

**KENT & MEDWAY**  
**DOMESTIC HOMICIDE REVIEW**

**Emily/2017**

Overview Report

Author: Paul Pearce

Commissioned by:  
Kent Community Safety Partnership  
Medway Community Safety Partnership

Report Completed: 1<sup>st</sup> July 2018

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# 1. Introduction

- 1.1 This Domestic Homicide Review (DHR) examines how agencies responded to and supported Emily Dale, a resident of Town A, Kent prior to her death in July 2017.
- 1.2 Emily was killed by her father, Clive, at his home in Kent. He then went to the home of her mother (and his ex-partner), Maureen Price, who he attempted to strangle. Maureen was able to escape and ran to the police station in Town A, which was almost opposite her home. Clive also went to the police station, where he told police officers that he had killed Emily. When they went to his home, they found her body. Clive was subsequently charged with Emily's murder and the attempted murder of Maureen.
- 1.3 On 11 January 2018, Clive pleaded not guilty to the manslaughter of Emily, but guilty to manslaughter on the grounds of diminished responsibility. His plea was accepted by the prosecution and he also pleaded guilty to attempting to murder Maureen. On 5 February 2018, he was sentenced to 10 years imprisonment, combined with a hospital direction under [S.45A of the Mental Health Act 1983](#).
- 1.4 This DHR examines the contact and involvement that organisations had with Emily (a mixed-heritage British woman, aged 19 years) and Clive (a white British man, aged 63 years), between 1 January 2014 and Emily's death.
- 1.5 The key reasons for conducting a Domestic Homicide Review (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 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; and
  - 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.

- 1.6 This Review began on 6 September 2017, following the decision by Kent Community Safety Partnership (CSP) that the case met the criteria for conducting a DHR.
- 1.7 This report has been anonymised and the personal names contained within it are pseudonyms, except for those of DHR Panel members.

## 2. Terms of Reference

- 2.1 The Review Panel met first on 22 September 2017 to consider draft Terms of Reference, the scope of the DHR and those organisations that would be subject of the review. The Terms of Reference were agreed subsequently by correspondence and form [Appendix A](#) of this report.

## 3. Methodology

- 3.1 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 Emily and/or Clive. An IMR is a written document, including a full chronology of the organisation’s involvement, which is submitted on a template.
- 3.2. 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 author nor the senior manager had any involvement with Emily or Clive during the period covered by the review.
- 3.3 In addition to IMRs, representatives of four organisations were interviewed by the Independent Chairman and each provided a report about its involvement with Emily and/or Clive.

## 4. Involvement of Family Members and Friends

- 4.1 The Review Panel considered who should be consulted and involved in the DHR process. The following have been contacted:

	In relation to:	In relation to:
Name:	<b>Emily Dale</b>	<b>Clive Dale</b>
<b>Maureen Price</b>	Mother	Ex-Partner
<b>Julie Thompson</b>	Aunt	

<b>Michael Stephens</b>	Cousin	
<b>Sandra Davis</b>	Aunt	Sister

- 4.2 In October 2017, the Independent Chairman met Maureen to explain the purpose of the DHR and wrote to other relatives. Due to the ongoing criminal proceedings, it was not possible to speak to any family members in more depth because they were potential witnesses. A copy of the Home Office DHR leaflet for family members was provided to all relatives.
- 4.3 Following Clive's conviction, the Independent Chairman contacted the relatives above. Maureen and Janice elected not to meet or discuss the case at that time. The Independent Chairman explained that he would be available if they changed their minds.
- 4.4 Julie and Michael initially made an appointment to see the Independent Chairman but cancelled this.

## 5. Contributing Organisations

- 5.1 Each of the following organisations were subject of an IMR:
- Kent Police
  - Kent & Medway NHS and Social Care Partnership Trust (KMPT)
  - East Kent Hospitals University NHS Foundation Trust (EKHUFT)
  - South East Coast Ambulance Service NHS Foundation Trust (SECAmb)
  - Kent County Council Adult Social Care and Health (Primary Care Mental Health Team)
  - Kent County Council Children, Young People and Education (Early Help and Prevention Services)
  - Kent County Council Children, Young People and Education (Education Safeguarding Team)
  - GP Practice 1 (Emily and Clive's GP) \*

\* To protect the anonymity of Emily and her family, GP practices are not named.

- 5.2 In addition to the IMRs, the Independent Chairman interviewed representatives of Sussex Partnership NHS Foundation Trust, Thinkaction, Porchlight and the Further Education College that Emily attended.
- 5.3 Having considered the IMRs and reports, the DHR Panel decided the involvement East Kent Hospitals University and South East Coast Ambulance Service NHS Foundation Trusts had with Emily was not relevant to the DHR.

Neither had a record of contact with Clive. The involvement of these organisations is not considered in this report.

## **6. Review Panel Members**

6.1 The Review Panel was made up of an Independent Chairman and senior representatives of organisations that had relevant contact with Emily and/or Clive. It also included a senior member of the Kent County Council Community Safety Team and an independent advisor from a Kent-based domestic abuse service.

6.2 The members of the panel were:

- Sallyann Baxter South Kent Coast CCG (Clinical Commissioning Group)
- Wendy Bennett Canterbury and Coastal CCG
- Louise Fisher Kent County Council Children, Young People and Education (Early Help and Prevention Services)
- Janet Guntrip Kent County Council Adult Social Care and Health (Safeguarding Unit)
- Susie Harper Kent Police
- Paul Pearce Independent Chairman
- Shafick Peerbux Kent County Council Community Safety
- Claire Ray Kent County Council Children, Young People and Education (Education Safeguarding Team)
- Liza Thompson SATEDA Domestic Abuse Service
- Cecelia Wigley Kent and Medway NHS & Social Care Partnership Trust

## **7. Independent Chairman and Author**

7.1 The Independent Chairman and author of this overview report is a retired senior police officer who has no association with any of the organisations represented on the panel and who has not worked in Kent. 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-organisation approach to dealing with domestic abuse.

7.2 The Independent Chairman has a background in conducting reviews (including Serious Case and Safeguarding Reviews), investigations, inquiries and inspections. He has carried out senior level disciplinary investigations and presented at tribunal. He has completed the Home Office online training on



DHRs, including the additional modules on chairing reviews and producing overview reports.

## **8. Other Reviews/Investigations**

- 8.1 Kent Police voluntarily referred Emily's death to the Independent Office of Police Conduct (IOPC), formally the Independent Police Complaints Commission. At the time of completion of this report, the IOPC has not published its findings but no misconduct or unsatisfactory performance by individuals or Kent Police have been identified.

## **9. Publication**

- 9.1 This overview report will be publicly available on the websites of Kent and Medway Community Safety Partnerships.

## **10. Background Information**

### 10.1 Emily Dale

- 10.1.1 Emily was 19 years old at the time of her death. She was the only child of Clive Dale and Maureen Price. She lived with both parents until she was about eight years of age, when they separated. Emily and her mother were then excluded from the family home by Clive and they moved into a house in Town A, which was owned by Maureen's sister. Maureen was still living in the house, which was owned by her sister, when Emily died.
- 10.1.2 Clive remained in Emily's life and although she lived with Maureen through most of the review period, she became increasingly reliant on him and appeared to see him as her primary carer. Towards the end of her life, Emily's time was spent between her father's and mother's homes.
- 10.1.3 Emily suffered mental health problems as a child and was under the treatment of the Child and Adolescent Mental Health Service from the age of 11 years. In the last years of her life, her mental health deteriorated, and she suffered from anxiety almost continuously.
- 10.1.4 During the years she would have attended secondary school, Emily was educated at home by a tutor. This was because of chronic anxiety she suffered when exposed to her peer group. She was academically bright, achieving five GCSEs, all with high grades. At the completion of her home schooling, she attended a Further Education College in Town B for three years. She did not have the social skills necessary to gain a qualification in line with her academic ability, but she persevered with her

studies, leaving in July 2016. From then until her death, she did not have any steady employment.

## 10.2 Clive Dale

10.2.1 Clive was 63 years old at the time of Emily's death and had lived alone on the outskirts of Town A, having separated from her mother when Emily was a child. In the months before Emily's death she spent time at his home, which was where she died.

10.2.2 Clive has worked for 30 years as a carer in a special school. In late 2013 he changed roles from being a member of the day staff to a night duty Residential Care Officer, looking after the welfare of pupils who were resident at the school.

10.2.3 Clive had no criminal convictions and was not known to Kent Police.

## 10.3 Equality and Diversity

10.3.1 There was no information available to the review that indicated Emily being mixed-heritage had any influence on the services she received from organisations. There is no record that Emily or her family felt she was being excluded from services because of this. Family members invited to participate in the review did not wish to do so, which meant it was not possible to explore this from their perspective.

10.3.2 Emily's mental health problems set her apart and made it difficult for her to integrate into her peer group. The way in which organisations attempted to treat and support her in this regard forms much of the content and analysis of their involvement.

# 11. The Facts and Analysis of Organisations' Involvement

## 11.1 Introduction

11.1.1 This section sets out facts and analysis of the involvement that Emily and Clive had with organisations between 1<sup>st</sup> January 2014 and Emily's death. The facts are based on IMRs and reports submitted by those organisations. The analysis is based on the facts; from it come conclusions, recommendations and lessons learned.

11.1.2 This section includes abbreviations, acronyms and references to terms that will be familiar to professionals working in relevant organisations, but which may need further explanation for other readers. In such cases, the

reader is referred to the glossary in [Appendix B](#), where abbreviations and acronyms are expanded, and more detail of some terms is provided.

## 11.2 Sussex Partnership NHS Foundation Trust (SPFT)

- 11.2.1 During the review period, SPFT provided child and adolescent mental health services (CAMHS) to people under 18 years of age in Kent and Medway. These services were commissioned by a consortium of the eight NHS Clinical Commissioning Groups (CCGs) covering the area. CAMHS provides secondary mental health services if a child or adolescent's mental health condition is too complex for their GP or other primary mental healthcare providers to manage.
- 11.2.2 Emily received care and treatment from CAMHS from the age of 11 years. This DHR considers the period from 1<sup>st</sup> January 2014 to the last CAMHS contact with her, which was in January 2015. During that time, the CAMHS staff that dealt with Emily and her family were: a Consultant Psychiatrist; a Case Manager; a Nurse; and a Family Therapist.
- 11.2.3 In February 2014, Emily and her parents attended a psychiatric review with the consultant psychiatrist: the case manager was also present. It was noted that there were family tensions and Clive said he found it hard to balance the demands that Emily placed on him with working night shifts.
- 11.2.4 The family had missed a planned appointment with the family therapist in January 2014 but were keen to attend another session. Emily also wanted to receive individual support from the nurse who was known to her.
- 11.2.5 In March 2014, Emily and her parents attended a CAMHS family review. The family therapist was unable to attend, so the meeting was run by the nurse Emily had expressed a wish to see. The discussion focused on Emily's difficulty in interacting with her college peers. Clive agreed to look for opportunities for her to meet friends and become socially engaged. The nurse told Emily that she was leaving the service and a closure session was arranged.
- 11.2.6 The closure session took place in April 2014, when the nurse took Emily out without her parents to discuss how she was feeling. The situation at college had improved and although her course was coming to an end she was planning to stay on for the next level of study. She appeared more positive and was enjoying horse riding weekly.

- 11.2.7 In May 2014, the case manager and family therapist discussed Emily's case. Individual sessions had finished because her nurse had left the service and no further family therapy was planned. The outcome from the meeting was a plan to offer the family an appointment to review further CAMHS involvement. There is no record this offer was made or that a meeting took place.
- 11.2.8 On 17 September 2014, the case manager spoke to Maureen by telephone after she contacted CAMHS. Maureen said the family had not had much contact with CAMHS since Emily's nurse had left and their case had been closed to family therapy. Emily's next psychiatric review had been moved from September to October and Maureen felt that further family therapy was needed.
- 11.2.9 As a result of this conversation, the family therapist spoke again to Maureen by telephone on 24 September 2014. Maureen explained that the sessions with the nurse who had left, had been helpful and added that Emily needed someone to talk to and would like contact with someone from the team. It had been recorded previously that individual sessions had stopped because the nurse conducting them had left the service. This does not seem to have been a decision based on patient need. There is no record that Emily's case was passed to another nurse who could have continued the sessions. It may have been that the nurse who was leaving felt that there was no need for further sessions, but this was not recorded.
- 11.2.10 The family therapist went on to explain to Maureen that conflict between her and Clive in therapy meetings meant that this approach had not been useful. The last family therapy appointment prior to this conversation had taken place in December 2013. There was no record made of family conflict within that meeting and following it, the family therapist recorded '*Will see again end of Jan 2014.*' On 31 January 2014, a record showed that Emily and her parents did not attend a family therapy appointment.
- 11.2.11 The family therapist told Maureen that individual work with Emily might be more helpful, perhaps in a community setting, rather than with CAMHS.
- 11.2.12 In October 2014, the case manager spoke to Maureen by telephone. Maureen explained that there was still tension within the family, which resulted in arguments between all three family members. A psychiatric review was planned for November: Maureen agreed to wait until then to discuss matters further, although she was offered an earlier review.

- 11.2.13 In November 2014, Emily and her parents attended a review with the consultant psychiatrist: the case manager was also present. It was decided that Emily would be discharged from CAMHS and a referral would be made to Porchlight, a charity that provided support for young people who needed help in gaining confidence and independence.
- 11.2.14 The consultant psychiatrist wrote to Emily's GP that day, stressing the progress she had made and explaining the reasons she was being discharged from CAMHS. The GP was asked to take over Emily's prescription for medication.
- 11.2.15 In January 2015, Maureen spoke to the case manager by telephone and said that Emily had met with a Porchlight worker, adding that further appointments were planned. She thanked the case manager for the support provided by CAMHS. Porchlight have no record of this referral and Maureen may have been confused by the earlier reference to referral to that organisation. The referral would have been made through the Common Assessment Framework process and as a result, Emily was referred to Kent Council Early Help and Preventative Services. Its involvement with her is described in sub-section 11.4 below.
- 11.2.16 Emily's discharge by CAMHS was based on a consultant's review; there was a clear rationale for it, and it was appropriate. Her anxiety had decreased to a level where secondary mental health services were not required and the tension between her parents in family therapy meetings meant that these were not helping her. The referral to Early Help and Preventative Services showed that CAMHS staff involved in her case had considered appropriate alternative therapies.
- 11.2.17 Clive mentioned the difficulty of balancing caring for Emily with working nights, but there is no record that he expressed significant concern about this in the way he would later to other agencies.

