Domestic Homicide Review (DHR)

Leanne

2019

Executive Summary

Author: Sean Beautridge

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: 19th October 2021

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

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On behalf of the Domestic Homicide Review Panel, its members, contributing organisations and myself, as 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.

1. The Review Process

1.1 The Focus of DHR

1.1.1. 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.

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

1.1.3. 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.

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

1.2 Contributors to the Review

1.2.1. Each of the following organisations were subject of an Independent Management Report (IMR):

- Medway Council Adult Services
- Kent Police
- Kent and Medway Partnership Trust
- Medway Foundation NHS Trust
- Kent and Medway Clinical Commissioning Group
- Kent Fire and Rescue Service

1.2.2. In addition to the IMRs, Medway Community Health, Choices (Domestic Abuse Service) and South East Coast Ambulance Service provided a short report.

2. Review Panel Members

2.1. 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.

2.2. The members of the panel were:

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

2.3. Members of the panel hold senior positions in their organisations and have not had contact or involvement with Leanne or David. The panel met on four occasions during the DHR. Later drafts of the report were agreed by panel members via email.

3. Author of the Overview Report

3.1. 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.

3.2. 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.

4. Terms of reference for the review

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

Background Information

4.2. 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,

work which eventually took her to London. She was career focussed and enjoyed her profession and it was an important part of her life.

4.3. In 1981 Leanne met her life partner, Michael. They had two sons together, David and Paul. Life was good for the family until sadly, in 2002 and whilst only in his 40s, suddenly and tragically Michael died of a heart attack. David was still of primary school age, and Paul was 5 years younger. The family remained in London.

4.4. 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 expulsion.

4.5. Leanne continued to work at the bank and 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 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.

4.6. 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 their involvement with the family until Leanne's death.

The Purpose of the DHR

4.7. The purpose of this review is to:

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

ii. identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

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

iv. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

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

vi. highlight good practice.

DHR Methodology

4.8. Independent Management Reports (IMRs) were submitted using the templates current at the time of completion.

4.9. This review is based upon the IMRs provided by the agencies that were notified of, or had contact with, Leanne and David in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse. IMR was prepared by an appropriately skilled person who did not have any direct involvement with Leanne and David, and who is not an immediate line manager of any staff whose actions were subject to review within the IMR.

4.10. Each IMR included a chronology and analysis of the service provided by the agency submitting it. The IMRs highlighted both good and poor practice, and made recommendations for the individual agency and, where relevant, for multi-agency working. The IMRs included issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.11. Each agency required to complete an IMR included all information held about Leanne from 23rd 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 23rd June 2015 was also included in the IMR.

4.12. Any issues relevant to equality, i.e., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, were identified.

4.13. IMRs received were considered by the DHR panel. The review report was then drafted by the Independent Chair and discussed at panel meetings.

Specific Issues Addressed

4.14. The following specific issues were considered within each agency IMR, and subsequently by the panel:

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 Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of 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 being effective? Was the victim subject to a MARAC or other multi-agency forums?

iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the

wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

ix. Was this information recorded and shared, where appropriate?

x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

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?

5. Summary Chronology

5.1. David was referred to Kent and Medway NHS and Social Care Partnership 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.

5.2. 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 been verbally abusive and aggressive and that she was frightened for her safety if he returned home with her. David was provided support from a variety mental health providers, services, and facilities over the coming years. Symptoms were also managed with antipsychotic medication. Staff would describe him as aggressive, intimidating, and intrusive.

5.3. Leanne was offered a carer's assessment.

5.4. 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. Police were called to Leanne's home in September 2015. 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 DASH assessment). Leanne did not want to support a prosecution. This was the first incident of domestic abuse recorded by Kent Police.

5.5. The first recorded contact by Adult Social Care (ASC) with David was in September 2015 when a request was made for an assessment under the Mental Health Act (MHA). The assessment resulted in David being detained. Medway Council contacted Leanne and forwarded details of the Carers First Service to her.

