother to bridge the support gaps and social isolation. At the time of Leanne's death, David lived alone.

16.51. The Care Act 2014 sets out how agencies should work together to support those suffering from mental health issues, and to consider well-being holistically. Isolation, loneliness, and boredom led David to other associated risks, such as crime, both as perpetrator and victim. Drug misuse and the probability that he had been targeted by drug dealers were featured. On occasions, David disclosed that drug dealers were waiting for him and that he was the victim of controlling behaviour. These incidents do not appear to have been explored further and were missed opportunities in which to undertake assessment and

provide safeguarding measures for him, and to gain a greater understanding of his lifestyle and the risks associated with him and those around him.

16.52. **Recommendation 9:** *It is recommended that KMPT and Medway Council Adult Services conduct a review of their joint working arrangements and consider the development of operational guidance.*

16.53. It is evident that Leanne required safeguarding and support right up to the time of her death, and it was good practice for the police to make a MARAC referral based on professional judgement rather than relying on scores. However, there were no meaningful discussions with any of the agencies about how she could keep safe. MARAC, designed for such purposes, failed her. No tangible actions emanated from either of the two MARACs. The chair discussed these issues with the MARAC lead for Kent, a Kent Police employee. They described a changed and improved situation since the events of this DHR as a result of learning from previous DHRs.

16.54. A case analysis of London DHRs by Standing Together Against Domestic Violence[10] identified consistent themes that appear within this DHR. Out of the 84 DHRs analysed for that report, 25 were adult family homicides (AFH). Key themes in AFH were that 60% had a lack of understanding of domestic abuse by non-DA agencies, 48% missed opportunities to share information, 44% missed opportunities to ask about victim's relationships, 40% lacked information sharing between health agencies, 40% lacked enquiry to the victim even when complex and multiple disadvantages were present, and 28% lacked referral to MARAC.

16.55. While assurances of improved MARACs within Kent and Medway have been given, learning for those involved in the MARAC process should be continuous, particularly for MARAC chairpersons. The evidence identified by the analysis of London DHRs by Standing Together Against Domestic Violence highlights the need for constant and unremitting scrutiny of MARAC within Kent and Medway. Effective MARAC processes are of vital importance in keeping victims safe.

10 https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5f633ee1e0e0be6ec5b858a1/1600339696014/Standing+Together+London+DHR+Review+Report.pdf

16.56. **Recommendation 10:** *It is recommended that a programme of review and evaluation of MARACs in Kent and Medway takes place. The findings of this review to be taken to the Kent and Medway Domestic Abuse Executive Board, and the Domestic Homicide Review Steering Group with recommendations for discussion. Kent and Medway Safeguarding Adults Board to be given sight of findings. (DA Leads for KCC, Medway Council and Kent Police)*

16.57. 'Think Family' is a recognised approach within safeguarding, yet this was not evident in the case of safeguarding Leanne and her family.

16.58. David's brother lived in the family home, as did his cousin. There is no evidence of engagement with them by agencies responsible for David and Leanne's welfare, and no considerations were taken regarding the risks to them. Leanne was forced to live with her elderly mother, whose interaction with David exposed her to potential danger. Her age placed her at risk, and this was not identified. Had Leanne's family been better engaged, they would have added weight to the information and concerns raised by Leanne. This is similar to a previous Kent and Medway DHR (Joan 2015), in which gaps regarding concerns about family members and subsequent engagement with family members were raised[11].

16.59. Despite David moving from the family home in 2017, he continued to visit and stay there. This should have been risk assessed, as it placed Leanne in harm's way, ultimately forcing her out of her own home. Multi-agency planning should have supported David in independent living, ensuring he remained away. The power of the courts and legislation to keep David away could have been invoked and enforced by the police. According to the KMPT risk summaries created on 2 July 2017 and 4 August 2017, David was given an overall rating as low risk. KMPT policy is that those patients subject to a CPA should be subject to a review every six months. This did not happen.

16.60. **Recommendation 11:** *KMPT to provide assurance that their staff are compliant with their CPA (Care Programme Approach) policy.*

[11] Overview-report-Joan-November-2015.pdf (kent.gov.uk)

16.61. Red board meetings are internal escalation forums within KMPT to manage those clients who are deemed not to be engaging. On most occasions when David failed to attend appointments, his case was not escalated to a red board meeting. Analysis has identified that this was often because staff wished to 'give him another chance'. The KMPT root cause analysis of this case identified that there was no apparent process for reviewing a pattern of missed appointments and behaviours. DNAs became part of the red board meetings in March 2019; however, it became evident that this was not being used robustly, as staff attendance was poor.

16.62. **Recommendation 12:** *It is recommended that KMPT red board meetings be monitored through audits, the results of which are presented at the Trust-wide patient safety and mortality review group meetings. Attendance at the red board meetings by staff should be mandated.*

16.63. When, in 2019, staff from supported accommodation raised concerns regarding David's behaviour, no risk assessment or review took place. The care coordinator did not consider arranging a joint home visit.

16.64. KMPT has a policy in place for circumstances where patients fail to attend meetings: the did not attend (DNA) policy. In February 2019, David did not attend his medical review. The psychiatrist flagged this to the care coordinator; however, the care coordinator did not follow this up and took no action. A further month went by without David being seen.

16.65. **Recommendation 13:** *Clients that do not attend meetings or who are unable to be contacted are managed under Section 7 of the DNA policy. The policy outlines the actions to be taken to attempt contact and to seek contact via other methods, through the GP for example. Escalation to a senior person and the rationale for all decisions and actions is to be documented. Service managers should provide additional scrutiny and challenge the use of DNA policy through meetings with their Head of Service.*

16.66. David's care plans were not updated in accordance with policy. There was only one update to the care plan from December 2018 to October 2019, in April 2019, following a letter sent to a GP. The last properly updated care plan was in November 2018, when David was in hospital.

16.67. There were other occasions leading up to Leanne's death where concerns about David's behaviour and subsequent actions were known and interventions could have been made. David's use of cocaine was documented on 10 January and 31 January 2019. This was not explored or subjected to review.

16.68. On 7 April 2019, a Sunday, Leanne reported to the CRHT nurse that David had been verbally abusive towards her and her niece and that they had to call the police. This was not followed up. On Sundays, there are reduced services, and the community team is not available. In such cases, information is sent by the CRHRR nurse to a general e-mail address in the care coordinators' team, from where it is placed into a pigeonhole to await action, thereby possibly delaying it. When spoken to, the care coordinator explained that had she known about the information, she would have acted upon it; however, no action was taken, and no contact with Leanne was made.