### 11.3 GP Practice 1

- 11.3.1 Emily was registered at GP Practice 1 (GPP1) in Town A from the age of four years. She presented at the practice suffering from physical and mental health conditions during the review period. She presented more frequently than an average patient (average was 4.91 contacts per registered patient in 2014/15). She saw each of the three GPs at the practice at various times.

- 11.3.2 The only chronic physical health condition Emily was diagnosed with during the review period was hypothyroidism (an underactive thyroid gland), for which she was prescribed medication.
- 11.3.3 GPP1 was told about the involvement CAMHS had with Emily in February 2014 and about her discharge from CAMHS in November that year. The remainder of her involvement with the practice during 2014 was for physical health conditions, including the diagnosis of hypothyroidism.
- 11.3.4 In January 2015, Maureen phoned GPP1 (she was also registered at the practice) to report Emily '*...having problems at college*'. The GP Maureen spoke to (GP A) offered a phone or face to face consultation with Emily, but this was not taken up.
- 11.3.5 In April 2015, GP A saw Emily for an anxiety review. She said she felt anxious and did not have friends. She mentioned that her father was worried about her. She declined counselling and Cognitive Behaviour Therapy (CBT), which she said had not been helpful in the past.
- 11.3.6 In late June 2015, Clive phoned the surgery asking for a GP to write a letter explaining Emily's anxiety, as part of her college application. The GP he spoke to (GP B) told him that the request must be in writing and should include her consent as she was nearly 18. Emily provided this and GP B forwarded a letter in the first week of July.
- 11.3.7 In September 2015, GP B referred Emily to Thinkaction, a charity specialising in talking therapies (see sub-section 11.5 below). The fact that a few months previously she had declined counselling and CBT as she believed they were unhelpful, indicates that GP B had taken time to convince her of its potential value. This was good practice. On 6 October 2015, GPP1 received a letter from Thinkaction, stating that Emily's condition meant talking therapy was not suitable and suggesting she be referred to the Community Mental Health Team (CMHT) for assessment.
- 11.3.8 In mid-October 2015, Emily was seen at GPP1 by GP C, who prescribed her the anti-depressant citalopram. This replaced her previous medication, fluoxetine. Anti-depressants can cause side effects and it may take some time to establish which best suits a patient.
- 11.3.9 In early November 2015, Emily was seen by GP C. Clive was also present. She described being very frustrated because she was not feeling any improvement in her mental state. She described having angry, irritable moods. Her anti-depressant medication was again changed, this time to sertraline.

- 11.3.10 In the meantime, Emily had been referred for CBT and on 11 December 2015, the referral was accepted. Having previously referred her to Thinkaction for CBT, the referral to an alternative provider to try to find an appropriate course of treatment - which Emily completed and appeared to benefit from in the short term - was good practice.
- 11.3.11 On 18 December 2015, GP A referred Emily to the CMHT after she said that her anxiety had worsened. When making the referral, GP A made a record summarising Emily's family situation. It stated that she was not complaining of suicidal or self-harm thoughts. The referral also noted *'Mum is scared of Emily as Emily forces her to do things she does not want...'* There is no record that this was explored further or that consideration was given to speaking to Maureen on her own. Some thought had been given to safeguarding but more questions could have been asked.
- 11.3.12 In the first week of January 2016, GPP1 received a letter from the CMHT which stated that Emily did not meet the criteria for the secondary mental health services. It advised that she should be offered counselling. Referring Emily to the CMHT was an appropriate professional decision. However, as it was made when she had just been referred for CBT, the decision of the CMHT to decline the referral until the results of this were known was perhaps to be expected.
- 11.3.13 In early March 2016, a letter to GPP1 from the CBT provider reported some progress had been made with Emily. The following day, she was seen by GP C with Maureen. She reported feeling less anxious and felt well enough to return to college.
- 11.3.14 Emily was next seen at GPP1 in mid-June 2016 with ongoing anxiety problems. Her GP again referred her to the CMHT, reiterating what primary care treatment she had received. She had started a counselling course about this time. The GP also suggested neuro-linguistic programming, a treatment widely debated in the psychiatric profession, which was not available on the NHS. There is no record that Emily took this up.
- 11.3.15 At the end of July 2016, GPP1 received a letter from the CMHT. Emily had not been accepted for treatment; the letter suggested counselling should continue as it had only just begun. In fact, Emily had stopped attending after two sessions.
- 11.3.16 In late August 2016, GP B sent another request to the CMHT for assessment. The reply received on 5 October was that Emily should be

re-referred for CBT and referred to the Primary Care Mental Health Team (PCMHT). After clarifying what the PCMHT was, GP B made a referral on 31 October 2016 (see sub-section 11.7 below for PCMHT actions).

- 11.3.17 In mid-December 2016, GP B saw Emily, who wanted to stop taking sertraline. GP B gave her instructions on reducing the dose gradually. Emily said she was doing some voluntary work at a library and GP B noted *'Looks positive'*.
- 11.3.18 Between December 2016 and March 2017, Emily was seen by a GP, at hospital A&E or called 111 (the NHS non-emergency number) on nine occasions for various physical conditions, none of which required extended treatment.
- 11.3.19 On 20 March 2017, Emily and Clive saw GP C. She reported ongoing anxiety and depression, for which she was reluctant to take anti-depressants or to undertake counselling. Two days later, GP C again referred Emily to the CMHT. In the referral, GP C noted that there was a lot of *'conflict and dysfunction'* in the family, and that during Emily's GP review she had been tearful and angry, with *'...clearly held animosity towards her parents.'*
- 11.3.20 On 23 March 2017, Clive spoke to GP B by telephone about a physical health problem Emily was suffering. GP B prescribed medication, which was appropriate for the symptoms, but which has known side effects. There is no record that Emily was a party to this discussion, nor that she consented to her case being discussed with her father. In addition, there is no record that the prescription was discussed with her or the possible side effects explained to her.
- 11.3.21 During the next week, Emily reported further physical conditions. On 28 March 2017, she presented to GP B with Clive, suffering from severe anxiety. GP B recorded that Clive was *'...very supportive and had taken time off to be with her.'*
- 11.3.22 During late March and early April 2017, GPP1 received letters indicating that Emily had accessed CMHT services. The letters referred to her medication and advised that she should be prescribed mirtazapine instead of sertraline. Emily expressed concern that taking mirtazapine might cause her to gain weight.
- 11.3.23 On 22 April 2017, GPP1 records show that Emily contacted 111 reporting suicidal thoughts. Later that day, she was seen at a clinic by the Crisis Resolution Home and Treatment Team (CRHTT) and GPP1 was updated



about her condition. A week later, Emily called 111 again about her feelings of anxiety.

- 11.3.24 GPP1 had received letters confirming that Emily was accessing secondary mental health services through the CMHT. A subsequent letter confirmed that she had also been seen by the CRHTT. When a person calls 111, their GP will be informed. Secondary mental health services will not be told unless the GP tells them. The information provided to GPP1 that Emily was experiencing suicidal ideation was significant to her mental health. GPP1 should have passed this information to the CMHT and CRHTT but there is no record this was done.
- 11.3.25 Clinical Commissioning Groups in Kent and Medway should advise GPs of the need to share any information they may receive about a patient who is being treated by KMPT, if that information might be relevant to the patient's mental health treatment or risk assessment. **(Recommendation 1)**
- 11.3.26 On 2 May 2017, Emily saw GP B, who suggested changing her anti-depressant medication to venlafaxine on the advice of a CRHTT psychiatrist. Emily did not want to do this and continued taking mirtazapine. The reviews of Emily's medication during the review period were regular, appropriate and took account of her views.
- 11.3.27 Emily saw GP B again on 4 May 2017, when she said that her nausea had improved since changing to mirtazapine, but she still suffered dizziness. GP B considered a CT scan and recorded questioning whether her dizziness was caused by anxiety or if it was a side effect of the anti-depressants.
- 11.3.28 In mid-May 2017, GPP1 received a letter from the CRHTT, describing contact with Emily after she self-referred. It noted that her father had '*gone away*' and described family tension.
- 11.3.29 On 16 May 2017, Emily saw GP A with Clive. She had seen the '*mental health team*' but was '*...unable to function and unable to go out on her own.*' Clive said he thought she had Asperger's Syndrome and questioned whether she had a personality disorder. She was prescribed propranolol tablets to take as needed. Propranolol is a beta blocker, rather than an anti-depressant, but it may be used for the short-term relief of social anxiety. This was the last time that Emily was seen by a GP about her mental health condition.

- 11.3.30 On 30 May 2017, Clive had a telephone conversation with GP B, and he explained that Emily was feeling dizzy. GP B prescribed prochlorperazine, an anti-psychotic drug that is used to treat some mental health disorders and which can also be prescribed for dizziness. Two days later, Clive saw GP B and they discussed Emily's mental health condition. On neither of these occasions was Emily involved or present, nor is there a record that she consented to her case being discussed with her father. There is no record that the prescription was discussed with her or the possible side effects explained to her.
- 11.3.31 Emily was seen once more at GPP1 before her death: she saw GP C on 13 June about a physical condition.
- 11.3.32 Between 20 June and 7 July 2017, GP B had three telephone conversations with Clive related to Emily's mental health. On the last occasion GP B prescribed hyoscine hydrobromide, a drug used to treat motion sickness and post-operative nausea and vomiting. It has known side effects and was not related to drugs previously prescribed to her. There is no record that Emily was involved or present during these calls, nor that she consented to her case being discussed with her father. There is no record that the prescription was discussed with her or the possible side effects explained to her.
- 11.3.33 Clive's first recorded involvement with GPP1 about his own health was on 18 April 2017. On 24 April, he was seen by GP C and described stress caused by the ongoing situation with Emily. He was signed off work then, and again following a phone call with GP C on 15 May.
- 11.3.34 On 17 May 2017, Clive was seen by a Healthcare Assistant at GPP1. He had hypertension (high blood pressure); notes from a previous GP practice he attended showed he had suffered from this before. He was fitted with a 24-hour blood pressure monitor and he saw GP A to discuss the results on 22 May 2017. It was noted that he suffered irritability and anger. He was prescribed citalopram daily and diazepam as required.
- 11.3.35 Clive had a telephone conversation with GP A on 24 May and on 5 June 2017. During both he mentioned stress caused by Emily's condition. The latter call was the last contact he had with GPP1 before Emily's death.
- 11.3.36 Emily had been registered at GPP1 most of her life; it was from there that she was referred to CAMHS as a child. When she visited GP A in June 2015, the first time since discharge from CAMHS, she had a recorded history of mental health problems on which to base decisions about future treatment.

- 11.3.37 From January 2017 until her death, Emily's health, both physical and mental, deteriorated significantly. During the last few months of her life there was interaction between Clive and GPs, when Emily's case was discussed with him in detail and on three occasions medication was prescribed.
- 11.3.38 During this period, Emily was an adult. There is no record in her GP notes that she consented to her case being discussed with Clive. She either did not give consent or there was an omission by not recording it. If she had consented to her case being discussed, medication should not have been prescribed without speaking to her about side effects and potential conflicts with her lifestyle. Again, it may have been done and not recorded but given the good standard of record keeping generally in Emily's case, this seems unlikely.
- 11.3.39 Emily visited GPs with Clive on several occasions and discussed her symptoms in his presence. It appears that she felt supported by him and there is no record of her expressing any concerns about his treatment of her. It was recorded that she was often emotional, and it may have been possible to get a more cogent description of her symptoms from him. However, a mental capacity assessment of Emily was never carried out, so the assumption could only have been that she was capable of making decisions about her treatment.
- 11.3.40 Discussing her case with Clive may have seemed a reasonable and pragmatic way of ensuring Emily received the best treatment, but it was not good practice. There is no record that a GP visited Emily's home during the review period and only one record of her discussing family dynamics during that time. On that occasion, the GP did not explore a concerning comment made by Maureen about Emily's behaviour.
- 11.3.41 In short, there is no record that Emily's GPs had a detailed understanding of the relationship between her family members. The potential risk of control and coercion as a motive for Clive wishing to speak to GPs without Emily being present does not appear to have been considered. This is something that must be considered and documented before details of the case of an adult with mental capacity are discussed with anyone else, regardless of how close the relationship between them is. This is pertinent to the prevention of domestic abuse.
- 11.3.42 CCGs in Kent and Medway must ensure that GPs are aware of the legal framework and their duties in assessing the mental capacity of their patients, which takes into account the legal position of parental responsibilities. **(Recommendation 2)**

11.3.43 Prescribing medication for Emily without discussing it with her was not good practice. She was an adult with mental capacity and even if she had given formal consent to her case being discussed with Clive in her absence, the potential side-effects of the medication should have been discussed with her before they were prescribed.

11.3.44 CCGs in Kent and Medway must ensure GPs discuss with a patient who has mental capacity, the potential implications and side effects of medication they intend to prescribe that patient, regardless of whether the patient has consented to details of their case being discussed with another person. **(Recommendation 3)**

11.3.45 There is no evidence that GPs discussed Emily's case with Clive, or prescribed her medication, for any reason other than to try and improve her physical and mental health. This best intention is understood but for the reasons outlined above, concerns about the potential consequences must outweigh it.

11.3.46 In the months before Emily's death, Clive was treated for depression. There is no record that the reason for this was explored but on one occasion he mentioned the stress caused by Emily's condition. There is no record that consideration was given to a carer's assessment referral to the local authority. This would have required Clive's consent, but it was not discussed with him. Given that this issue arises elsewhere in this DHR, CCGs in Kent and Medway must include the provisions of the Care Act 2014 relating to carer's assessments in local GP training.  
**(Recommendation 4)**

#### 11.4 Kent County Council Children, Young People and Education – (Early Help and Preventative Services)

11.4.1 Early Help and Preventative Services (EHPS) provides services for families to help them to do well, stay safe and resolve problems at the earliest possible opportunity, before they become more serious. EHPS is based in locations across Kent, so families can access its services locally. A detailed explanation of what EHPS does can be found in the [EHPS Manual](#).