5.6. Leanne's fear, and the fact that she was struggling to cope was evident. A risk assessment does not appear to have taken place. It would be a further 10 months before a Multi-Agency Risk Assessment Conference (MARAC) referral was made by Kent Police.

5.7. In November 2015 David was arrested and cautioned for committing criminal damage at Leanne's property.

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

5.9. In 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. During the assessment David reported low concordance with medication for the last week and the medication had given him a headache.

5.10. During the same assessment it is documented that David was aggressive towards his mother. David reported that he had placed his hands around her neck. 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.'

5.11. During October 2016 Leanne disclosed controlling behaviours by David. 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 (CRHT) who offered an initial assessment at this stage. However, the police thought it was safer to arrest. Whilst in custody police requested a MHA assessment. However, David then agreed to an informal admission. He was released on conditional bail under care of his aunt whilst a bed was being found. A bed was then found on 14th October. David was discharged on 19th October and returned to his mother's home. A risk assessment at this time noted no psychosis.

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

5.13. Leanne was referred into MARAC. The referral was received into Choices on 25th October 2016. The Choices Independent Domestic

Violence Adviser (IDVA) made contact with Leanne. She spoke about David confirming his diagnosis of paranoid schizophrenia and Bi-polar Disorder. David was using cannabis and cocaine; the cannabis use having started in 2007. The transition to cocaine started in 2009, whilst 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. She was fearful as she was unable to predict David's behaviour and that he will hurt her again. Leanne stated that David was financially controlling and made unreasonable demands of her. Leanne stated that her greatest priority was that David was accommodated elsewhere and that she wants to be able to get back to her own home.

5.14. The IDVA sought to liaise with 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 relayed concerns that David was not taking his medication and was demonstrating sexualised behaviour towards Leanne resulting in Leanne leaving her house for her own safety.

5.15. The MARAC was held in November. Only one action emanated: to 'Chase' the adult social care referrals via an e-mail.

5.16. An assessment of David's social care needs was completed, and it was determined that he needed alternative housing to remove him from the home to mitigate the risk towards his mother. It was further determined that he may have required supported accommodation due to his lack of independent living skills. Due to David's presentation a request was made to review his anti-psychotic medication. 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.

5.17. 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 advised 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.

5.18. In December 2016 David assaulted his mother. Police attended and David was detained under section 136 Mental Health Act. Police deemed the matter High Risk, and a second MARAC referral was made.

5.19. David remained detained under section 2 (converted to section 3) of the Mental Health Act. He would later be transferred to a KMPT rehabilitation facility in March 2017.

5.20. Leanne's IDVA continued to support her and liaise with other agencies. Particularly keen to seek mental health input at the MARAC. At the MARAC meeting on 15th December 2016 no actions were raised.

5.21. In January 2017 Kent Fire and Rescue Service (KFRS) received a referral from Choices domestic abuse charity for Leanne. KFRS called Leanne to book an appointment for a Safe & Well visit. Advice was given regarding escape routes, closing doors at night, general electrical and fire safety. Leanne agreed to discuss with the Police regarding a personal attack alarm at the property. It is 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. Unfortunately, KFRS could not contact the Police liaison officer regarding David's discharge. Leanne stated that she understood and thanked KFRS for their assistance.

5.22. David remained detained within the Mental Health care system for much of 2017, however not without incident.

5.23. When he was discharged, David moved to supported accommodation. Between 26th September 2017 and 29th January 2018, a support plan commenced led by adult social care. On 30th January 2018 David's case was transferred to the long-term support team of Medway Council Adult Services.

5.24. On 3rd April 2018 staff from David's supported living accommodation provider emailed David's care coordinator at KMPT to relay concerns raised by Leanne. David's lack of motivation, his reliance upon her and general attitude towards her as well as his financial troubles were reported by Leanne, as was David's use of cocaine. Leanne disclosed that she had become impatient with David and felt like she may 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 he was spending more time with her.