16.69. **Recommendation 14:** *KMPT should review its methods of notification to care coordinators from other departments and agencies to ensure that out-of-hours contacts are correctly recorded, tracked, and actioned.*

16.70. The RCA identified some silo working, which hampered an overview of escalating behaviours. There was a lack of consistency in clinical reviews, as reviews were delivered by different doctors over the period of a year. It is understood that, because of the RCA, those silos have now been removed.

16.71. There was a systemic lack of case oversight, utilisation of history and chronology to capture the events taking place in David's life. There was an overreliance upon shorter assessments, telephone assessments, and reviews via the depot clinic, and this became common practice. The staff recognised that this was insufficient.

16.72. KMPT policy directs that Care Programme Approach (CPA) reviews should take place every six months, or when new risks are identified. Section 117 of the MHA places a legal duty upon health services to provide aftercare and social services to those persons identified under Section 3, Section 37, Section 47, Section 48, and Section 45A of the Act following discharge from hospital. The aim of Section 117 is to provide aftercare services to prevent re-admission to

hospital. A CPA review was carried out on 25 September 2018, but there was no further review until 16 August 2019, almost one year later. This was poor practice, and against the KMPT policy.

16.73. On 25 April 2019, the supported accommodation worker reported to the care coordinator that David's behaviour was a concern, believing this to be due to his medication. When spoken to, the care coordinator explained that she had believed that, as he was on a low dose of depot, his actions were behavioural due to his childhood. No further action was taken.

16.74. On 11 June 2019, the care coordinator discussed David's case at a multi-disciplinary team (MDT) meeting. It was agreed that the care coordinator would meet David at his next depot clinic appointment to assess his mental state and risk. The MDT meeting failed to identify that the risk assessment had not been updated for a period. There were no attempts made to visit David or recognise the fact that he remained on a CTO. There was an overreliance on the planned depot clinic meeting and not enough scrutiny of David's history or his records.

16.75. On 6 July 2019, David was reported to be behaving aggressively and refusing to leave the house. Police officers attended and found him sitting on the sofa. He was compliant when spoken to. When asked to leave, David did so willingly. He told officers that his mother favoured his brother and that she did not want him (David) in the house. He discussed his mental health issues with the officers and informed them that, while he had medication, he did not take it all the time. During discussions with Leanne, she told the attending officers that she wanted David gone and nothing further to be done. David was taken home and advised to seek help from his GP.

16.76. The incident was recorded as a domestic abuse incident, and DASH was undertaken. The risk was assessed as medium. The attending officers considered whether the risk should be assessed as high risk; however, following a discussion with a supervisor, it was decided that the risk assessment should remain a medium risk.

16.77. All victim-based crimes, except for fatalities, are automatically notified to the victim support scheme unless the victim opts out. Non-crime incidents (NCIs) are not notified of victim support. On both occasions, in April and July 2019,

while the reports were marked ‘yes’ for victim support contact, as they were both non-crime incidents, no notification was sent.

16.78. **Recommendation 15:** *Kent Police should undertake a review of non-crime incidents, marked ‘yes’ for victim support contact, to determine whether this is an isolated incident or a systemic failure requiring correction.*

16.79. On 28 August 2019, a supervision session took place between the line manager and the care coordinator at which the care coordinator raised concerns regarding her ability to complete necessary administration and record keeping. It was noted within the supervision documentation that ‘no issues’ were identified, an inaccurate reflection of the discussion. Additionally, the care coordinator raised low staffing during the summer as an issue, along with a lack of attendance at MDT meetings. The first caseload review was conducted on 6 September 2019.

16.80. It is evident that the care coordinator had other complex cases to manage and required more support and regular supervision, which was not provided.

16.81. The ability of staff to either predict or ascertain the level of risk David posed to Leanne and potentially to others was hindered by poor communication between different team members and a lack of adherence to risk mitigation systems, policies, and processes. Poor supervision and management were significant contributors to the tragedy that unfolded.

16.82. **Recommendation 16**: *KMPT must significantly strengthen oversight of caseload numbers and ensure the Trust identifies staffing within teams as a risk. This is a major organisational risk and should be overseen by senior management.*

16.83. **Recommendation 17:** *KMPT should evaluate the risk identification, mitigation, and management relating to domestic abuse and mental health. Audits and inspections should feature in the organisational diary and the results embedded within organisational memory through delivery programmes.*

16.84. On 25 September 2019, Leanne raised concerns regarding David’s illegal drug taking, and that people were ‘hanging around’ David on the days that he

received benefits. The care coordinator did not consider a safeguarding referral, referral to the police, or a safeguarding team discussion. The care coordinator instead asked Leanne to attend David's next appointment with him; however, David failed to attend his next meeting.

16.85. At the time of Leanne's death, David was registered at GP Practice 1, having been moved from GP Practice 2 in 2017.

16.86. In November 2019, shortly after Leanne's death, following inspection, GP Practice 1 was found to be inadequate for providing safe services and inadequate in terms of safeguarding. This was due to all staff not having adequate training or up-to-date disclosure and barring service checks.

16.87. When, in December 2017, David was moved to GP Practice 1, letters from mental health teams were not scanned before this move and consequently have been difficult to trace.

16.88. At the time of her death, Leanne was registered at GP Practice 2 (Parkwood Surgery). This practice has now been archived by the Care Quality Commission (CQC), and it has been taken on by another provider. The practice underwent a CQC inspection in May 2019 and was found to require improvement overall.

16.89. During his time at GP Surgery 2, David was followed up for the most part by GP A and was always seen with Leanne at face-to-face appointments. David was seen for a follow-up review of post-mental health admissions on several occasions. Compliance with medications was reviewed at most appointments, and risk assessments took place, but not at every review.

16.90. In 2016, there was a handover of David's care from GP A to GP B. In June 2016, David was noted to have stopped all medication on the advice of the mental health team; however, there was no correspondence to this effect in the GP's record. The GP telephoned the care coordinator to ensure a follow-up appointment, which took place several weeks later.

16.91. There were several visits to GP B by David with physical health complaints that were thought to be due to somatisation (the tendency to experience

psychological distress in the form of symptoms and to seek medical help for those symptoms), one of the features of David's mental health condition.