11.4.2 Prior to June 2015, EHPS was split into separate services for adolescents and families with younger children. It was the former to which Emily was referred and this was then known as the Kent Integrated Adolescent Support Service. The service transformation into the current EHPS began in June 2015, when her case was still open.

- 11.4.3 Emily was referred to EHPS by CAMHS when she was discharged from that service in December 2014, aged 17 years. The referral requested support around the relationship between Emily's parents, which it said was sometimes tense and could affect family dynamics. In addition, the referral stated that Emily had requested befriending support rather than the therapeutic intervention she had in CAMHS.
- 11.4.4 Emily's case was allocated to an EHPS Detached Youth Work Manager (YM1), who contacted Maureen within the organisation's target time for an initial referral. An arrangement was made to meet Emily at a coffee shop in Town B. Such a meeting would usually have taken place at a client's home and it is not clear why it took place elsewhere. YM1 may have felt that because the relationship with her parents was a reason for her referral, meeting elsewhere would be more beneficial. If so, it showed sound professional judgement and was good practice.
- 11.4.5 The meeting took place in January 2015, and Emily attended with Clive. There was a missed opportunity for YM1 to contact CAMHS before it, to get more background about Emily and her family. This would have been helpful because the referral flagged family tensions.
- 11.4.6 In addition, there is no record that EHPS contacted Emily's GP. As well as the potential for finding out more about her medical and family background, it would have informed the GP, potentially preventing a duplication of activity. EHPS must remind staff of the importance of asking for consent from clients to allow information to be obtained from GPs and other relevant services, to better inform ongoing action.
- (Recommendation 5)**
- 11.4.7 YM1 recorded that Emily was not very talkative and Clive spoke on her behalf. YM1 assessed that Emily did not have '*confident social skills*'. They discussed ways of addressing Emily's social skills and anxieties; YM1 noted that she was happy to engage with these.
- 11.4.8 In late January 2015, YM1 met Emily from college and took her home. Maureen was there but Emily commented that Clive was better than her mother at managing her (Emily's) needs. Emily and YM1 agreed a plan to address her needs.
- 11.4.9 During the next six weeks, Emily and YM1 met regularly and Emily attended an organised session, aimed at building her confidence in social situations. On 2 March 2015, during a home visit by YM1, Emily said she found it easier to ask her father for help rather than do things herself. YM1 made a note to contact Clive the following day to discuss this as his

intervention could negatively impact on building up Emily's social confidence. Further home visits took place during March and at one of these Clive was present. YM1 challenged him about doing things for Emily rather than allowing her to do them herself.

- 11.4.10 In April 2015, Emily went to another organised group session, where YM1 observed she was very withdrawn. She spoke to Emily about this the following week and Emily said she felt her social anxiety was getting worse again.
- 11.4.11 On 14 April 2015, YM1 had a meeting with her supervisor to discuss Emily's case. They spoke about her increasing anxiety and the need for Clive to encourage her to become more independent by allowing her to speak for herself. YM1 was directed to speak to Clive again about this but there is no record that she did. There was also no record that contact with CAMHS to discuss Emily's mental health history was considered.
- 11.4.12 On 21 May 2015, YM1 completed a full assessment of Emily. In 2015, there was no target time for the period between referral and completion of this assessment, but six months was too long. This is indicated by the 20 working days target that has since been introduced. On the same day, YM1 contacted the college that Emily was attending to arrange a meeting to discuss her case. This may have been prompted by completion of the assessment; good practice would have been to have made contact sooner.
- 11.4.13 A meeting took place at the college on 4 June 2015. Emily and Clive were present. Concerns were raised about Emily's mental health and YM1 recorded that '*...it was felt she needed to access adult mental health services when she turned 18 years old.*' There was no rationale recorded as to why the referral to secondary mental health services should be delayed until Emily became an adult. If it was felt these services were needed, she could have been referred to CAMHS directly by EHPS. Alternatively, EHPS could have discussed a referral with Emily's GP.
- 11.4.14 At the meeting, it was agreed that Clive would '*...look into applying for an [Education, Health and Care Plan \(EHCP\)](#)*' for Emily because of concerns about her mental health impacting on her learning.
- 11.4.15 YM1 last saw Emily on 11 June 2015, when she visited Maureen's home to collect the assessment she had left with the family. Clive was present and said that he had not heard anything about the EHCP. There is no record of any discussion with or about Emily, or of any support being given to Clive's application for an EHCP.

- 11.4.16 In the first week of July 2015, YM1 spoke to Clive by telephone. He said that in respect of the EHCP, he had contacted the right professional and been asked to make the application in writing. YM1 asked Clive to contact her when he had done this. There is no record that Emily's condition or wellbeing were discussed. YM1 made further calls to Clive on unspecified dates during July but there was no response from him.
- 11.4.17 In late August 2015, YM1 met with her supervisor and a decision was made to close Emily's case. A closure report dated 25 September 2015 detailed what work had been undertaken on Emily's case. One entry states '*Clive was advised to take Emily back to her GP and ask for a referral back to CAMHS, seek private assistance for her anxiety or refer to adult services when she is 18.*' There was no previous record that Clive was advised of these options or that any assistance was offered to him in implementing them.
- 11.4.18 Not asking for Emily's consent to contact CAMHS and her GP for background information was a missed opportunity to find out more about the background to her case. Apart from this, EHPS involvement with Emily started well, with YM1 engaging with her regularly and recording their meetings comprehensively. It was identified correctly that the degree of support given to Emily by Clive was potentially preventing her from becoming more independent. He was spoken to about this once, but that was unlikely to have been enough to change established behaviour. Despite supervisory direction to challenge Clive further about this, it was not discussed with him again.
- 11.4.19 The formal assessment of Emily and contact with her college both happened later than they should have. It was following the latter that there seemed to be a deterioration of the service provided to her. The criteria for EHPS closing a case are that the goals of involvement have been achieved or that the client disengages from the service. Neither applied in Emily's case. First, her condition was deteriorating and there was no clear evidence that EHPS helped to address this. Second, it was EHPS that disengaged with her. Clive's failure to return calls was not relevant; Emily was the client.
- 11.4.20 The organisational transformation of the EHPS took place in June 2015, about the time when the service given to Emily started to deteriorate. Major organisational change can adversely impact on service because staff become focused on internal issues, particularly their own roles.
- 11.4.21 EHPS should examine this case to identify the shortcomings and missed opportunities. It should then confirm that changes have been made to

ensure the voice of the child is clearly heard under the transformed service. **(Recommendation 6)**

- 11.4.22 There was nothing recorded by EHPS to suggest that domestic abuse was taking place within the family. There was some tension and a difference of opinion between Emily's parents about what was best for her, but this was not an indicator of domestic abuse. Whilst Clive may have felt he was being supportive of Emily, his constant presence may have been inhibiting the development of her ability to interact with people.

## 11.5 Thinkaction

- 11.5.1 Thinkaction is part of Addaction, a charity that provides specialist drug, alcohol and mental health treatment across the UK. Thinkaction is commissioned by NHS Clinical Commissioning Groups to provide primary mental health services in Kent and Medway. It delivers talking therapies for those suffering mental health problems, in line with NHS England's Improving Access to Psychological Therapies (IAPT) programme.
- 11.5.2 Thinkaction does not offer psychiatric or prescribing services, nor does it work with those who have complex mental health conditions, which require treatment by a secondary mental health service provider.
- 11.5.3 Thinkaction staff are qualified therapists, practitioners and/or counsellors. All have received training as part of the IAPT programme. Its Cognitive Behavioural Therapists are members of the British Association for Behavioural and Cognitive Psychotherapies.
- 11.5.4 On 15 September 2015, Thinkaction received a referral from Emily's GP. The referral was screened and accepted. It was noted that the GP referral contained no information '*...apart from the client's contact details*' and no clear reason for the referral. Thinkaction state that this is unusual.
- 11.5.5 The responsibility for providing such information, which may allow Thinkaction to make better informed decisions, rests with the referrer. However, Thinkaction has now implemented the practice that when a referral contains incomplete personal details and medical background, its staff will contact the referrer and request it.
- 11.5.6 A Thinkaction administrator contacted Emily by telephone on 21 September 2015. She recorded that Emily had been suffering from anxiety for some time and was currently taking medication at an appropriate dose for a person suffering from this condition.



- 11.5.7 After a patient has been accepted through its screening process, a Thinkaction therapist will assess their mental health condition and decide whether they appear suitable for one of the organisation's talking therapies. The assessment is usually carried out by telephone but because of Emily's age and mental health history (which she had disclosed during the screening process), it was decided that a face to face meeting was appropriate.
- 11.5.8 On 22 September 2015, Emily was seen by a Cognitive Behavioural Therapist at the Thinkaction branch closest to her home. The decision to see her in person the day after screening was good practice. She had given permission for Clive to be present and the therapist noted he answered a lot of questions on her behalf. Emily appeared withdrawn and depressed.
- 11.5.9 The therapist made a comprehensive note of the meeting, recording Emily's mental health history and noting that she had received CBT previously, which she had not found helpful. Emily said she had no thoughts, plans or intentions of harming herself or others.
- 11.5.10 The therapist concluded that Emily '*...appears to be too severe for [Thinkaction] service. To discuss at supervision*'. On 1 October 2015, Thinkaction's Senior Supervising Clinician recorded that her case would be referred back to her GP. Emily was told of the decision that day and about a week later, a letter confirming the outcome of the assessment was sent to her, her GP and Kent and Medway NHS & Social Care Partnership Trust, the secondary mental health service provider. Thinkaction had no further involvement with Emily.
- 11.5.11 Thinkaction's decision to assess Emily in a face to face meeting demonstrates each case is considered according to the client's circumstances. This is good practice. Emily's assessment appointment was carried out a week after her referral and she was informed of the decision about continued treatment being inappropriate about a week after it. This is indicative of Thinkaction providing a prompt service.
- 11.5.12 Emily consented to Clive being present during her assessment. During it, she referred to the presence of her parents as helping in social interactions. Thinkaction prefer to conduct assessments on a one to one basis but if a client wants someone present and will only attend if that is the case, it is better to agree to this. If the therapist feels that the presence of the other person at an assessment is constraining the client, they will suggest that one to one time would be helpful. The assessor did not feel this was an issue in Emily's case, so Clive was present

throughout. If assessment of a client results in them receiving therapy, Thinkaction insist on this being conducted one to one. The nature of the therapies is such that this is essential.

- 11.5.13 Nothing recorded in Emily's case notes raises concerns about her being a victim of domestic abuse, either at the hands of her father or anyone else. Domestic Abuse is not a specific subject explored during assessment, although there is a heading on the assessment form for safeguarding, which in Emily's case was recorded as 'N/A'.
- 11.5.14 Coercion and control is central to domestic abuse; a perpetrator might pressure or force a victim into allowing them to be present at consultations. Victims suffering from mental health conditions may be more vulnerable to this kind of control and coercion. For this reason, it is recommended that in every initial assessment, the Thinkaction assessor should ask for the person being assessed to agree to a short time alone with the assessor. **(Recommendation 7)**
- 11.5.15 A specific heading of 'Domestic Abuse' on the assessment form would be helpful in prompting therapists to ensure that this is considered. Thinkaction should consider including a heading of 'Domestic Abuse' on its assessment form to prompt the assessor to consider this as a specific issue. **(Recommendation 8)**
- 11.5.16 In 2015, it was the usual practice for Thinkaction to refer clients back to their GP if they presented with a mental health condition too severe for the service. This was done in Emily's case and the letter was also copied to Kent and Medway NHS and Social Care Partnership Trust (KMPT), the secondary mental health services provider, which was good practice. Since then, the provision of a single point of access within KMPT has made it easier for Thinkaction to refer patients directly. Consideration of the most appropriate referral route is now part of Thinkaction's process.

## 11.6 Kent & Medway NHS and Social Care Partnership Trust (KMPT)

- 11.6.1 KMPT provides secondary mental health services for adults and is commissioned to do this by a consortium of the eight NHS Clinical Commissioning Groups in Kent and Medway. KMPT delivers its services in the community through [Community Mental Health Teams \(CMHT\)](#) and [Crisis Resolution Home Treatment Teams \(CRHTT\)](#)
- 11.6.2 The CMHT covering Emily's home town differs from those in the other seven CCG areas in Kent and Medway in that its staff and management are not based in one location. This is because of the geographical size of

the area it covers. During the review period, clinical staff were based in two locations and its social work staff in a third. The latter now work in one of the clinical locations. All subsequent references to CMHT in this report refer to the team covering Emily's home town.

- 11.6.3 During the review period, there were separate operational and advanced practitioner management structures in each of the clinical locations, and one Service Manager oversaw both. During the period that KMPT was involved with Emily's case (March–July 2017), the average staff absence rate at the CMHT was 9.48%, with a peak of 11.24% in July 2017. The KMPT average during that period was 4.8% against a target absence rate of 3.8%.
- 11.6.4 The staff vacancy rate in the CMHT during the same period averaged 19.69%, peaking at 26.29% in May 2017. The KMPT average during that period was 12.55% against a target of 10%.
- 11.6.5 In June 2017, the combined absence/vacancy rate in the CMHT reached 34.77% - over a third of posts were unfilled through sickness or vacancy. A decision was taken to prioritise the screening of new referrals in order to meet initial assessment targets. This required the suspension of all routine contact by care coordinators with their existing patients (of whom Emily was one) from the beginning of July 2017.
- 11.6.6 KMPT decided not to communicate this decision to other elements of the NHS, from which new referrals are received – this includes GPs. The decision meant the number of new referrals did not decrease – this is significant because on average, nearly one in five referrals did not meet the criteria for secondary mental health services.
- 11.6.7 Better communication and education about the criteria for secondary mental health services might have resulted in a reduction in referrals and reduced the risk of routine services being withdrawn from existing patients, who might lapse into crisis without it.
- 11.6.8 The requirement to have separate CMHTs, each with its own management structure, for each CCG area makes it more difficult for KMPT to even out absence and vacancy rates across Kent and Medway. Smaller, discrete teams are less resilient to absence and vacancies; they also require more supervisors and managers. The most senior position (Operational Lead) in the CMHT location covering Emily's home town was vacant between 6 April and mid-June 2017 – Emily was in KMPT care throughout that time.