5.25. In 2018 reports were made to the Police involving David's harassment of a woman (Female A) whom he had met whilst detained in hospital. In August that year allegations of indecent exposure by David towards

Female A were made. However, they did not wish to pursue a prosecution and no further action was taken.

5.26. In September 2018, David's consultant psychiatrist agreed to reduce David's depot injection to Depixol 50mg every three weeks due to the side effects he was experiencing. This was further reduced to 50mg every four weeks.

5.27. A social worker visited David in March 2019. David was on his way out, but he informed the social worker that he was moving into his own flat the next day. Following two attempts to speak with David on the telephone the social worker made a referral to the Adult Social Care 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.

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

5.29. In April 2019 Leanne reported to CRHT (Community Resolution Home Treatment Team) nurse that David had been verbally abusive towards her and her niece and that they had to call the Police.

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

5.31. On 27th April 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.

5.32. On 11th 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 over reliance upon the planned depot clinic meeting and not enough scrutiny of David's history or his records.

5.33. David attended the depot clinic on the 19th June, he was looking well, he reported that he had expected his depot dose to have been reduced, which it had from 40 to 30mg.

5.34. On 6th 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. A DASH assessment was graded as medium risk.

5.35. Also, on 6th July 2019 Female A contacted 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.

5.36. On 9th July 2019, the Medway CMHT Dr agreed to David's request to reduce medication of Flupentixol decanoate to 20mg every 4 weeks.

5.37. On 17th 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 20mg dose.

5.38. On 23rd 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. She did not want to pursue a prosecution at the time but later contacted Police advising them that she had changed her mind. She stated it was not an intimate relationship.

5.39. In August 2019 Female A contacted Police again reporting harassment by David. She informed Police that she had never been in a relationship with David. She did not want to support a prosecution.

5.40. On 14th August 2019 David was seen in the depot clinic where he received his 20mg 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.

5.41. Three hours after David's attendance at the depot clinic the care coordinator received a call from Leanne disclosing what appeared to show escalating symptoms. David was exhibiting paranoia and felt that he was being watched by others when out in public. 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.

5.42. On 16th August 2019 David attended a follow-up appointment. A CPA review was undertaken which noted that David remained stable on 40mg Flupentixol Decanoate every four weeks however, since the reduction to 20mg 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 (11th September and 9th October). The prescription chart was not amended and additionally the care coordinator did not monitor David in line with CTO policy.

5.43. On 15th 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.

5.44. In October 2019 Police were contacted by the Ambulance Service stating they were attending a knife attack incident, upon arrival they discovered Leanne dead at the scene.

6. Conclusions

6.1. 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. Her loss is acutely felt.

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

6.3. 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 may have resulted.

6.4. Over reliance on MARAC for information sharing may have prevented earlier discussions between front line 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.

6.5. 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 concerning. 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.

6.6. David's care coordinator was relatively new in post and newly qualified. It is evident from the IMR that her introduction to her new role was unsupported through 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 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 involvement with David.

6.7. David's continued use of cannabis and cocaine affected his medication and mental state, a situation undoubtedly compounded by administering of the wrong, reduced dosage of anti-psychotic medication prior to Leanne's homicide.

6.8. The timeline of events highlights incidents of throat grabbing and attempted strangulation. Research and evidence have been gathered over recent years identifying the increased risk that this behaviour should alert professionals to. "*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 seven-fold."*[1] The Domestic Abuse Act 2021 is leading to the creation of a new criminal

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

offence of non-fatal-strangulation and suffocation[2]. 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.

6.9. Leanne's family have 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.

7. Lessons to be Learnt

7.1. 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 with enduring mental health issues as was the case with David.

7.2. 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 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 was as a direct consequence of his poor mental health, exacerbated by his using cannabis and cocaine.

7.3. Leanne's relationship with David as his mother placed her at the epicentre of his attention, often painful and unwanted. In relation to the protected characteristic 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 impactive domestic abuse can be. It dominated virtually every aspect of her life for several years. Her life choices, her spending, denial of her own home and sustained fear.