16.92. It appears that the somatisation and paranoid thoughts surrounding this escalated between June 2016 and November 2016. There is no documentation of discussion with the mental health team regarding this.

16.93. In November 2017, David was admitted to hospital for 72 hours due to a breach in his CTO. This was the first time that a CTO was detailed within the GP notes, and there are no other details regarding the full terms of the CTO, which would have made it difficult for primary care to act upon breaches. There was no follow-up by the GP following David's hospital discharge. David was not seen by GP B again before Leanne's death.

16.94. During David's time registered at GP Practice 2, there is no record of a yearly mental and physical health review, which is required under the quality and outcomes framework (QOF) used to monitor the quality of care for patients. These reviews provide an opportunity to undertake physical assessments and a review of mental health, including risk assessments for the patient.

16.95. It was difficult for the author of the primary care IMR to ascertain whether these were omitted due to the reviews being completed by the community mental health team, as there were no letters scanned into the GP notes at this practice. There was one occasion when David's increasingly paranoid thoughts were recorded. On this occasion, he stated that he had been raped every night for a year; this was not passed on to the mental health team.

16.96. David registered with GP Practice 1 in December 2017.

16.97. David was first seen by a GP nine months after registering at GP Practice 1. It is good practice to review new patients upon registering. Frequently, patients are offered a new patient review, and if this is declined, no further action is taken. However, if they are on medication that needs monitoring by the GP, or they have health needs, this is followed up. Before his registration at GP Practice 1, David was subject to depot injections managed by the community mental health team, which could indicate why a review was not undertaken.

16.98. **Recommendation 18:** *GP practices should follow best practice guidance and offer new patient reviews where medication is prescribed for mental health concerns. Where a discharge letter from a mental health hospital is received, it should be processed by an appropriately trained professional in order to identify if any further action is required by the practice.*

16.99. It is considered lacking in terms of clinical assessment and safeguarding vulnerable patients that someone with complex mental health needs who had attended the ED following the air weapon incident was not invited into the practice for review. Additionally, in July 2018, the mental health team wrote to the GP asking them to monitor symptoms of tremor secondary to antipsychotic medication, and this does not appear to have been undertaken.

16.100. During the period of this DHR, Leanne was registered with GP Practice 2. She was seen in 2013 with a low mood, and she disclosed her struggles with emotional abuse from 'him'. There is no evidence of exploration of 'him' within the notes, but given the background of mental health illness, cannabis use, and 'his own home', the author of the primary care IMR has concluded that these were references to David. The history of emotional abuse was not explored during the consultation, and potential safeguarding concerns may not have been identified as a result.

16.101. In 2015, one of the practice nurses noted that Leanne had hazardous drinking levels; however, the reasons behind these levels were not discussed. This could have been an opportunity to explore psychosocial stressors and might have triggered discussions about safeguarding concerns.

16.102. **Recommendation 19**: *To explore the function of the Kent and Medway Care Record to ascertain if a note can appear on screen to consider domestic abuse or be triggered when hazardous alcohol intake is identified.*

16.103. In November 2016, Leanne was discussed at MARAC. There are no details in the GP notes regarding the report sent to MARAC, and no report from MARAC with which to determine the outcomes of the meeting. Of note is the fact that David had permission to collect Leanne's prescriptions for her, and this was not reviewed considering MARAC. Leanne was not seen again following MARAC,

so no new information or risk assessments regarding domestic abuse were undertaken.

16.104. **Recommendation 20:** *The Royal College of General Practice guidelines state outcomes and actions from MARAC should be evidenced within the notes. It is recommended that MARAC and CCGs review its processes to ensure relevant information is shared with GP surgeries when appropriate to support this requirement. (Kent Police and CCG)*

16.105. In March 2019, a review of Leanne's notes was undertaken, but no safeguarding concerns were identified. Leanne attended the GP practice infrequently. The reference to abuse found in the notes is not explored further in the notes, and there are no documented follow-ups of this in the following consultations. There were no documented referrals or signposting to agencies that would be able to help Leanne. Improved record keeping would have aided the reviewer in determining whether a referral to local domestic violence services was warranted. It is clear from the GP records that Leanne's wishes and feelings were not ascertained or followed up.

16.106. There were several examples of effective practice that can be taken from GP Practice 2. It is good practice to attempt to review mental health patients upon registration at the practice and following their discharge from mental health hospitals where possible. In addition, GP Practice 2 has a lead clinician with mental health experience.

16.107. When a referral for a safe and well visit is received at KFRS, a case is created on the case record management (CRM) system. An appointment is made over the telephone, a safe and well booking is made, and the visit is undertaken. Depending upon the circumstances and requirements of the customer, additional follow-up visits may be arranged.

16.108. Safe and well staff, including call representatives, attend 'Protecting Vulnerable People' safeguarding training run by Kent Police. In addition, all KFRS staff undertake a safeguarding e-learning training package accessed through the KFRS.

16.109. KFRS actions in relation to the initial referral from Choices were in line with KFRS policy and with the service's approach to identifying the needs of the customer and taking relevant measures to assist them, home safety visits, and electrical and fire prevention advice.

16.110. Leanne had wanted the attending KFRS safe and well officer to ascertain information about David's release from hospital. It was usual practice for permission to be granted from a manager before contact with other agencies could be made. In accordance with KFRS procedures at the time, the request from Leanne was denied. However, there is no record of this decision.

16.111. Domestic abuse had already been identified by Choices, who had referred Leanne's circumstances to KFRS. The attending KFRS safe and well officer received detailed concerns from Leanne and the disclosure of criminal offences such as assault, coercion, and controlling behaviour against her.

16.112. Under the Data Protection Act and the Human Rights Act, information can be shared when it is necessary to prevent crime, protect the health and safety of the victim, and protect the rights and freedoms of victims of violence and their children. It must be proportionate to the level of risk of harm to the individual. Guidance for fire services can be found via the Chief Officer Fire Association website at www.cfoa.org.uk . The guidance sets out the roles and functions of MARAC. Importantly, the guidance sets out the need to share information where necessary 'to prevent crime, protect the health and safety of the victim'. Leanne disclosed that she was the victim of violence from David. Her request to know his release date was valid for her safety planning. She should have received more support, including signposting to other agencies. MARAC should have been considered and a record of justification as to why a decision was made.