- 11.6.9 During this period, staff noted they had difficulty accessing supervision due to vacancies in the management structure. The high absence and vacancy levels had other consequences. From February 2017 through to the end of the review period in July 2017, the percentage of staff who had attended KMPT's Level Two safeguarding course (which includes domestic abuse training) varied between 69% and 78%. KMPT's target attendance was 85%.
- 11.6.10 The potential impact on the treatment and care Emily received in the context of the staffing problems in the CMHT are considered at the end of this sub-section.
- 11.6.11 CRHTTs deliver services primarily in patient's homes. CRHTT boundaries in Kent and Medway are not all coterminous with those of the CMHTs. There are five CRHTTs covering Kent and Medway, the one covering Emily's home town did not have significant absence and vacancy issues during the review period. In this report CRHTT refers to the team covering Emily's home town.
- 11.6.12 For new patients with an urgent or emergency mental health problem, KMPT provides a [Single Point of Access \(SPoA\)](#) telephone number.
- 11.6.13 The first record KMPT have of Emily is a copy of a letter received on 6 October 2015, sent by Thinkaction to GPP1. This explained that Emily's mental health condition was too complex for Thinkaction's therapies. There was no requirement for KMPT to respond to this, it was for Emily's GP to make a referral if necessary.
- 11.6.14 On 31 December 2015, a referral was received from GPP1 about Emily's anxiety. It described family conflict as exacerbating this. She was not considering suicide or self-harm, which is a significant factor in deciding whether a patient is eligible for secondary mental health services. It also stated that she was due to start counselling. At a multi-disciplinary team (MDT) meeting held on 5 January 2016 to screen referrals, it was decided that Emily did not meet the criteria for KMPT services.
- 11.6.15 In mid-June 2016, a further referral for Emily was received from GPP1. This stated that she was experiencing extreme anxiety which was impacting on her life and education. The referral mentioned counselling she had begun receiving from the Community Counselling Service. At the end of July 2016, after consideration at an MDT meeting, GPP1 was told that Emily did not meet the criteria for KMPT services.

- 11.6.16 On 7 September 2016, a third referral was received from GPP1, in which the GP said that all avenues in primary care had been explored without an improvement in Emily's condition. A letter was sent to GPP1 on 5 October 2016, stating Emily did not meet the criteria for KMPT services and recommending she be referred to the Primary Care Mental Health Team (PCMHT).
- 11.6.17 The decision that Emily did not meet the criteria for secondary mental health services was appropriate on each of the three occasions she was referred.
- 11.6.18 On 21 March 2017, a Community Psychiatric Nurse (CPN1) working in the CMHT spoke to Clive in response to a message left by him. He described Emily's condition and the pressure it was putting him under. He asked that she be assessed and said that '*...he had come to the end of his tether, was burnt out and could no longer cope with Emily, who was extremely challenging.*' No plan of action was recorded following this call.
- 11.6.19 Later that day, Clive called again and spoke to a Healthcare Assistant (HCA1) at the SPoA. He referred to his earlier call, in which he had been told that someone from the CMHT would contact Emily the same day (this had not been recorded). He explained that she did not engage on the telephone and needed a face to face assessment. He was advised to wait for a call to Emily the following day.
- 11.6.20 The next morning, Clive called the CMHT and spoke to CPN2 who said his concerns would be discussed in the screening meeting that morning and '*...someone would call him back later in the day.*' The same morning, the SPoA received an urgent referral for Emily from GPP1.
- 11.6.21 The following day, one of the regular conference calls between CMHTs and the SPoA was held. These meetings discussed new referrals but no one from the CMHT called into the meeting. The SPoA therefore sent her GP's referral to the CMHT by email. Later that day, Clive telephoned the CMHT and spoke to CPN2. He said that he had not heard from the SPoA and CPN2 recorded that he said '*...he was fine to wait.*' There is no record that any action was taken following this call or that CPN2 was aware of the GP's referral.
- 11.6.22 It is concerning that neither the calls made by Clive, nor the urgent referral made by Emily's GP, were the subject of action.
- 11.6.23 On 27 March 2017, Emily called the CMHT and left a message. CPN1 called her back; this was the first contact KMPT had with Emily. CPN1

recorded that she was struggling with anxiety. They discussed issues with her medication and CPN1 advised Emily to contact her GP to discuss it further. CPN1 also recorded '*No referral received*', indicating that he was unaware of the GP referral emailed to the CMHT by the SPoA four days previously. There is no record that this referral was ever considered.

- 11.6.24 The failure of the CMHT to participate in the conference call resulted in a failure to consider the urgent GP referral. KMPT must ensure CMHTs participate in conference calls with the SPoA. **(Recommendation 9)**
- 11.6.25 On 30 March 2017, Clive called the SPoA twice. He spoke first to HCA2, describing Emily as distressed and tearful all the time. A few hours later, he spoke to a KMPT Social Worker (SW1), who also spoke to Emily and '*...attempted to screen her over the phone.*' SW1 described Emily as being '*...acutely distressed.*'
- 11.6.26 SW1 asked appropriate questions in line with the KMPT screening process. She booked an urgent appointment for Emily to be seen at the CMHT clinic the following morning. This was good practice. Emily was seen then by a social worker (SW2); the first face to face contact KMPT had with her. Clive and Maureen were present at the meeting.
- 11.6.27 SW2 carried out a risk assessment with Emily and booked an appointment for her to see a consultant psychiatrist on 9<sup>th</sup> May 2017. SW2 also telephoned Emily's GP to update him and discuss her medication. This was followed up with a letter. Calling the GP and confirming in writing was good practice. However, SW2 did not request a copy of Emily's CAMHS notes, which would have described her mental health history and informed the assessment.
- 11.6.28 SW2 recalled tension between Clive and Maureen about how they should be supporting Emily. Emily was reliant on Clive to explain her circumstances, and she appeared to have a closer relationship with him than with Maureen. SW2 described Clive as rational and supportive.
- 11.6.29 On 7 April 2017, Emily attended an appointment with CPN2 at the CMHT clinic; Clive was also present. He explained he had taken time off work to be with Emily, who could not understand why he was unable to be with her 24/7. There is no record of any actions arising from the meeting.
- 11.6.30 A Kent Police officer phoned the SPoA on 9 April 2017, after being called to Emily's home. CPN3 at the SPoA then spoke to Clive, who said he could no longer cope. CPN3 paged the CRHTT and CPN4 from that team called Clive within 10 minutes. The correct actions were taken promptly

by both. Clive said that '*...this morning [Emily] physically attacked him.*' CPN4 offered an assessment of Emily that afternoon. Although, this was an appropriate response within a reasonable time, Clive was unhappy with the delay. CPN4 tried discussing coping strategies with him, which he dismissed by saying all had been tried and nothing was working. This was an indication of the stress he was feeling.

- 11.6.31 Two telephone calls were made to Emily's home later that day by CRHTT staff: the first by CPN5, the second by CPN6. On neither occasion was she spoken to: the first time because she was asleep, the second time because Clive said she was calmer. During the second call, he and Maureen said they did not feel an assessment was needed at that time (after 11pm).
- 11.6.32 The following day, CPN7 from the CMHT called Emily but spoke to Clive. He described Emily as out of control and not taking her medication. CPN7 told him she would call when '*...we were able to get her to see a doctor.*'
- 11.6.33 On 11 April 2017, CPN8 and CPN9 from the CMHT went to Emily's home. Although at first Emily agreed to speak only with her father present, both Clive and Maureen were asked to leave the room and she was spoken to alone. The family situation was tense. Coping mechanisms were discussed with Emily and she was given breathing exercises, which quickly calmed her down.
- 11.6.34 The CMHT made repeated attempts to speak to Emily to arrange an assessment and then visited her at home. This showed persistence, which was good practice. Asking her parents to leave the room was the right course of action, particularly as it was clear that there was tension between them, which was causing Emily distress. The actions planned – to discuss admission to the CRHTT service and an appointment for a doctor to review Emily's medication - were appropriate.
- 11.6.35 CPN9 discussed the CRHTT referral with the CMHT Operational Lead, who decided that this would not be appropriate because there was no risk of suicide or self-harm. Contact with the CRHTT would only be appropriate for out of hours emergencies. The agreed plan was:
- Emily to be seen by CMHT locum consultant psychiatrist on Thursday 13/04/17.
  - To be assessed and care plan to be completed.

- Kent Enablement & Recovery Service [see subsection 11.7 below] to be considered to support Emily towards independence and engage her in age appropriate purposeful activities.
  - Open Dialogue to be considered as an option to support family dynamics and Emily's recovery.
- 11.6.36 Considering the actions agreed in the plan, the first two of which ensured continuing KMPT involvement with Emily, the decision not to begin CRHTT treatment was appropriate.
- 11.6.37 Clive spoke to CPN10 of the CRHTT later that day; Emily declined to speak. CPN10 offered to fax the CMHT and ask them to make contact the next day; Clive agreed to this. Maureen later spoke to CPN10, who confirmed she had sent the fax. There is no record that the CMHT received it.
- 11.6.38 On 13 April 2017, as part of the action plan from two days earlier, Emily was seen by a Consultant Psychiatrist (CP1) at the CMHT outpatient clinic. Clive and Maureen were also present. A lengthy assessment of Emily was undertaken. Clive explained the history of her mental health condition and she explained how it was currently affecting her. Clive referred to an occasion when the police were called because Emily became aggressive. The assessment was restricted due to her emotional state and because she left the room when alternative medication was being discussed.
- 11.6.39 Later that day, Emily telephoned the CRHTT and spoke to HCA3, demanding that she be found an immediate respite placement. HCA3 agreed to fax the CMHT and ask them to contact her to discuss this. There is no record that the fax was sent or received. About 9pm that day, HCA4 made a *'supportive telephone call'* to Maureen, who was reporting that Emily had been hysterical since about 3pm.
- 11.6.40 This was the second time that a fax communication had failed. Fax is an inefficient way to communicate; without telephone confirmation there is no guarantee that it had been received. It is also insecure; the sender cannot be sure who will see the document at the receiving end. It is surprising that faxes were still being sent within KMPT in 2017. KMPT should review its use of fax as a method of communication and seek to phase it out as soon as possible. **(Recommendation 10)**
- 11.6.41 The next day, Emily was visited at home by an Occupational Therapist (OT1) from the CRHTT. The OT recorded that *'[Emily and Clive] both said*



*they did not feel in need of assessment at the current time. No longer in crisis.'*

- 11.6.42 On 19 April, Emily's case was discussed at a multi-disciplinary team meeting. It was agreed that she would be '*...placed on priority allocation list [for a Care Coordinator].*' The same day, her case was discussed by the CMHT Psychological Service, which was an action from the assessment carried out by CP1. It was recorded that Emily would not be '*...accepted for psychology/art therapy as [she] has not been allocated a Care Co-ordinator and care spell not opened. We will re-consider once this has been done.*'
- 11.6.43 This provides evidence of the importance of a Care Coordinator being appointed – not having one at the time meant an avenue of treatment was blocked to Emily. The decision also suggests that access to the Psychological Service is based on process (a Care Coordinator being appointed, and/or a care spell being opened) rather than on the patient's needs. KMPT must ensure that access to its Psychological Service is based on the needs of a patient, not on an administrative process.
- (Recommendation 11)**
- 11.6.44 On 20 April, Clive spoke to CPN1. He said Emily was refusing to take her medication. CPN1 told him she should be encouraged to take it and explained that Emily was on the '*...waiting list for allocation [of a Care Coordinator]*'.
- 11.6.45 The same day, CPN1 was told by a Primary Care Mental Health Team (PCMHT) social worker (SW3) that Emily had cancelled her appointment with the Kent Enablement and Recovery Service, was not willing to engage and not able to benefit from the service. SW3 spoke to CPN1 the following day after receiving a phone call from Maureen. CPN1 recorded that SW3 said the PCMHT would '*...step back and discharge [Emily] back to CMHT - to be referred back [to the PCMHT] in future if she is more settled.*' Sub-section 11.7 below considers the PCMHT involvement with Emily.
- 11.6.46 On 21 April 2017, a member of staff from the organisation Carer's Support who was conducting Maureen's carer's assessment, spoke to CPN1 and told him that Maureen was finding it difficult to manage Emily's mood and mental state. There is no record of any action taken or advice given. Later that day, Emily called the CRHTT and spoke to CPN11, who gave her advice about coping with her anxiety and panic.

- 11.6.47 In the early hours of 22 April, a Kent Police officer, who was at Emily's home, spoke to CPN12 of the CRHTT. The officer was concerned for Emily's safety. She was very anxious and considering cutting herself to get rid of the tension that she was feeling. The officer feared that the situation was escalating.
- 11.6.48 CPN12 then spoke to Emily, who said she had been feeling suicidal for the first time recently and this frightened her. She had no current plans to kill herself, but the suicidal ideas were constantly on her mind, *'...which is also of concern to those that surround her.'* She felt she could not keep herself safe at that moment because she did not know what she would do next. There is no record of her being asked if she had experienced feelings of anger and/or violence to others.
- 11.6.49 The escalation of Emily's thoughts to self-harm and suicidal ideation was a significant event. Her risk assessment was reviewed and raised to High and CPN12 recorded that there was a *'...plan for CRHTT to review.'* If a patient's risk assessment is reviewed and the risk raised, there must be a clearly documented plan of how the increased risk is going to be managed. There is no record that such a plan was created. KMPT must review its procedures to ensure that it is clear to their staff what action must be taken when a patient discloses information that causes their risk to be raised to High. **(Recommendation 12)**
- 11.6.50 During the afternoon of the same day, a CRHTT Occupational Therapist (OT2) called Emily, who had left a pager message. OT2 visited Emily at home within four hours, which was a prompt response. Maureen was present throughout this assessment meeting. There is no record that Emily repeated her thoughts about self-harm or suicidal ideation. CPN12 had recorded what Emily told him on her electronic case notes, which OT2 would have been able to access prior to her visits – she should have done this as a matter of course, to ensure she was aware of the latest case history. OT2 did not record knowing about the suicidal ideation and despite Emily receiving a call from the Samaritans during her visit, there is no record that OT2 asked her whether she had contemplated self-harm and suicide.
- 11.6.51 OT2 then recorded *'Medication discussed. Taken on for home treatment with a plan for daily home visits to monitor safeguarding issues, medication concordance and mental state, and to support Emily's parents.'* This entry and the decision to start daily visits was positive. It suggests that OT2 decided there were safeguarding issues but did not fully record them.