7.4. There is learning about how agencies work to support victims of domestic abuse and those suffering with mental health issues. How agencies work within the context of their own areas of responsibility and with statutory partners and voluntary agencies. IMR writers have been

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

robust and straight forward in their identification of failures. Poor practices, failures to comply with their own policies and many missed opportunities to have engaged more closely with both Leanne and David and to have gained better understanding of the complex circumstances of their lives and the identification of risks.

7.5. 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 supervisory failure of a new member of staff contributed to the most serious of consequences, in this case homicide.

7.6. Kent and Medway DHR Jason 2016[3], identified failings within the MARAC system which was repeated in the case of Leanne. Two MARACs were held in quick succession in relation to 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 of 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 little forward thinking about continued monitoring of this toxic situation in which Leanne continued to be in leaving her needs as a victim unmet.

7.7. Other opportunities for referral to MARAC appeared throughout the period of this DHR. David's presentation at his GP surgery and at the ED. His appearances at the depot clinics and his presentation to staff there. His involvement and criminal activity towards 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.

7.8. 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 provide invaluable guidance and support to MARAC, its attendees, and chairs.

[3] Domestic Homicide Reviews - Kent County Council

www.safelives.org.uk/marac/ResourcesforpeopleinvolvedinMARAC.html Safe Lives recognise that It is essential that the MARAC considers information about the alleged perpetrator, and the actions are agreed 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 which involve physical ability, weapons, access to specialist detective or IT skills.
- Any vehicles, premises, and IT systems the perpetrator has access to.
- Drug or alcohol misuse and/or mental health issues.
- Risks to professionals.
- Health or wellbeing issues which affect their likelihood of further perpetration.
- Other relevant information, e.g., financial difficulties, pet abuse, cultural practices, fire setter status.

7.9. 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, 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 on the victim and any children. It is essential that the chair outline the risks identified from this information and invites other representatives to highlight any additional concerns that may have been overlooked.

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

- Homeless
- Self-harming or threatening suicide
- Misusing drugs or alcohol

- Demonstrating behaviours which 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.

7.11. Actions to address these risks and behaviours in relation to the alleged perpetrator fall under 4 main headings.

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

7.12. Perpetrators can go to extreme lengths to facilitate their abuse and MARAC teams need to be creative in the actions they offer, and 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 Anti-Social Behaviour Order
- Referral to substance abuse services
- Ensuring links are made with Child Protection and family courts hearings.
- Referral to Respect www.respect.uk.net , Samaritans, or other perpetrator support networks.

7.13. 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.

7.14. Following 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. Better sharing of information and a more robust use of MARAC.

8. Recommendations

The Review Panel makes the following recommendations from this DHR:

	Recommendation	Organisation
1.	Economic abuse is not always evident to or considered by agencies as controlling forms of perpetrator behaviour. Training on this subject should be delivered to all agencies contributing to this DHR.	All agencies subject to this DHR
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.	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 & MFT
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.	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

	Recommendation	Organisation
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 this is an isolated event or systemic, and to take appropriate action if required.	KMPT
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.	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 sign posting is known about and referred to.	All agencies subject to this DHR
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 & Medway Council Adult services
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
11.	KMPT to provide assurance that their staff are compliant with their CPA (care programme approach) policy.	KMPT

	Recommendation	Organisation
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.	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.	KMPT should review its methods of notification to care co-ordinators from other departments and agencies to ensure that out of hours contacts are correctly recorded, tracked, and actioned.	KMPT
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.	Kent Police
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.	KMPT should evaluate the effectiveness of its internal audit and Inspection processes with regards to risk identification, mitigation and management relating to domestic abuse and mental health. Audit and inspections should feature in the organisational diary and the results embedded within organisational memory through delivery programmes.	KMPT
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

	Recommendation	Organisation
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.	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
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.	KFRS
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 commissions services were appropriate.	KFRS
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.	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.	The National Institute for Health Care Excellence (NICE) provide 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	KMPT

	Recommendation	Organisation
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