16.113. **Recommendation 21:** *It is recommended that KFRS review its information-sharing policies and processes to ensure that, in the case of domestic abuse, policies do not create a barrier via the provisions of the Data Protection Act or Human Rights Act*.

16.114. **Recommendation 22***: KFRS to review how to support victims when DA is identified or suspected. KFRS to review current training for frontline staff and also roles within the organisation that are case managing. Explore partnerships*

arrangements for specialist agencies to complete DASH and update guidance documents to include the use of referrals to the police and to other commissioned services where appropriate.

16.115. In December 2018, David visited the home of Female A and used violence to secure his entry to the premises. He was arrested and charged with that offence and for assaulting the attending police officers. While in custody, no mental health assessment was undertaken, even though the officer in the case was aware of David's previous mental health concerns. Risk assessments were completed; however, David was not identified as a vulnerable person or someone requiring a mental health assessment. David received a conditional discharge at court.

16.116. Kent Police has conducted a separate review of the period when David was in custody. David should have been recognised as a vulnerable person with a mental health assessment being completed by either a custody nurse or a community psychiatric nurse (CPN). There have been changes and improvements to the risk assessment processes, booking procedures, and management of vulnerable persons in custody. Custody staff are given continuous guidance, and an 'All Vulnerability' model has been introduced. This model provides a two-tier level of support staff for custody suites. Liaison and diversion practitioners (LDPs) are provided in every custody suite every day. Their function is to proactively speak to detainees to identify all aspects of vulnerability and arrange immediate interventions or sign postings, as appropriate. The LDPs can then refer specific cases to a senior liaison and diversion practitioner (SLDP) who can arrange immediate mental health interventions and referrals as required. Improvements to inspector reviews of detention are also planned.

16.117. Other than the allocation of David's case, during the ten months between 28 March 2018 and 18 January 2019 there is no mention in the Medway Council Adult Services IMR of any management review or management intervention other than e-mail allocation of the case. During this ten-month period, behaviours such as David's attitude towards his mother, his reliance upon her, his spending a great deal of time at her house, her fears, and his drug taking were apparent.

16.118. During the same ten-month period, David came to the attention of the Kent Police on several occasions, all of which were of concern, not least when considering his previous history. There were incidents of harassment of a female whom he had met while detained in hospital. As a result of one of these instances, David was shot with an air weapon. In August 2018, allegations of indecent exposure were made against David. In November 2018, David was arrested for criminal damage following his threatening behaviour to a hairdresser when armed with a knife. While in custody for that matter, he was deemed unfit to be detained, so he was admitted to hospital for a mental health assessment. In December 2018, David was arrested for violence to secure entry and assault upon two police officers. This was for the ongoing harassment of the woman he had met in the hospital.

16.119. In January 2019, David's case was allocated to a new social worker, who visited David on 7 March 2019. David was on his way out, but he informed the social worker that he was moving into his own flat the following day. Following two attempts to speak with David on the telephone, the social worker made a referral to the Community Support Outreach Team (CSOT) to provide support for David in getting 'some essentials' for his new flat. David was staying at his mother's address. During June and July, the CSOT made efforts to support David's request, and in August, David declined further support from them. A theme regarding barriers to engagement for service users in Kent and Medway has been identified in DHRs, safeguarding adult reviews, and serious case reviews[12].

16.120. **Recommendation 23:** *There will be those clients who either refuse or are reluctant to engage with service providers. Guidance should be provided to KMPT and Medway ASC staff with strategies to assist them with client engagement, including escalation and upward reporting to supervisors and management oversight where engagement becomes an issue. (KMPT Medway Council ASC)*

16.121. On 10 January 2019, David telephoned a health care assistant (HCA) in Medway SW CRHT (KMPT) asking for help. He disclosed that he did not seem

[12] Engaging with service users - Joint learning from DHR SAR SCR (kmsab.org.uk)

able to take control of his drug use, and that he lied to his mother and his care coordinator. There is no evidence that this contact was followed up.

16.122. David was subject to several changes of workers from ASC. There is evidence that some of these changes were professionally managed with appropriate discussions, but this was not always the case. Some staff members were not professionally qualified, and oversight and management were lacking. For several periods, David would not have been allocated a worker.

16.123. During the period of this DHR, KMPT's CPA and DNA policies were consistently not followed. David's care coordinator was newly qualified and relatively new in the post. This was exacerbated by poor levels of supervision. The lack of a preceptorship period, including the formal support of this relatively new care coordinator, was neither robust nor conducive to safe and effective skill development and linked client care.

16.124. **Recommendation 24:** *Preceptorship is a period of practical experience and 'on the job' training that is supervised by a person with knowledge and tutorship/mentorship skills. It is recommended that KMPT examine its provision of preceptorship to those joining its organisation or to those existing staff requiring it.*

16.125. During the summer of 2019 warning signs were becoming apparent that David's mental health was deteriorating. On 17 July 2019 and 14 August 2019 David attended the depot clinic, where it was noted that he was unpredictable and irritable and 'slightly elated'. Three hours after his attendance at the depot clinic on 14 August 2019, Leanne telephoned the care coordinator disclosing that David appeared to be showing escalating symptoms. He exhibited paranoia and felt that he was being watched by others when in public places. Leanne explained that David was making delusional statements, saying that he was 'going to explode at someone'. Leanne also disclosed that a fast-food restaurant had recently refused to serve David because of his aggressive behaviour.

16.126. David again attended the depot clinic on 16 August 2019, where he presented as hyper-vigilant, finding it difficult to maintain eye contact. He was fidgety and unable to keep still. He reported poor sleep and only eating one meal per day.

His medication was increased. David was not seen by his care coordinator for the remainder of the time leading up to Leanne's death.

16.127. The prescribing doctor stated that had he known of other factors in David's life, it would have altered his decision making.

16.128. On 16 August 2019, a CPA review took place. It was recorded that David did not feel that he was relapsing, but that Leanne was genuinely concerned about his recent presentation. It was further noted that David remained stable on 40 mg flupentixol decanoate every four weeks; however, since the reduction to 20 mg, he was experiencing a relapse. Records clearly showed that the medical consultant had requested an increase in medication for the next depot; however, this increase was not reflected in a timely fashion on the prescription chart. His medication chart was not reviewed, and as a result, over the next two months, David had a reduced depot dose on two occasions. The prescription chart was not amended, and the care coordinator did not monitor David in line with CTO policy. KMPT CMHT depot antipsychotic policy has been updated, with clear instructions about prescribers taking responsibility for changes made in medication charts. Practice across all CMHTs in KMPT has been changed, so that patients on CTO are on the dashboard for monitoring and discussion at the daily huddles meeting (red board).