- 11.6.52 A series of daily visits to Emily's home began the following day, the first being made by CPN6 and CPN13 of the CRHTT. Despite the recognition that daily visits were needed, a Care Coordinator was still not appointed.
- 11.6.53 On 24 April, a Consultant Psychiatrist (CP2) visited Emily at home and assessed her. She was offered a further assessment in hospital but declined because Clive would not be present. CP2 recorded '*She was not judged to be detainable under the [Mental Health Act] today.*'
- 11.6.54 During the assessment, Maureen accused Clive of causing bruises that were present on Emily's body. CP2 did not consider speaking to Emily alone because she wanted her father with her. He did not consider the safeguarding aspect of Maureen's allegations because Clive appeared supportive, and said he had expertise in handling Emily's behaviour because of his job working with young people with challenging behaviour.
- 11.6.55 The failure to consider safeguarding issues when bruises were present on a patient and an allegation was made that they were caused by a person she lived with, is hard to comprehend and should be of concern to KMPT. It is even more concerning given that Clive disclosed his job involved working with young people with challenging behaviour. KMPT must ensure all its consultant psychiatrists have a clear understanding of how safeguarding should be incorporated into their assessments and the actions they should take if concerns arise. (**Recommendation 13**)
- 11.6.56 On 25 April, the daily visit was made by a CRHTT pharmacist. Clive said he was worn out and had been signed off work. He also said Emily began screaming if he tried to leave the house. Emily said she felt her physical conditions were her main problem; it was these that made her feel anxious. There was a lengthy discussion with her about the potential benefits to her of using Diazepam appropriately. The pharmacist identified the stress that Clive was under and one of the recorded actions arising from her visit was '*Support family, especially father*'. How this would be achieved and by whom was not explained.
- 11.6.57 It is not clear whether the sequence of the first four daily visits involving CPNs, a consultant psychiatrist, an occupational therapist and a pharmacist respectively was planned. If so, it was good practice because it ensured that professionals from different disciplines saw Emily and were able to contribute their specialist knowledge to her case. However, Clive told professionals from three disciplines that he was under stress due to caring for Emily, but it is not clear whether this was communicated between them in a way that might have corroborated how much he was suffering.

- 11.6.58 The home visit on 26 April was made by CPN14. He found Clive was again vocal in expressing his feelings about the burden of caring for Emily.
- 11.6.59 The following day, CPN9 wrote to GPP1 asking that Emily's thyroid condition be explored '*...possibly a referral to a specialist as the family believe that this could be the underlying problem in regard to Emily's presenting mental health deterioration. May I also request for your surgery to conduct regular monitoring of Emily's thyroid function as the family again believe that 6 monthly checks are insufficient.*'
- 11.6.60 Sub-section 11.4 refers to Emily's hypothyroidism, which was diagnosed in 2014, years after she began to suffer mental health issues. There is no evidence that the medication prescribed for the condition had a positive impact on her mental health but CPN9's request showed that she was thinking widely about the potential causes of Emily's anxiety. Her request to GPP1 was good practice.
- 11.6.61 The same day, CPN2 spoke to the KMPT Open Dialogue service. This service, which started on 1 February 2017, is a community-based integrated treatment system which engages families from the start of a patient's involvement with KMPT.
- 11.6.62 As a newly established service, Open Dialogue's capacity allowed it to take only urgent referrals for new patients from the SPoA or the Early Intervention for Psychosis service. During the review period, Open Dialogue did not accept referrals for patients such as Emily, who were already in receipt of other KMPT services. Open Dialogue now considers referrals for existing cases, including those open to the CMHT. Regardless of the criteria at the time, CPN9's discussion with Open Dialogue again showed a wider consideration of services that might help to support Emily's parents - it was good practice.
- 11.6.63 On 28 April, Clive was contacted by CPN15 who told him that a doctor's review of Emily, scheduled for that day, would not take place. Clive became angry and said he was recording the conversation, so the call was terminated. He then sent a message apologising and saying the call had not been recorded. This episode was a further indication of the strain he was under.
- 11.6.64 A meeting was held that day between an KMPT Assistant Medical Director, CP2 and CPN15. The meeting record stated '*Agreed that Emily's behaviour is a chronic problem, but that recent deterioration has resulted in carer breakdown. Informal admission [to hospital] to be*

*offered again and if refused consideration to be given to a Mental Health Act assessment if the situation has changed to the extent that it would be warranted.'* This demonstrated that there was an understanding that Emily's parents could not cope with caring for her.

- 11.6.65 Later that day, CPN15 and CPN16 visited Emily's home. They had a conversation with Emily alone and she disclosed details about her feelings. This included that she was '*...aware that she needs support to learn how to cope differently, especially as she has little confidence in herself and has become over dependent on her parents.'* Clive and Maureen were then invited back into the room and they were able to give an honest account of the issues they faced, both with Emily and ongoing family tension. The summary of the meeting noted '*Emily appeared far more relaxed when seen without her parents present and there appears to be ongoing difficult family dynamics compounded by Emily's anxiety and fear of abandonment.'*
- 11.6.66 CPN15 had been present at the meeting where carer breakdown was recognised by professionals. The same day, she made a home visit which confirmed Emily was more relaxed without her family present. There is no record that she was offered informal admission to hospital or that Clive or Maureen were offered a carer's assessment. A Care Coordinator had still not been appointed for Emily.
- 11.6.67 On 29 April, the CRHTT was made aware that Emily had called Kent Police and Social Services in distress. In addition, she telephoned the CRHTT early in the morning where she spoke to HCA4, telephone again later that morning when she spoke to HCA5 and late afternoon when she spoke to HCA6. On the second occasion, she was told '*... that SPoA was for new referrals and we would be unable to help.'* She was given no advice or support, nor was she told who she could contact.
- 11.6.68 The text content of KMPT's webpage for its [Single Point of Access](#) at the time of this review is reproduced in Appendix B of this report. The capitalisation and emphasis are as the webpage. The SPoA is intended for people who have urgent or emergency mental health problems – people in crisis. However, the first two paragraphs explain what a person not in crisis should do and the third places a caveat on those who are. It does not appear to have been written with an understanding that a person in crisis is unlikely to be fit to read a text full of conditions and caveats.
- 11.6.69 KMPT must change its Single Point of Access webpage to ensure that it is immediately clear to those with urgent or emergency mental health needs,

what number they can call or text to receive the help they need at that time. **(Recommendation 14)**

- 11.6.70 In the early evening of 29 April 2017, CPN17 called Emily. She had reported Clive missing but CPN17 was able to reassure her that he had spoken to Clive who would be back home at some point to see her. She said she wanted to be rehoused because she said she did not feel safe without her father. She was told that the CRHTT could not rehouse her; the reason for her feeling unsafe was not explored. This demonstrated a lack of understanding of safeguarding.
- 11.6.71 Later that day, Kent Police called the SPoA and spoke to CPN18. He was told that Clive was safe and well, but Clive did not want this information passed to Emily. CPN18 recorded that Emily's case was '*Currently open to CRHTT, so close to SPOA.*'
- 11.6.72 On 30 April 2017, CPN5 contacted Emily to confirm the daily home visit. Emily declined and she was advised to page the CRHTT if necessary.
- 11.6.73 A home visit was made on 1 May 2017 by CPN19. Emily's main concern was that Clive had left home and she did not know if he would return. It was noted that after the planned doctor's review the following day, visits should be reduced to alternate days to promote independence from the CRHTT.
- 11.6.74 On 2 May 2017, CP2 conducted a doctor's review at Emily's home. He recommended that after a further home visit by CRHTT, Emily's care should be transferred to the CMHT. One of the actions was to '*Support mother*' but there was no suggestion how or by whom.
- 11.6.75 On 4 May 2017, CPN2 received a call from Clive. Emily was heard screaming in the background and Clive said he and Maureen could no longer cope with her behaviour. He said he wanted Emily to be assessed under the Mental Health Act (MHA). CPN2, who was CMHT staff, explained that Emily was still under the care of the CRHTT. There is no record that CPN2 contacted the CRHTT about the call, although the summary of it was recorded on Emily's computerised notes.
- 11.6.76 Later that day, CPN14 attempted a home visit but got no reply. Emily was spoken to by telephone and apologised, saying she had been out. A home visit was arranged for the following day. Clive had left a pager message for the CRHTT early that morning and in the late afternoon CPN20 called him. He said he could no longer cope and asked if an MHA assessment could be carried out. CPN20 advised him to contact the

Approved Mental Health Practitioner (AMHP) service directly as he was Emily's nearest relative. After initially refusing to take the AMHP's phone number, stating that CRHTT arranged MHA assessments previously, he changed his mind and was given it.

- 11.6.77 Although the AHMP service in Kent carries out mental health assessments and a person has a statutory right to request a mental health assessment, it was not appropriate to advise Clive to call the AMHP direct. First, because the appropriate way to make a request was through the CRHTT and CPN20 could have initiated this if he thought it appropriate. Second, because redirecting a person who is clearly under pressure to another part of KMPT, where they would have had to explain their circumstances again, was poor service.
- 11.6.78 KMPT must ensure that clinical professionals and public facing staff understand the Approved Mental Health Practitioner service referral criteria in order that they can advise patients and service users correctly. **(Recommendation 15)**
- 11.6.79 On 5 May 2017, Emily was visited at home by CPN11 and a student nurse. Her transfer from the CRHTT to the CMHT was explained and discussed with her. It was recorded that '*...she felt this was the right way forward for her.*' Later that day, the student nurse contacted CPN2 at the CMHT and told her about Emily's transfer from CRHTT and that a follow up would be needed within the next seven days.
- 11.6.80 The transfer of Emily's care from the CRHTT to the CMHT was appropriate. The fluctuation in her anxiety level was an ongoing (chronic) condition, not an acute crisis with a suicidal or psychotic basis. The role of the CRHTT includes providing intensive support at home to prevent admission to hospital. Admission to hospital was not felt to be appropriate in Emily's case, so the plan would be for a more therapy based, community-based approach delivered by the CMHT.
- 11.6.81 During the evening of 11 May 2017, Emily called the CRHTT several times and spoke to CPN21 who offered to refer her to the night shift CRHTT. This offer calmed her.
- 11.6.82 In the early hours of 12 May 2017, CPN22 from the CRHTT went to Emily's home, where Maureen and five other adults were also present. Emily was seen with her mother; she said she did not want to stay at home with Maureen, and Clive had gone away.

- 11.6.83 CPN22 felt that Emily was presenting in a similar way she had when under the care of the CRHTT. As part of a plan arising from this visit, she would be taken on again by the CRHTT and daily visits would resume that afternoon. *'Support mother and father'* was another action but how this was to be done and by whom was not recorded.
- 11.6.84 About 9am that morning, after Emily and Maureen had turned up in a local council office in distress, CPN2 asked them to come to the CMHT. Emily said she felt unsafe with Maureen, who could not support her; both wanted Emily rehoused. Maureen had a bruise on her wrist, which she said was caused by Emily. Maureen wanted a safeguarding alert raised; this was discussed with a KCC Designated Safeguarding Officer, who felt it was not appropriate at that time.
- 11.6.85 CPN2 contacted Crossroads, a carers charity, who agreed to accept a referral for a carer's assessment. It is unclear whether CPN2 was aware of the home visit made by CPN22 hours earlier and that CRHTT daily visits were to begin that day.
- 11.6.86 CPN5 from the CRHTT made a home visit later that day. During it, Emily called 101 (the police non-emergency number) to report Clive missing. The actions from the meeting included a resumption of daily visits and *'Support parents'*. Again, there was no plan for how this would be provided and by whom. Later that evening, Kent Police called the SPoA as Emily had contacted them to say she needed 24-hour support because she could not look after herself.
- 11.6.87 On 13 May, Clive called the CRHTT and spoke to CPN6. He said Emily was with him at his home. Later that day, CPN19 telephoned Emily, who said she did not need a visit that day as she was with Clive.
- 11.6.88 The following day, HCA7 from the CRHTT called Emily to arrange a home visit. She did not want to be seen because she was with Clive. She said the same when OT2 called her the following day. This was the clearest indication that Emily's anxiety decreased when she was alone with Clive.
- 11.6.89 On 16 May, Emily was seen at Clive's home by CPN11 and CPN23. She and Clive felt the current crisis had abated. She was sleeping at Clive's home and spending the day with Maureen. Clive had arranged for her to see a private psychologist that week. The key decision from the meeting was to again transfer Emily's care from the CRHTT to the CMHT. The following day, CPN9 of the CMHT called Emily to confirm that this had happened and to arrange a seven-day follow-up appointment.



- 11.6.90 The next contact was on 24 May, when HCA8 at the CMHT took a call from Maureen, who said that Emily was in crisis. Emily was seen later that day at the CMHT clinic. Clive was present and expressed his exhaustion from caring for Emily. He said his job was at risk and he was taking periods of sick leave. He said he saw his job as a '*...therapeutic tool to cope.*'
- 11.6.91 Eight actions came out of the meeting. The plan was to refer Clive and Maureen for separate carer's assessments, which Clive consented to. CPN9 was told that only one carer was eligible for assessment, so she chose Clive. The information she was given was incorrect: S.10 of the Care Act 2014 does not place a limit on who can be offered a carer's assessment. CPN9 wrote to the social work assistant responsible for dealing with applications for carer's assessments but there is no record it was actioned. CPN9 did not follow this up. This was a significant missed opportunity to provide support for Clive.
- 11.6.92 Family dynamics were significant in this case, particularly the strain Clive was under. He repeatedly told KMPT professionals that he could not cope with caring for Emily. That he was under great emotional strain was recognised and recorded, but KMPT was not the agency best able to help him. The need to provide support to Emily's parents was a recorded action at least three times after assessments but there was no consideration as to how this would be achieved and by whom.
- 11.6.93 On one occasion Clive was offered a carer's assessment, which he accepted. A referral was made but there is no record that it was received. If it was, it was not actioned. It appears that most of the KMPT staff involved in Emily's case did not understand the provisions of the Care Act 2014 in relation to carer's assessments; if they did, they failed to implement them.
- 11.6.94 KMPT must ensure that its staff understand and implement the provisions of the Care Act 2014 relating to carer's assessments. **(Recommendation 16)**
- 11.6.95 KMPT must establish why the request for a carer's assessment was not actioned in this case and ensure that a robust process is put in place to ensure that future applications are correctly managed, and decisions recorded. **(Recommendation 17)**
- 11.6.96 On 4<sup>th</sup> June, OT2 received a call from a Kent Police officer because Emily had turned up at a police station in distress. Her current state of mind was discussed and OT2 said that she would ask the CMHT to follow up

the next day. When spoken to by a student social worker (SW4) the following day, Emily expressed a wish to meet CPN9. SW4 arranged this but when she called Emily back, she said she had spoken to Clive and no longer needed the appointment.

- 11.6.97 SW4 rearranged the appointment, and on 13 June CPN9 saw Emily at home with Clive and later Maureen. Clive explained that he felt helpless when trying to cope with Emily's distress and had taken time out recently for respite. His absence resulted in Emily and her mother calling the CRHTT and going to a police station. CPN9 found it impossible to maintain the right environment in the meeting with both Clive and Maureen present. She agreed with them that future meetings would be held at a CMHT clinic or a neutral venue. An action was for Emily to engage with KERS.
- 11.6.98 An entry in Emily's notes, dated 14<sup>th</sup> June and made by a consultant psychiatrist (CP3), described CPN9 as her Care Coordinator. If this was the case it was not explicitly recorded in Emily's notes, so other staff may not have been aware of it. This in turn could have led to uncoordinated activity.
- 11.6.99 On 20 June, CPN9 made a referral to a Support Time and Recovery worker, based in the CMHT because the Kent Enablement and Recovery Service had declined to admit Emily. This was good practice; it showed persistence by CPN9 in trying to get Emily relevant help.
- 11.6.100 The same day, Clive called the SPoA and spoke to HCA9. He said he wished to stop involvement with the CRHTT because he no longer wanted them attending his home. He said he was going to trust Emily, who had agreed there was no longer a reason for the CRHTT to attend. Clive then paged the CRHTT and spoke to CPN13, who recorded that he did not want to speak to the CRHTT anymore because the situation had calmed down.
- 11.6.101 This showed that Clive was unaware or confused that it was the CMHT, not the CRHTT, who had been managing Emily's care for over a month. The CRHTT had not been involved with her since then. This illustrates how clear professionals must be when explaining to people, particularly those under stress, exactly what service they are receiving and from whom. The difference between a CRHTT and a CMHT may be obvious to professionals; it is unlikely to register with people suffering from a mental health crisis or acute stress.
- 11.6.102 On 4 July, Emily and Clive were seen by CPN9 at the CMHT clinic. She had stopped taking medication and was spending some of the week with

Clive and an aunt. She was finding the latter a positive experience. CPN9 explained she was unable to conduct routine visits due to resourcing issues at the CMHT. This was confirmed when CPN9 sent a letter to Emily, copied to GPP1, in which she wrote *'Due to unforeseen circumstances, we are currently unable to offer any routine appointments. Please contact the Duty Team on [phone number given] if you need an urgent appointment. We are sorry for any inconvenience this may cause.'*

- 11.6.103 In short, anyone being treated by the CMHT would receive no further care or treatment for an unspecified time, unless they initiated contact in urgent circumstances. Neither Emily nor her family members had further contact with KMPT services before her death.
- 11.6.104 KMPT's involvement with Emily took place during a period of less than four months. During that time, over 30 of the trust's professionals had contact with her face to face or by telephone. There were examples of good individual practice, which have been highlighted as they have arisen in this report. They show dedicated staff were thinking of alternative ways to care for and treat Emily. Where issues have arisen that require action to improve services in the future, recommendations have been made.
- 11.6.105 The staff shortages in the CMHT during the period Emily was in KMPT's care resulted in the failure to appoint a Care Coordinator at an appropriate stage, and the withdrawal of service from her in early July.
- 11.6.106 The appointment of a Care Coordinator, who can be a CPN, a social worker or an occupational therapist, is important if a person is likely to become a KMPT patient for an extended period. Without a Care Coordinator, there will not be a professional who has an in-depth understanding of the case. Rather than a structured care plan, the staff they meet are more likely to deal only with the issues present at that time.
- 11.6.107 The patient may have to explain their symptoms and history each time they have contact with KMPT staff. This may be frustrating and distressing for them and is an inefficient use of the trust's resources. In addition, treatment that has failed in the past may be repeated and professionals from other disciplines, such as GPs, will not have a point of contact with whom to discuss the patient's needs. In Emily's case, the difficult family dynamics made an in-depth understanding even more important. Failing to allocate a Care Coordinator at an early stage was poor practice, albeit brought about by a staff shortage.
- 11.6.108 The decision taken in July 2017 to concentrate on the initial screening of referrals at the expense of the routine care of current patients impacted

directly on Emily. It meant a complete withdrawal of the service being provided to her and ended any support that Clive might have received.

11.6.109 It is not clear at what management level the decision to withdraw routine care and prioritise the screening of newly referred patients was taken. The NHS target of 18 weeks for non-urgent consultant-led referrals applies to mental health patients. There is no target adversely impacted by the withdrawal of routine care and treatment for patients within secondary mental health services.

11.6.110 Staff absence and vacancies are a challenge across the whole of KMPT, but this CMHT was the only one that took such a significant decision. KMPT must consider how it will better manage its resilience in future to ensure that a Community Mental Health Team experiencing a temporary staffing crisis that risks the shutdown of part of its service can be supported and this action averted. **(Recommendation 18)**

#### 11.7 Kent County Council Adult Social Care and Health (Primary Care Mental Health Team and Kent Enablement & Recovery Service)

11.7.1 The KCC Primary Care Mental Health Team (PCMHT) was set up in April 2016. It is staffed by qualified social workers who have undertaken post-qualifying training relevant to providing social care to people suffering from mental health conditions. The team serves people in the community who are suffering from such problems and who need social care support, rather than clinical treatment. There is no time limit applied to provision of social care by the PCMHT.

11.7.2 The PCMHT receives referrals from various sources, e.g. GPs, KMPT (the secondary mental health service provider), and third sector organisations (charities and other voluntary organisations). Referrals may be made to the PCMHT directly or via KCC's central duty service. A referral from KMPT, for example, might be made when a person recovers sufficiently to be discharged back to their GP but is identified as needing social care. If a client's mental health deteriorates, PCMHT staff can refer them to their GP or directly to KMPT if they believe secondary mental health services are needed.

11.7.3 The Kent Enablement and Recovery Service (KERS) was transferred from KMPT to KCC on 1 April 2016. KERS works with people experiencing mental health difficulties to address social care needs over a short period of time (up to 12 weeks). The service supports people in the following ways:

- accessing community resources, groups, activities, clubs and organisations;
- regaining confidence to use public transport, and getting out and about;
- managing uncomfortable social situations;
- enabling independent management of their finances;
- helping them gain confidence with training, education or work-related activities; and
- helping them access housing and benefit advice.

11.7.4 KERS workers are not professionally qualified; they deliver part of a care plan produced by a qualified worker in the PCMHT or KMPT. However, the KERS worker assigned to Emily had attended several safeguarding training sessions.

11.7.5 Emily was referred to the PCMHT by her GP on 31 October 2016, following a recommendation made by KMPT. A PCMHT screening worker spoke to her by telephone on 16<sup>th</sup> November after several failed attempts. Emily gave background information about her historical and current mental health condition. An appointment was made for her to be seen at home and assessed for PCMHT services.

11.7.6 A PCMHT social worker (SW3) met Emily at her Mothers' home on 6 December 2016. She was seen with Clive, who spoke for her most of the time. He also described his circumstances, in which he worked permanent full-time night shifts and then slept for three hours before supporting Emily during the day. SW3 offered him a carer's assessment which he declined. Maureen arrived home towards the end of the assessment and accepted the offer of a carer's assessment. SW3 demonstrated an understanding of carer's assessments, which were offered on first contact. This was good practice.

11.7.7 The outcome of the assessment was that SW3 would refer Emily to KERS. This she did and on the following day, she spoke to Emily by telephone and told her that a KERS worker would be in touch in the New Year.

11.7.8 On 10 January 2017, a KERS worker (KW1) met Emily at home. Clive and Maureen were also present. Emily said she wanted to be able to go out without having to rely on her parents or best friend. She agreed to work with KW1 on graded exposure and social inclusion.

11.7.9 On 31 January, KW1 met Emily at home again, intending to complete a goal plan to establish what success would look like. Clive was present

and speaking for Emily, who was very emotional. KW1 decided not to complete the plan then but to meet her again and go out. They met on 9<sup>th</sup> February, when KW1 recorded that Emily was much more positive. The goal plan was completed, and Emily apologised for not speaking up at the previous meeting due to being in a low mood.

- 11.7.10 Emily was next seen by KW1 on 2 March, when they walked to the local town centre. She said her mood had lifted and agreed to graded exposure work on the bus at the next meeting. This took place a fortnight later and went well.
- 11.7.11 On the day of the next planned meeting, 6 April, Clive phoned KERS and spoke to a worker: it is not recorded whether this was KW1. He said that Emily did not want to go out, was suffering from anxiety and had been *'really bad'* for the previous couple of weeks. When he tried to hand Emily the phone at the KERS worker's request, Emily screamed "*I don't want to speak to her*". Clive said, "*This is what I have to deal with*". The KERS worker recorded that she told Clive if Emily would not come out, she would close her case to KERS services, but she could be referred again when she is ready to go out with support. The KERS case was then closed.
- 11.7.12 SW3, who had referred Emily to KERS, was not consulted or told about her case being closed. She found out on 11 April, when one of her colleagues spoke to Maureen. SW3 then spoke to Emily by telephone later that day and Emily said that she had been ill on the day of the last planned KERS meeting and was confused about why it had stopped. She thought it may have been because she was being referred to KMPT. SW3 explained that KERS can provide its service to people who are engaged with primary or secondary mental health providers. Given what Emily told SW3, there was a missed opportunity to contact KERS and find out why they had closed her case.
- 11.7.13 SW3 made enquiries with KMPT because Emily's case was still open to the Primary Care Mental Health Team and she (SW3) wanted to discuss whether primary or secondary services were most appropriate. On 20<sup>th</sup> April, SW3 spoke to a KMPT CPN, who advised that Emily's case was currently being managed by the KMPT Community Mental Health Team (CMHT) and was awaiting the allocation of a Care Coordinator.
- 11.7.14 SW3 made the decision to close Emily's PCMHT case because she was now being treated by the CMHT. She suggested that the CMHT should offer Clive the opportunity to reconsider having a carer's assessment. This showed a continuing appreciation by SW3 of Clive's situation and how an assessment might produce results that would benefit him and

Emily. SW3 also said that Emily had previously agreed to KERS intervention and that if she wished to consider reengaging, the CMHT could make a direct referral.

- 11.7.15 On 8 June, a KMPT occupational therapist referred Emily to KERS. A senior KERS worker (SKW1) declined the referral because she had been referred previously. He added that there was no current care plan for Emily and previous work had been undertaken around graded exposure, travel training and volunteering/work, so the acceptance of the referral would be inappropriate.
- 11.7.16 There was further email correspondence between the KMPT occupational therapist and SKW1 during the next week. SKW1 confirmed his reason for not accepting the referral and offered a meeting to discuss Emily's case further. The response from the occupational therapist suggests that she either did not receive or did not understand SKW1's replies or rationale, although she said she would endeavour to prepare a care plan.
- 11.7.17 The KERS response began well; KW1 gained Emily's confidence and reported that meetings went well. However, there was no clear rationale as to why her case was closed. KW1 was aware that Emily's moods fluctuated, although it is not clear if she (KW1) was the person who made the decision or whether she was consulted about it. In any event, there was no consultation or communication with SW3, who had referred Emily to KERS.
- 11.7.18 KERS has operating protocols that include a section on closing cases. It sets out the issues that will result in a case being closed, one of which is *'Non-engagement with the [KERS] team or declining a service'*. While the KERS worker may have felt that Emily met that criterion by refusing to speak on that occasion, there was no reason to close her case without a further attempt to engage her, or before discussing her case with SW3. The operating protocol states *'...that where possible [the reasons for closing the case] will be discussed with the [client] and referrer'* - the opportunity to do this was missed.
- 11.7.19 At the time of the case closure, neither SKW1 nor KW1 had received formal training about the KERS operating protocols, although the former had read them as part of his induction after joining the organisation. He assumed that KW1 had also read them. All KERS workers have now received two training sessions on the operating protocols, held in May and November 2017.

- 11.7.20 SKW1's decision not to accept the later referral of Emily by the KMPT occupational therapist showed a lack of flexibility. He was right to say that she had received some enablement service, but she had failed to complete this, having initially engaged well. While SKW1 did offer to meet the occupational therapist, it appears he had already made the decision that she could not have further KERS service.
- 11.7.21 SKW1 was new in post at the time and his decision was informed by his understanding of the protocols, coupled with his interpretation of the circumstances of the closure. He did not realise that Emily had not completed her KERS course or that KERS had not consulted the referrer before closure. This may have inhibited his professional judgement and discretionary decision making.
- 11.7.22 KERS must ensure that its staff who make decisions about referrals and case closures understand both the requirements of the operating protocols and the full circumstances of a case before making decisions.  
**(Recommendation 19)**
- 11.7.23 Neither the PCMHT or KERS were made aware of anything that suggested there were domestic abuse or safeguarding issues relating to Emily.

## 11.8 Porchlight

- 11.8.1 Porchlight is a Kent-based charity that was established in 2007 to encourage the local community to support homeless people. Since then, it has expanded to provide other support services, which include mental health, young person's supported accommodation, family support and help with jobs, education and training. Porchlight now provides services outside of Kent: in the London Borough of Bexley and in East Sussex.
- 11.8.2 People can access Porchlight via its free 24-hour helpline. Calls are recorded and the call taker has access to a bespoke computer system, which allows free text entries to be made. These entries are timed and dated; the system also includes tags and prompts to assist the call taker. In addition to the helpline, people can access some of Porchlight's services, e.g. supported accommodation, by completing a referral form and emailing it to the charity. Other agencies can: recommend a client to contact Porchlight; or make a referral and ask Porchlight to contact the client.