16.129. During the time of this DHR, the staff delivering depot injections were only afforded 15 minutes patient/client time. However, staff now have half an hour with each patient. Depot staff report that this is a positive change.

16.130. **Recommendation 25:** *The National Institute for Health Care Excellence (NICE) provides guidelines for the administration of psychotropic drugs, and it is recommended that KMPT evaluate its depot administration processes in conjunction with NICE guidelines*. www.nice.org.uk

16.131. In August 2019 Female A contacted the police, reporting harassment by David ringing her doorbell in the middle of the night, sometimes two or three times a week. She was clear that there had never been a relationship between them. There was no opportunity for a MARAC referral, as this was not a domestic abuse situation.

16.132. On 15 September 2019, Female A rang Kent Police in the early hours of the morning, stating that David was outside ringing on her doorbell and those of her neighbours. She added that he was 'touching himself', although not exposing himself. She informed the police that she had not been in an intimate relationship with David. Due to this, it appears the incident was not dealt with as an incident of domestic abuse, despite David having stated there was a relationship.

16.133. **Recommendation 26:** *It is recommended that Kent Police review its domestic abuse policy for situations where one person claims a relationship to have been intimate yet denied by the other. It is recommended that in such circumstances Kent Police err on the side of caution and record the relationship as an intimate one, thus affording safeguarding protocols, risk assessments, and resulting actions.*

17 CONCLUSIONS

17.1. Leanne's homicide was a tragic event; the manner of her death was brutal and witnessed in part by her son Paul and her niece Ellie. Her loss is acutely felt.

17.2. The police investigated Leanne's homicide, and the facts identified by them were presented at Maidstone Crown Court. While David was deemed unfit to enter a plea because of his mental health, the facts of Leanne's homicide were proven.

17.3. Missed opportunities for intervention with David and support for Leanne have been identified. Opportunities for referrals were not always actioned; had they been, a more positive outcome might have resulted.

17.4. Overreliance on MARAC for information sharing may have prevented earlier discussions between frontline practitioners and those making decisions about David. Not all the events occurring in David's life were shared between the agencies, hindering a holistic view with which to determine threats, treatments, and courses of safeguarding action over a period of years.

17.5. David's involvement with Female A, the assault upon her, indecent exposure to her, and using violence to secure entry to her premises were significant

behavioural indicators. Breach of bail and possible witness intimidation were of concern. Nearer to Leanne's homicide, David's drug abuse, the reasons for the change of pharmacy, reports from the accommodation worker regarding David's behaviour, the depot clinic presentations, and the reports from Leanne herself should have invoked a response, and safeguarding activity.

17.6. David's care coordinator was relatively new in the post and newly qualified. It is evident from the IMR that her introduction to her new role was unsupported by guidance or tutorship. Supervision was non-existent, thus exposing David and Leanne to poorly managed mental health support and coordination of services. The CPA policy states that the patient should be seen face-to-face by the care coordinator at least monthly. David's care coordinator took 20 weeks to see him. There was a systemic lack of case oversight, utilising history and chronology compounded by a lack of awareness of other agency involvements with David.

17.7. David's continued use of cannabis and cocaine affected his medication and mental state, a situation undoubtedly compounded by administering the wrong, reduced dosage of antipsychotic medication before Leanne's homicide.

17.8. The timeline of events highlights incidents of throat grabbing and attempted strangulation. Research and evidence have been gathered in recent years identifying the increased risk to which this behaviour should alert professionals. "*Strangulation is the second most common cause of death for women as a result of domestic violence, after stabbing, and is a known indicator for homicide. Attacks on women involving strangulation increased the risk of death sevenfold."*[13] The Domestic Abuse Act of 2021 has led to the creation of a new criminal offence of non-fatal strangulation and suffocation[14]. The offence of non-fatal strangulation was not available to the police at the time of Leanne's death, as it was not written into statute; however, this offence will come into force during 2022. With the new offence and awareness of the seriousness of non-fatal strangulation, professionals will be better equipped to assess risk and respond.

[13] https://domesticabusecommissioner.uk/commissioners-endorse-non-fatal-strangulation-amendment-to-the-domestic-abuse-bill/

[14] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/strangulation-and-suffocation

17.9. Leanne's family has engaged with the process of this DHR at every point; they have done their utmost to provide a valued and meaningful contribution under difficult and challenging times for them. The review panel extends its thanks to them.

18 LESSONS TO BE LEARNT

18.1 This has been a complex review which has identified many interactions with Leanne and with David by the agencies participating in this DHR. Throughout this review, it has become apparent that the single biggest issue is the management of those suffering from enduring mental health issues, as was the case with David.

18.2 The impact of his mental health upon David, his mother Leanne, their family, and others close to him (Female A) was colossal. Schizophrenia and bipolar disorder controlled every aspect of David's life, and he was a victim of his mental health. His acts of violence, abusive behaviour, controlling tendencies, and continued threat to Leanne were a direct consequence of his poor mental health, exacerbated by his use of cannabis and cocaine.

18.3 Leanne's relationship with David as his mother placed her at the epicentre of his attention, often painful and unwanted. Regarding the protected characteristics of sex, being a woman and David's mother often meant that she was the victim of violence and abuse in many forms. Leanne's experiences show how impactful domestic abuse can be. It dominated virtually every aspect of her life for several years, including her life choices, her spending, her denial of her own home, and sustained fear.

18.4 There is learning about how agencies work to support victims of domestic abuse and those suffering from mental health issues, and how agencies work within the context of their own areas of responsibility and with statutory partners and voluntary agencies. IMR writers have been robust and straightforward in their identification of failures, such as poor practices, failures to comply with their own policies, and many missed opportunities to engage more closely with both Leanne and David and gain a better understanding of the complex circumstances of their lives and the identification of risks.

18.5 The key areas of learning stand out as supervision, multi-agency working, CPA and CTO adherence and the effectiveness of MARAC. The need to support newly qualified and inexperienced staff can best be served through effective and meaningful supervision; this is especially important in areas of complex and challenging working environments in which great demands are placed upon staff. The results of the supervisory failure of a new member of staff contributed to the most serious of consequences, in this case, homicide.

18.6 Kent and Medway DHR (Jason 2016)[15] identified failings within the MARAC system which were repeated in the case of Leanne. Two MARACs were held in quick succession concerning David and Leanne, but there were other opportunities following on from this to have made referrals to MARAC. Individually, the participating agencies had information at hand on the history, behaviours, and current events at that time, and it is reasonable to have expected them to have met the needs of both Leanne and David as a result. The contributing agencies clearly needed to be better at sharing information with one another. One action in the form of a 'chase up' e-mail emanated from MARAC before closing the case. There appears to have been little forward thinking about continual monitoring of this toxic situation in which Leanne remained, leaving her needs as a victim unmet.

18.7 Other opportunities for referral to MARAC appeared throughout the period of this DHR, such as David's presentation at his GP surgery and the ED, his appearances at the depot clinics and his presentation to staff there, his involvement with and criminal activity toward Female A, and his continued abuse of and criminality towards his mother. His documented inability to control his use of cannabis and cocaine, and his own vulnerability and likely victimisation by drug dealers were some of the examples requiring further action and referral.

18.8 While the central focus of the MARAC is on the safety of the adult victim and children, this can be achieved if the behaviour of the alleged perpetrator is addressed effectively. The Safe Lives charity provides invaluable guidance and support to MARAC, its attendees, and chairs.

[15] Domestic Homicide Reviews - Kent County Council

www.safelives.org.uk/marac/ResourcesforpeopleinvolvedinMARAC.html Safe Lives recognises that it is essential that the MARAC considers information about the alleged perpetrator, and that the actions are agreed upon within the safety plan that directly addresses their abusive behaviour. It is the role of representatives at MARAC to bring information about the alleged perpetrator's circumstances, and their behaviour for every case, as well as information about the victim and any children. MARAC representatives (including the police) should research and share information such as:

- Accurate, up-to-date personal details, including aliases
- Whether the person is a serial perpetrator
- Child protection concerns.
- All intimate relationships and children they have contact with
- Offending behaviour, police markers and intelligence relevant to domestic abuse, including arson, threats to kill, sexual violence, extreme levels of control or stalking
- Any employment, interest, or activities that involve physical ability, weapons, access to specialist detective, or IT skills
- Any vehicles, premises, or IT systems to which the perpetrator has access
- Drug or alcohol misuse and/or mental health issues
- Risks to professionals
- Health or well-being issues that affect their likelihood of further perpetration
- Other relevant information, for example. financial difficulties, pet abuse, cultural practices, fire setter status

18.9 The chair should ensure that all information relevant to the perpetrator, and factors that are likely to increase the risk of abuse to the victim, harm to children and other vulnerable parties, and risk that agency staff could be harmed, is heard at the meeting. This would be in addition to the usual proportionate and relevant information shared by the victim and any children. It is essential that the chair outlines the risks identified from this information and invites other representatives to highlight any additional concerns that may have been overlooked.

18.10 Some examples of risks specifically relating to the alleged perpetrator may include the fact that they are:

- Homeless
- Self-harming or threatening suicide
- Misusing drugs or alcohol
- Demonstrating behaviours that suggest they may be suffering from a mental illness, and these which may be exacerbating the risk of continued abuse of the victim and any children
- Ignoring or breaching bail conditions or court orders
- Stalking and harassing the victim or their friends/family/colleagues
- Threatening the victim or their friends/family/colleagues

18.11 Actions to address these risks and behaviours of the alleged perpetrator fall under four main headings.

1. Divert
2. Manage
3. Disrupt
4. Prosecute

18.12 Perpetrators can go to extreme lengths to facilitate their abuse, and MARAC teams need to be creative in the actions they offer, so this list is not comprehensive.

- Arresting and charging the perpetrator with a criminal offence
- A disruption plan managed by a single point of contact within the police or probation service, using surveillance, overt targeting, ANPR systems, flagging, uniform patrols
- Consideration by the police for potentially dangerous person status where there is no previous criminal conviction www.acpo.police.uk/documents/crime/2010/20110301CBAACPO(2010)guidanceonprotectingthepublicv2mainversion.pdf
- Consideration for MAPPA management www.justice.gov.uk/downloads/offender/mappa/mappa-guidance-2012-part1.pdf
- Consideration for integrated offender management www.gov.uk/integrated-offender-management-iom
- Community mental health assessment

- Consideration of an antisocial behaviour order
- Referral to substance abuse services
- Ensuring links are made with Child Protection and family court hearings
- Referral to Respect www.respect.uk.net, Samaritans, or other perpetrator support networks

18.13 The Office of the Police and Crime Commissioner (OPCC) have very recently launched a pilot perpetrator programme throughout Kent and Medway. Perpetrators are offered either a 12-session group programme, or ten sessions of individual one-to-one work. This is available if the perpetrator is able to accept a level of responsibility for their behaviour and are motivated to make a change. Non-abusive parties are referred into their local domestic abuse service to ensure that they are supported whilst their perpetrator works through the programme. Referral pathways include via police or other professionals, and also by self-referral. The pilot was launched in September 2021 and is being fully evaluated by a local university.

18.14 Following the conclusion of the review, opportunities for agencies individually and collectively to improve services to victims have been identified. The need for staff to be better supported through meaningful supervision is essential, along with better sharing of information and more robust use of MARAC.

19 RECOMMENDATIONS

19.1 The review panel makes the following recommendations from this DHR:

	Paragraph	Recommendation	Organisation
1.	16.11	**Recommendation 1.** Economic abuse is not consistently considered by agencies as controlling and coercive behaviour. Training on this subject should be delivered to all agencies contributing to this DHR.	All agencies subject to this DHR