- 11.8.3 Porchlight had telephone contact with Emily on several occasions. The first was on 29 April 2017 when she spoke to an Advice and Information Worker (PW1). She said she had been advised by the '*crisis team*' to contact the charity. She said that due to tensions with her mother, she could not continue living at home and was seeking alternative accommodation.
- 11.8.4 When a person calls the helpline, the call handler carries out initial screening to establish if Porchlight can provide support and if so, which of its projects is appropriate. The computer system prompts assist in ensuring that the person gets the appropriate referral or advice. Dependent on the answers given and the needs of the client, Porchlight may either refer them to one of its projects or signpost them to alternative services.
- 11.8.5 As a result of this initial screening, Emily was referred to Porchlight's young persons supported accommodation project, known as 'Seventy-Four Seventy-Six', which caters for the age range 16-24 years. This project does not offer emergency housing; it cannot provide immediate accommodation. Emily would have joined a waiting list and be asked to attend a formal assessment of her needs and eligibility for the service. Porchlight understand the need to manage clients' expectations; it was explained to Emily that alternative accommodation was neither immediate nor guaranteed.
- 11.8.6 On 3 May 2017, Emily called the helpline again and said she no longer needed alternative accommodation. She did not explain the reason for this. A week later, she called the helpline several times. On each occasion she spoke to PW1. She was emotional and tearful during these calls and said she felt unsupported. The theme of the calls was her wish for someone to go to her home and help her, which is not a service that Porchlight can provide.
- 11.8.7 PW1 identified that Emily had mental health problems and offered to refer her to Live Well, a community wellbeing and mental health delivery network that works across Kent. In some Clinical Commissioning Group areas in Kent and Medway, Porchlight provide the Live Well service. In others, including that covering Emily's home address, it is provided by the Shaw Trust, another charity that supports people in need. At the time, Porchlight had access to the Shaw Trust's computer system and could make a referral using this.
- 11.8.8 PW1 also suggested to Emily that she could contact Release the Pressure, a 24/7 telephone and online service run by Kent County

Council, which helps people with emotional problems. PW1 identified appropriate support services for Emily, offering to make a referral in one case and providing contact details in the other.

- 11.8.9 PW1 was sufficiently concerned about Emily's mental health and wellbeing to make an email referral to the [Central Referral Unit \(CRU\)](#). This was the appropriate way for Porchlight to make a referral to KMPT, the secondary mental health service. In the email, he set out his concerns about her mental health. He had asked her about suicidal thoughts and self-harm, and although her replies were negative, her presentation gave him cause for concern. He included the Porchlight helpline number in the CRU referral for use if further details were required. Both the questions asked of Emily and the referral were good practice.
- 11.8.10 Porchlight did not receive confirmation that the email had been received or read, or the result of any action taken (the referral was received, and CRU staff decided it did not constitute a safeguarding alert). Having received the email, the onus was on the CRU to update Porchlight on its decision. However, if Porchlight do not receive a response within a reasonable time in such cases, it may be that a follow up email or phone call would be appropriate to confirm receipt.
- 11.8.11 On 12 May, PW1 called Emily who said she had spoken to social services and they could not help her. He explained that he would be sending a referral to Live Well, Kent.
- 11.8.12 On 23 May, PW1 phoned Emily again because he needed further information for the Live Well referral, which had not yet been made. Emily's phone went to voicemail, so he left a message asking her to contact Porchlight. Emily did not respond to the voicemail request.
- 11.8.13 Between that date and 31 May, 11 calls were made to Emily by Porchlight staff. On most occasions, a voicemail message was left. Emily did not call Porchlight again and after 31 May, her case was closed.
- 11.8.14 The action taken by PW1 in response to the calls made by Emily was comprehensive and appropriate. This included following up the call she made on 11 May.
- 11.8.15 When PW1 recognised he needed further information to complete the referral to Live Well, he and other Porchlight staff tried numerous times to contact Emily without success. Porchlight have a practice of attempting contact three times before closing a case but went beyond

this in her case. Closing the case following these attempts was appropriate.

- 11.8.16 Porchlight gave Emily a service that was appropriate to her known needs. She disclosed family tension, specifically with her mother. This was the reason she first contacted Porchlight seeking alternative accommodation. Family tension is not the same as domestic abuse and what Emily disclosed did not constitute domestic abuse. However, when people are seeking support, particularly something as significant as alternative accommodation, consideration should be given to exploring with them what the family tension involves, as in some cases it might constitute domestic abuse. This may have been done but if so, it was not recorded.
- 11.8.17 Porchlight should consider whether an appropriate prompt can be included in the initial screening for the call handler to consider domestic abuse. **(Recommendation 20)**

## 11.9 Kent Police

- 11.9.1 Kent Police had its first recorded involvement with Emily and Clive in April 2017, about three and half months before Emily's death.
- 11.9.2 On the morning of 9 April, Clive called Kent Police via the 999 system from the house where Emily lived with her mother. He explained that Emily had mental health issues and had lost control. He added that he had locked himself in a room to make the call and the call handler could hear Emily shouting in the background '*Let me in*'.
- 11.9.3 Police went to the house and found the situation had calmed down. They provided Clive with a contact number for the KMPT Crisis Team (CRHTT). About three hours later, Clive called Kent Police again via 999 from the house. The gist of the call was that he could not cope with Emily.
- 11.9.4 Police again attended but as Emily was not presenting a danger to herself or others and she was indoors, there was nothing they could do. A Kent Police call handler rang Clive later: he said the situation was under control and the CRHTT were going to attend about 5pm that day. Providing the CRHTT contact number then calling back to update and check on the situation was good practice.
- 11.9.5 In the early hours of 22 April, Emily telephoned Kent Police via 999 from her home. She was there with her mother and a friend, but she wanted her father. She described feeling helpless and said her home situation

was falling apart. The call handler spoke to Maureen and confirmed that Emily had not harmed herself.

- 11.9.6 Police attended; they confirmed that Emily was not alone and had not harmed herself. She was described as feeling anxious and wanting her father. The police officers contacted the duty CRHTT. Kent Police responded to and dealt with the call appropriately.
- 11.9.7 During the day on 29 April 2017, Kent Police received a call from Catching Lives, a homeless charity, which had in turn received a call from Emily, who was in a distressed state. No police patrols were available to attend Emily's home, so a message was left on Clive's phone for him to call Kent Police. Emily was also called, and the situation was explained to her.
- 11.9.8 Clive called Kent Police later. He stated that he needed '*...to keep away from Emily for a while, she constantly needs help from him and he can no longer cope.*' Kent Police contacted the CRHTT and recorded '*CRHTT have stated that there is nothing for police, this is a mental health issue and they are continuing to deal with it. They have asked that a note be put on the [Kent Police call handling] system that if Emily calls in again, unless she is in immediate danger then to refer her to [CRHTT].*' As a result, when further calls were received that day from Emily, stating she wanted to see Clive, no further action was taken after confirming her mother was with her.
- 11.9.9 The next call from Emily was on 11 May 2017 and she was again very distressed. She said that Clive normally looked after her and that she could not be left with her mother, who also suffered from severe anxiety. Clive had left the house and said he would not be coming back that day. Kent Police contacted CRHTT, who had also received calls from Emily that day.
- 11.9.10 In the early hours of the following day, Emily called Kent Police and said that she felt the CRHTT were not offering the support she needed. The call handler confirmed Maureen was with her. That evening, Emily reported Clive missing. A short time later he called Kent Police and stated he '*...just needed to get away and was staying with friends. It was not the first time Emily had reported him missing. Emily has everyone trying to help, it seems that she feels that [Clive] needs to be at home all the time.*'
- 11.9.11 During the evening of 24 May, Emily telephoned Kent Police from Clive's home. She said he had left the property because he was unable to cope. In the early hours of the following morning, Emily and her mother went to

a Town B police station. Clive was contacted but declined to become involved. Kent Police established that appropriate organisations were involved in Emily's care and she left in a taxi with her mother.

- 11.9.12 Kent Police received their next call relating to Emily nearly two months later, on the morning of 18 July. Maureen called and said that Clive had been to her house and taken Emily. She had gone with him willingly, but Maureen had tried to prevent it and Clive had struck her on the arm. Emily and Clive went to Town A police station a few hours later and he told staff there that he had picked Emily up from her mother's home earlier at Emily's request. They had left without her medication and he asked if a police patrol could collect it. This was done, which was a good example of Kent Police trying to assist.
- 11.9.13 Later that evening Maureen called Kent Police saying someone had been banging on her door. The following morning, Maureen reported Emily missing. She was known to be with Clive, so Kent Police took no further action. Later that day, Clive and Emily went to Town A police station where he expressed concern about Maureen who had screamed at him when he called on her the previous evening.
- 11.9.14 That evening and the next day, 20 July, Kent Police received calls from Clive's brother Garry and his wife Sarah. These were about numerous calls they had received from Maureen, who accused them of having Emily locked up in their home. Sarah said in one call that Maureen had threatened her.
- 11.9.15 During the morning of 21<sup>st</sup> July, Kent Police reviewed the calls involving Maureen and concluded that the threat made to her did not raise any immediate concerns and was '*...probably just made in the moment.*' A check made with CRHTT made by Kent Police showed no record of Maureen.
- 11.9.16 About 2pm that day, Maureen went to Town A police station and reported that Clive had tried to kill her. About half an hour later, Clive went to the police station and said that he killed Emily. Police officers went to his home, where they found Emily's body.
- 11.9.17 The interactions that Kent Police had with Emily, Clive, and Maureen confirmed Emily's mental health problems, that Clive was struggling to cope with these and that there was tension in the family. The number and nature of the calls between the first contact with Kent Police in April 2017 and Emily's death indicated that the situation was deteriorating. However, there was nothing in the involvement that Kent Police had with Emily and

her parents or the information they received from the CRHTT that would have given rise to concerns that Clive was going to harm her.

11.9.18 The telephone calls made to Kent Police were recorded; the recordings were available to the review. They confirm that appropriate questions were asked, and risk assessments were undertaken, with sign posting to appropriate agencies and direct contact by police when necessary. Call handlers showed empathy to the needs of Emily, Clive and Maureen in sometimes difficult circumstances.

11.9.19 In considering whether domestic abuse took place, the incident on 19 July where Maureen alleged that Clive struck her arm fitted the definition of domestic abuse. However, the circumstances of it were not part of a pattern of abuse involving any element of control or coercion and were indicative of family conflict. There is nothing in Kent Police's records of involvement with Emily and her parents that suggested Clive was likely to harm her.

## 11.10 Further Education College

11.10.1 The Further Education College that Emily attended specialises in land-based education, such as horticulture and animal management. It has five campuses across Kent and Greater London. Emily was a student at the college between September 2013 and July 2016.

11.10.2 Although the establishment is a mainstream college, over a third of the students attending the campus where Emily studied have mental health issues and/or special education needs. The college welcomes applications from such students; it has experience of helping and supporting them to study towards the qualifications it offers.

11.10.3 Emily applied to the college to study for a Level 3 diploma in animal management, a qualification that is equivalent to an A level. Her GCSE results qualified her for the course and her application was successful. Her mental health issues were disclosed in her application and the college's Learning Support Co-ordinator (LSC) was present at her interview, as were Clive and Maureen. She was described as very tearful during it. The LSC felt that Emily's CAMHS nurse (see sub-section 11.2 above) played a key role in supporting her application.

11.10.4 When Emily embarked on the course it soon became clear that the difficulties she had with social interaction meant, despite her academic aptitude, she would be unable to continue it. It became obvious she was not used to mixing with people of her own age and although college staff

encouraged her to become involved, she did not have the level of communication skills necessary for such a course.

- 11.10.5 Having identified that the Level 3 course was beyond Emily, she was offered the opportunity to switch to a Level 1 diploma. Academically, this course is at pre-GCSE level, but it offered more support to students with challenging issues from within the college's resources. It required less social interaction (Emily's major issue) and the tutor groups had less students.
- 11.10.6 The college's experience with students who have challenges means that it can offer some level of additional support, such as a quiet room, mentors and a support card system. These were offered to Emily, but it was felt that her condition meant she would benefit from further support. The college therefore made a Learning Disabilities Assessment application to Kent County Council for 14 hours of one to one support for Emily during college time, and a further three hours of one to one support outside of the course to cover mentoring and social support. The application was rejected by KCC, who felt the college had not fully explored additional support from within its own budget.
- 11.10.7 With support from the college, Emily completed the Level 1 diploma. Her academic ability ensured that she passed the examination with ease. She then enrolled for the Level 2 diploma, beginning in September 2014. In October that year, the college's LSC met with Clive, with Emily present. They disclosed that her CAMHS nurse was leaving the service and that family therapy had broken down. College staff were aware of tension between Emily's parents, on one occasion witnessing evidence of this in the reception area.
- 11.10.8 In June 2015, college staff endorsed the [Education, Health and Care Plan](#) application made by Clive (see sub-section 11.4 above). EHCPs had replaced the Learning Disabilities Assessments, one of which had been submitted soon after Emily arrived at the college. The EHCP was also refused.
- 11.10.9 Emily completed the Level 2 Diploma course in July 2015 and passed the examination with distinction. It was felt that the social interaction requirements of the Level 3 course were still beyond her, so in September 2015, she embarked on a gateway to employment course at the college. She struggled with this course but did form a friendship with a fellow student, seeing her outside college and sharing sleepovers. Part of the course involved two weeks work experience which Clive attended throughout with her.

- 11.10.10 During her time at the college, Emily was very reserved and had difficulty communicating with her peers. When her coursework required her to seek advice or instruction, she found this very difficult and would often 'freeze' until she was approached. She was not disruptive and found it easier to talk to adults. She wanted to form friendships but had no experience of this when she came to the college. Staff feel that the friendship she did form with a fellow student was helpful.
- 11.10.11 College staff witnessed the relationship between Emily and Clive over a more sustained period than any other agency. They knew he worked nights and then drove Emily to college, staying there and sleeping in his car before driving her home. He described himself as 'pulling his hair out' and staff advised him to visit his GP because he appeared so unwell. He shared some of his concerns, including guilt about whether he had contributed to Emily's condition and his worries about what would become of her if he could no longer support her. He told staff that Emily relied on him and expected him to be there and find things for her to do.
- 11.10.12 Staff at the college worked hard to support Emily and despite times when she felt she could not continue, she was encouraged to do so and completed three years there, leaving in July 2016. Staff there saw the strain that Clive was under, but he appeared to be a loving father who cared for his daughter and did everything he could to support her. There was nothing to suggest domestic abuse or safeguarding concerns.