	Paragraph	Recommendation	Organisation
2.	16.18	**Recommendation 2:** It is recommended that training be delivered to ED staff in relation to referring and discussing carer assessments, controlling and coercive behaviour, and domestic abuse to adult parents.	Medway Foundation NHS Trust
3.	16.21	**Recommendation 3:** Oasis to offer MFT and KMPT (Medway) domestic abuse and MARAC training to staff in A&E (ED) including liaison psychiatry service (LPS). MFT and KMPT to ensure A&E and LPS staff attend (jointly where possible) this training, offered and delivered by Oasis.	Oasis, KMPT and MFT
4.	16.25	**Recommendation 4:** Timely, routine, and effective supervision is essential in supporting hard-working frontline professionals. KMPT expectations of supervisors, including time scales for completing assessments and reviews, should be formalised, mandated, and educated through aid memoirs, guidance manuals, training, and staff appraisals.	KMPT
5.	16.36	**Recommendation 5**: It is recommended that Kent Police review this investigation to determine any lessons to be learnt regarding the use of bail conditions and the notification to the victim (Leanne) of those conditions and implications. In addition, Kent Police should examine the messaging to the victim of any changes in bail. Was Leanne notified in a timely and correct fashion? The notification to Leanne that the police could not do anything further because of David's mental health should be examined for any learning opportunities.	Kent Police
6.	16.42	**Recommendation 6:** The Choices report for this DHR makes it clear that mental health	KMPT

	Paragraph	Recommendation	Organisation
		professionals would have better supported David had they paid closer attention to the information being provided to them from those closest to him, his mother and his family. Increasing behaviours, continued illicit drug misuse, and other lifestyle concerns could have shaped mental health service responses. It is recommended that mental health service managers explore this to determine whether this is an isolated event or systemic, and to take appropriate action if required.	
7.	16.46	**Recommendation 7:** It is recommended that when offering carer assessment referrals, KMPT document the outcome, and review the decision when there is evidence of domestic abuse. KMPT staff should be surveyed to ascertain understanding of the difference between carer support and responding to domestic abuse, and the role of the nearest relative in relation to those subject to the MHA.	KMPT
8.	16.48	**Recommendation 8:** It is recommended that each agency review staff training to include domestic abuse where a parent is the victim of domestic abuse from their children, including adult children, to ensure the best advice and signposting is known about and referred to.	All agencies subject to this DHR
9.	16.51	**Recommendation 9:** It is recommended that KMPT and Medway Council Adult Services conduct a review of their joint working arrangements and consider development of operational guidance.	KMPT and Medway Council Adult services
10.	16.55	**Recommendation 10:** It is recommended that a programme of review and evaluation of MARACs in Kent and Medway takes place. The findings of this review to be taken to the Kent	DA leads for KCC, Medway

	Paragraph	Recommendation	Organisation
		and Medway Domestic Abuse Executive Board, and the Domestic Homicide Review Steering group with recommendations for discussion. Kent and Medway Safeguarding Adults Board to be given sight of findings.	Council and Kent Police
11.	16.59	**Recommendation 11:** KMPT to provide assurance that their staff are compliant with their CPA (care programme approach) policy.	KMPT
12.	16.61	**Recommendation 12:** It is recommended that KMPT red board meetings be monitored through audits, the results of which are presented at the Trust-wide patient safety and mortality review group meetings. Attendance at the red board meeting by staff should be mandatory.	KMPT
13.	16.64	**Recommendation 13:** Clients that do not attend meetings or who are unable to be contacted are managed under Section 7 of the DNA policy. The policy outlines the actions to be taken to attempt contact and to seek contact via other methods, through the GP for example. Escalation to a senior person and the rationale for all decisions and actions is to be documented. Service managers should provide additional scrutiny and challenge the use of DNA policy through meetings with their Head of Service.	KMPT
14.	16.68	**Recommendation 14:** KMPT should review its methods of notification to care coordinators from other departments and agencies to ensure that out-of-hours contacts are correctly recorded, tracked, and actioned.	KMPT
15.	16.77	**Recommendation 15:** Kent Police should undertake a review of non-crime incidents marked 'yes' for victim support contact, to	Kent Police

	Paragraph	Recommendation	Organisation
		determine whether this is an isolated incident or a systemic failure requiring correction.	
16.	16.81	**Recommendation 16**: KMPT must significantly strengthen oversight of caseload numbers and ensure the Trust identifies staffing within teams as a risk. This is a major organisational risk and should be overseen by senior management.	KMPT
17.	16.82	**Recommendation 17:** KMPT should evaluate the risk identification, mitigation and management relating to domestic abuse and mental health. Audits and inspections should feature in the organisational diary and the results embedded within organisational memory through delivery programmes.	KMPT
18.	16.97	**Recommendation 18:** GP practices should follow best practice guidance and offer new patient reviews where medication is prescribed for mental health concerns. Where a discharge letter from a mental health hospital is received, it should be processed by an appropriately trained professional in order to identify if any further action is required by the practice.	CCG
19.	16.101	**Recommendation 19**: To explore the function of the Kent and Medway Care Record, to ascertain if a note can appear on screen to consider domestic abuse or be triggered when hazardous alcohol intake is identified.	CCG
20.	16.103	**Recommendation 20;** The Royal College of General Practice guidelines state outcomes and actions from MARAC should be evidenced within the notes. It is recommended that MARAC and CCGs review its processes to ensure relevant information is shared with GP surgeries when appropriate to support this requirement.	MARAC Coordinator and CCG

	Paragraph	Recommendation	Organisation
21.	16.112	**Recommendation 21:** It is recommended that KFRS review its information-sharing policies and processes to ensure that in the case of domestic abuse, its policies do not create a barrier via the provisions of the Data Protection Act or Human Rights Act.	KFRS
22.	16.113	**Recommendation 22:** KFRS to review how to support victims when DA is identified or suspected. KFRS to review current training for frontline staff and also roles within the organisation that are case managing. Explore partnership arrangements for specialist agencies to complete DASH and update guidance documents to include the use of referrals to the police and other commissioned services where appropriate.	KFRS
23.	16.119	**Recommendation 23:** There will be those clients who either refuse or are reluctant to engage with service providers. Guidance should be provided to KMPT and Medway ASC staff, with strategies to assist them with client engagement to include escalation and upward reporting to supervisors and management oversight where engagement becomes an issue.	KMPT and Medway Council Adult Services
24.	16.123	**Recommendation 24:** Preceptorship is a period of practical experience and 'on the job' training that is supervised by a person with knowledge and tutorship/mentorship skills. It is recommended that KMPT examine its provision of preceptorship to those joining its organisation or those existing staff requiring it.	KMPT
25.	16.129	**Recommendation 25:** The National Institute for Health Care Excellence (NICE) provides guidelines for the administration of psychotropic	KMPT

	Paragraph	Recommendation	Organisation
		drugs, and it is recommended that KMPT evaluate its depot administration processes in conjunction with NICE guidelines. www.nice.org.uk	
26.	16.132	**Recommendation 26:** It is recommended that Kent Police review its domestic abuse policy for situations where one person claims a relationship to have been intimate yet denied by the other. It is recommended that in such circumstances, Kent Police err on the side of caution, and in such instances record the relationship as an intimate one, thus affording safeguarding protocols, risk assessments, and resulting actions.	Kent Police

APPENDIX A - TERMS OF REFERENCE

Victim – Leanne

These terms of reference were agreed by the DHR Panel following their meeting on 16 January 2020.

Background

In October 2019, Leanne was killed by her son, David, at her home. David had a long history of mental health issues.

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 5th November 2019. It was agreed that the criteria for a DHR had been met, and the chair of the Kent and Medway Community Safety Partnership confirmed that a DHR would be conducted.

The chair of the Kent and Medway Community Safety Partnership have ratified that agreement and the Home Office has been informed.

The Purpose of a DHR

The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

The Focus of the DHR

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

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

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

The full subjects of this review will be the victim, Leanne, and the alleged perpetrator, David.

DHR Methodology

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

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

IMRs and reports will be prepared by an appropriately skilled person who has not had any direct involvement with Leanne, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

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

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

Each agency required to complete an IMR must include all information held about Leanne from 23 June 2015 to the date of her death in October 2019. If any information relating to Leanne being a victim, or David being a perpetrator, of domestic abuse before 23 June 2015 comes to light, that should also be included in the IMR.

Information held by an agency that has been required to complete an IMR that is relevant to the homicide must be included in full. This might include, for example, previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Leanne. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2014, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, such as disability, sexual orientation, culture and/or faith should also be considered by the authors of IMRs. If none is relevant, a statement to the effect that these have been considered must be included.

When each agency that has been required to submit an IMR does so within the agreed-upon timescale, the IMRs will be considered at a meeting of the DHR panel, and an overview report will then be drafted by the Independent Chair. The draft overview report will be considered at a further meeting of the DHR panel, and a final, agreed-upon version will be submitted to the chair of Kent CSP.

Specific Issues to be Addressed

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

i. Were practitioners sensitive to the needs of Leanne and David, knowledgeable about potential indicators of domestic violence and abuse, and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for DASH risk assessment and risk management for domestic violence and abuse victims or perpetrators, and were those assessments correctly used in the case of Leanne? Did the agency have policies and procedures in place for dealing with concerns

about domestic violence and abuse? Were these assessment tools, procedures, and policies professionally accepted as effective? Was the victim subject to MARAC or other multi-agency forums?

iii. Did the agency comply with domestic violence and abuse protocols agreed upon by 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 this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working,

training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

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

xvii. How accessible were the services to Leanne and David?

APPENDIX B - GLOSSARY

Abbreviations and acronyms are listed alphabetically. The explanation of terms used in the main body of the overview report is listed in the order in which they first appear.

Abbreviation/Acronym	Expansion
AAFDA	Advocacy After Fatal Domestic Abuse
ACPO	Association of Chief Police Officers
APVA	Adolescent-to-parent violence and abuse
ASC	Adult Social Care
CCG	Clinical Commissioning Group
CJLADS	Criminal Justice Liaison and Diversion Service
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CRHT	Crisis resolution homecare treatment team
CRHTT	Crisis Resolution and Home Treatment Team
CRHTT	Crisis Resolution Home Treatment Team
CRM	Case record management
CSOT	Community Support Outreach Team
CTO	Community Treatment Order
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking, and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
DNA (Policy)	(KMPT) Did Not Attend
ED	Emergency Department
FLO	Family Liaison Officer
GP	General Practitioner
HCA	Health care assistant
HIDVA	Hospital independent domestic violence advisor
IDVA	Independent Domestic Violence Adviser
IMR	Independent Management Report
KFRS	Kent Fire and Rescue Service
KMPT	Kent and Medway NHS and Social Care Partnership Trust
LDP	Liaison and diversion practitioners
LPS	Liaison Psychiatry Service
MARAC	Multi-Agency Risk Assessment Conference
MCH	Medway Community Health
MDT	Multi-Disciplinary Team

Appendix B

Abbreviation/Acronym	Expansion
MHA	Mental Health Act
NCI	Non-Crime Incidents
NHS	National Health Service
NICE	National Institute for Health Care Excellence
PICU	Psychiatric Intensive Care Unit
QOF	Quality and Outcomes Framework
RCA	Route Cause Analysis
SLAM	South London and Maudsley
SLDP	Senior Liaison and Diversion Practitioner
SSAFA	Soldiers, Sailors, Airmen, and Families

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

The domestic abuse, stalking and harassment and honour-based violence model (DASH) (2009) was agreed upon by the Association of Chief Police Officers (ACPO) as the risk assessment tool for domestic abuse. A list of 29 pre-set questions will be asked of anyone reporting being a victim of domestic abuse, the answers to which are used to assist in determining the level of risk. The risk categories are as follows:

Standard Current evidence does not indicate the likelihood of causing serious harm.

Medium There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm, but is unlikely to do so unless there is a change in circumstances.

High There are identifiable indicators of risk of serious harm. A potential event could happen at any time, and the impact would be serious. The risk of serious harm is a risk that is life-threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

In addition, the DASH includes additional questions, asking the victim whether the perpetrator constantly texts, calls, contacts, follows, stalks, or harasses them. If the answer to this question is yes, further questions will be asked about the nature of this.
A copy of the DASH questionnaire can be viewed here.

Domestic Abuse (Definition)

The definition of domestic violence and abuse states:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have*

been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *economic*
- *emotional*

Controlling behaviour is:

a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is:

an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Community Mental Health Team (CMHT)

CMHTs deliver mental health services to people with long-term mental issues in community health conditions, rather than at inpatient facilities. CMHTs in Kent and Medway cover geographical areas that are usually coterminous with NHS clinical commissioning groups. More information about CMHTs can be viewed here.

Crisis Resolution and Home Treatment Team (CRHTT)

The CRHTT is a service set up to respond to and support adults who are experiencing a severe mental health problem that could otherwise lead to inpatient admission to a psychiatric hospital.

As the name implies, the aim of the team is to resolve the immediate crisis and put treatment in place at a person's home. There are several CRHTTs in Kent and Medway, each of which covers a geographical area.

More information about CRHTTs can be found by clicking here or at: http://www.liveitwell.org.uk/support-help/community-mental-health-teams-cmhts/help-in-a-crisis/