#### 11.11 Kent County Council Children Young People and Education – (Education Safeguarding Team)

- 11.11.1 Clive worked at a residential special school. The school has a mix of day pupils and weekly boarders. At the time of Emily's death, Clive had completed 30 years' service at the school, all of which had been spent working in the care team.
- 11.11.2 KCC's Education Safeguarding Team (EST) was asked to contribute to this DHR to consider whether Clive's employer had any concerns about his behaviour, which may have indicated that he was considering harming Emily. The school had no contact or involvement with her.
- 11.11.3 In April 2014, Clive successfully applied for a night staff position at the school, having previously worked day shifts. His manager believed the reason Clive wanted to work nights was to support his daughter, who would soon be starting college. He did not refer to Emily's mental health problems, which reflected the fact he did not talk openly about his family



at work. At that time, he did not discuss being under any pressure in his private life.

- 11.11.4 Clive became a member of a team of six or seven night-staff. He was on a four-weekly shift rota, working 37 hours a week, including one weekend in four. His job involved supporting boarders at the school at night, responding to them if they woke. He also carried out administrative and light domestic tasks.
- 11.11.5 The school had no indication of the pressure that Clive was under at home until 2017. In January of that year, he and other staff at the school were told that some posts would be subject to redundancy and were asked to consider voluntary redundancy. Clive expressed the wish to take this, but in the summer term between 17 April and Emily's death in July he was told that this job was safe, and the redundancy offer was withdrawn.
- 11.11.6 Clive's attendance record had been good until April 2017. He was then absent for 26 working days, from the start of the summer term in April until mid-June. Doctor's notes stated the reason for this absence was stress related problems. His managers understood that this was due to family matters, specifically problems with his daughter.
- 11.11.7 The record of the return to work interview with Clive does not detail what was discussed or any support given to Clive. A subsequent supervision meeting held in early July does not evidence discussion about the absence, or any support offered. The school buys in a staff support service offering a helpline and counselling services. The return to work interview template refers to this but there is no record on the form completed for Clive's interview as to whether this was discussed or offered.
- 11.11.8 At the time of Clive's extended absence, the school had a current and comprehensive staff absence policy which covered referrals to the contracted occupational health service. The policy stated that after an absence of six weeks managers should consider whether a referral would be appropriate. Clive's absence was for less than six weeks and there is no record that a referral was considered or discussed with him.
- 11.11.9 On 20 July, Maureen telephoned the school and said that Clive had kidnapped Emily. The school's designated safeguarding lead took advice from the Education Safeguarding and Local Authority Designated Officer Teams and when Maureen called back, she was advised to contact the

police. The school were unable to speak to Clive about the event that day; the following day he killed Emily.

- 11.11.10 The Headteacher of the school described a significant level of stress generally in the school's caring team during the relevant period in 2017. This was due to budget restrictions and difficulty in recruiting staff with the skills and experience required for extremely demanding care roles.
- 11.11.11 Clive's managers and colleagues described him as a valued member of staff who was good at his job. He had a vast amount of experience in his role. In the months preceding Emily's death, he had agreed to alter his shifts so that he could support a young man who responded particularly well to his care. This allowed him to work one less weekend night. His manager reported that young pupils at the school enjoyed listening to Clive playing his guitar to them, something he was not required to do.
- 11.11.12 Clive's employer had no detailed knowledge of the fact that, before her death, Emily had serious mental health problems. In common with many employees, Clive did not discuss his private life at work, with colleagues or managers. Although he repeatedly told mental health service staff that he was effectively at the end of his tether, there is no evidence that anything about his work environment was a factor in him not disclosing this to his supervisors.
- 11.11.13 The fact that he decided to take voluntary redundancy, but the option was removed might have added to his feelings of stress, but he did not articulate this.
- 11.11.14 Clive's experience of caring for young people pre-dated Emily's birth. While this might have helped him to manage her problems when they became apparent, the increased stress on staff at the school, coupled with Emily's worsening condition, meant that latterly his waking hours were filled with the most challenging interactions.

## **12. How Organisations Worked Together**

- 12.1 If organisations that are involved with domestic abuse victims work well together, the risk of harm is reduced by sharing information and ensuring support is provided by the most appropriate organisation(s). It also makes the best use of limited resources. The success of inter-agency working relies on effective communication to ensure that each organisation knows when its services are required and has the information on which to base decisions about action it might take.

- 12.2 There were two instances where there was either evidence or allegations of assault, the first by Clive on Emily, the second by Emily on Maureen. The first was more serious and the failure to explore it further is subject of a recommendation. The only recorded occasion when Emily said she felt unsafe, she was referring to times when Clive was not present.
- 12.3 Similarly, there were no significant safeguarding issues identified by agencies, or apparent during the review. The report has highlighted occasions when more professional curiosity could have been shown about safeguarding but even with hindsight, there is no evidence that the lack of this resulted in a significant issue going undetected.
- 12.4 The family circumstance in this case was of an adult with mental health issues being cared for by her parents. The inclusion of specific provisions in the Care Act 2014 relating to carer's assessments is a recognition that this was not a situation that would previously have generated a formal multi-agency response, unless there were safeguarding concerns. The Act introduced a formal process for carer's assessments, which the local authority has a duty to conduct if the criteria are met. All agencies who might be involved with families that have a carer or carers need to understand the provisions of the Act and share information with the local authority to ensure that they can discharge their duties in this regard.
- 12.5 There is evidence in the review that there is patchy understanding across agencies of the Care Act provisions relating to carer's assessments. This is an area in which multi-agency training led by local authorities (where the duty and therefore most expertise lie) would be beneficial.
- 12.6 Although the family circumstance was one which would not trigger multi-agency working in the way that domestic abuse or safeguarding might, there is little doubt that if a representative from each agency subject of this review who had involvement with Emily and/or Clive had met in a room and discussed the case, all would have left knowing more and there would potentially have been more effective action taken to address the needs of both. Any one of the agencies involved with Emily could have invited other agencies to a professionals meeting once it was established which were involved with her.
- 12.7 The review panel recognises that the number of cases to which this could apply is such that meetings of this nature cannot be held for all. Value in the most serious cases is improved client outcome and more focused resource expended in achieving it. A risk-based approach is required. Had that approach been taken, the fact that Clive's whole life was spent caring for people, coupled with his repeated assertions that he could no longer cope with Emily's needs, may have been enough to have provided the family with more support.

## 13. Conclusions

- 13.1 This was a tragic case because all the information available to the review both from agencies and family members, suggests that Clive loved Emily and was devoted to trying to provide the best care he could for her. There is no evidence that she was the victim of domestic abuse at any time before the act that led to her death. Equally, there is nothing to suggest that Clive had planned her death.
- 13.2 Two incidents that may have been physical assaults are highlighted in the review, one committed by Clive, the other by Emily. Both fit the definition of domestic abuse but neither Clive nor Emily could be described as domestic abusers. The incidents were minor and took place in a very stressful family environment. What separates family conflict from domestic abuse is coercion and control of one party by another. There is no evidence of deliberate coercion or control in this case.
- 13.3 When sentencing Clive, the trial judge said to him *'In any view, Emily had considerable needs. You supported her, as any good father would, and you spent a vast period of time with her. You tried to seek out the best treatment possible. You tried to the best of your ability and within the framework of the income you had.'* No information available to this review contradicts that.
- 13.4 The involvement of individual agencies is considered in detail in section 11 and recommendations are made where it appears there are opportunities to improve the treatment, care and service provided in future. However, two key issues arise from this case. First, the treatment and care available to people living in the community who suffer from chronic mental health conditions. Second, how agencies can better identify and support carers who are suffering from stress and approaching a point where they can no longer cope.
- 13.5 Emily had suffered from mental health issues for which she had received treatment since she was a child. She was treated by CAMHS and her discharge before she reached adulthood was appropriate.
- 13.6 There is evidence from staff at the college she attended that her anxiety, particularly around relationships with her peer group, was severe. This was to the extent that she could not study for a qualification she would have almost certainly gained based on her academic ability.
- 13.7 It was after leaving college that Emily's mental health deteriorated to a point where she needed support from Kent and Medway NHS Social Care & Partnership Trust (KMPT), the secondary mental health provider in Kent. She came under KMPT treatment and care when her local Community Mental Health Team was facing a dire staffing situation, which ultimately led to it withdrawing service from current patients. Patients were able to contact

the Crisis Resolution and Home Treatment Team if in crisis but by this time Emily was in crisis almost daily. She needed a coordinated and sustained approach to her treatment and care, and this was withdrawn from her.

- 13.8 The decision to do this was not based on individual patient need; there is no evidence that a risk assessment was carried out on patients before the decision to withdraw treatment and care was made. The review does not draw conclusions from the proximity of the decision, taken in early July 2017, to Emily's death less than three weeks later but it would have been clear to her (and Clive) that any coordinated treatment she was receiving was being withdrawn.
- 13.9 NHS staff, from those delivering services to patients through to senior leaders, are facing the challenge of increasing demand on limited resources. This has been building for several years and continued as this review was conducted. Difficult choices are having to be made and deciding to withdraw a service provided by the CMHT that was treating Emily was one of those. It is important that individual patient care is demonstrably the overriding factor.
- 13.10 Through no fault of Emily's, caring for her placed great demands on Clive. She craved his presence and attention, relying on him to organise her life. The strain he was under increased as Emily grew older and his change to night working shows that he was doing his best to adapt to her needs.
- 13.11 There was frequent reference by professionals dealing with Emily about the tension between her parents. There is no evidence that this was explored after family therapy was abandoned in early 2014 and this may have been because as an adult, the role of her parents in her life ceases to have the significance for professionals that it does for children and adolescents. However, as her parents were her carers, some support might have been helpful.
- 13.12 Caring for a loved one with a long-term illness, physical or mental, can be very demanding. This has been recognised and the Care Act 2014 places a duty on local authorities to assess whether a carer has support needs. Identifying these is fundamental to ensuring that the person with care needs is safeguarded. S.10 of the Act sets out the duty in relation to an adult caring for another, S.58 does this for carers of children who are likely to require continuing care after they reach the age of 18 years.
- 13.13 The Act places the duty to conduct carer's assessments on local authorities, but all agencies with a responsibility for safeguarding children and adults must be aware of its requirements. For example, the police or a health agency may become aware of concerns about a carer's resilience or ability to cope before the local authority. They should then make a referral.

- 13.14 For months before Emily's death, Clive had been telling professionals that he could no longer cope. His work involved caring for children with special needs, so most of his waking life was spent caring. When Emily left college, the support she had there and the relief this gave Clive stopped.
- 13.15 The agencies that engaged with Clive, either directly or as Emily's father and carer, knew that he was under strain because he told them. Opportunities were missed to offer him a carer's assessment and when he accepted an offer, it was not followed through. The tragic outcome of this case must reinforce to agencies the value of carers who provide a vital part of the treatment, care and support of those suffering serious, chronic health conditions both mental and physical. Failing to consider the carer's needs could have a serious adverse effect on the patient.
- 13.16 As well as these key issues, there are some other considerations that do not lend themselves to recommendations, but which are worthy of reflection and consideration.
- 13.17 There was frequent reference by professionals dealing with Emily about the tension between her parents, who were her carers. This was relevant enough to be recorded on numerous occasions, but no agency sought to address this by speaking to them about it separately or together. The tension that was evident in the presence of professionals and Emily, would almost certainly have been taking place in the home. The significance of tension between carers looking after a person suffering from extreme anxiety seems to have been lost.
- 13.18 Family therapy was abandoned in early 2014 because of the tension between Emily's parents. Once she became an adult, the role of her parents in her life ceased to have the significance for professionals that it does for children and adolescents. However, as her parents were her carers, some support for them might have been helpful.
- 13.19 Emily was spoken to with Clive present on many occasions and it is positive that some professionals recognised that this was not always helpful. Others made no attempt to speak to her alone and while she wanted him present, this indicated a lack of appreciation of safeguarding issues. In addition, it would have encouraged dependency on him, which in turn may have increased the strain he was feeling.

## **14. Lessons Identified**

### **14.1 Professionals must understand that the demands of caring for a loved one can place such strain on a carer that tragic consequences may result.**

14.1.1 The strain that Clive was under is a significant issue in this review and professionals must recognise that such pressure may put both the carer and the cared for at risk.

14.1.2 The provisions of the Care Act 2014 relating to carers must be understood and implemented by professionals dealing with cared for people.

### **14.2 Professionals should seek to speak to patients, clients and service users alone for at least part of their consultation whenever possible.**

14.2.1 This may not always be possible because the patient, service user or client may not wish to be alone. Professionals should respect this but be alert for any indication that they are being pressured into this decision. The aim is not to exclude family or others who care for the person but to ensure that the person's safeguarding is not at risk.

### **14.3 Professionals must not assume that patients, clients or service users understand the structure of the organisation providing them with treatment, support or service.**

14.3.1 Professionals must ensure that patients, clients and service users understand what service they are receiving and from whom. The difference between departments and teams in an organisation will be clear to those working in them but not to a person suffering the strain of a traumatic incident or chronic condition.

### **14.4 Organisations must consider the impact that service withdrawal may have on individuals and carry out risk assessments where appropriate.**

14.4.1 Withdrawing services from someone currently using them may have serious implications for that person. Organisations must ensure that patients, clients and service users understand what it will mean for them and how they can access the service in an emergency or crisis.

## 15. Recommendations

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

	<b>Paragraph</b>	<b>Recommendation</b>	<b>Organisation</b>
1.	11.3.25	Clinical Commissioning Groups in Kent and Medway should advise GPs of the need to share any information they may receive about a patient who is being treated by KMPT, if that information might be relevant to the patient's mental health treatment or risk assessment.	Kent and Medway CCGs
2.	11.3.42	CCGs in Kent and Medway must ensure that GPs are aware of the legal framework and their duties in assessing the mental capacity of their patients, which takes into account the legal position of parental responsibilities.	Kent and Medway CCGs
3.	11.3.44	CCGs in Kent and Medway must ensure GPs discuss with a patient who has mental capacity, the potential implications and side effects of medication they intend to prescribe that patient, regardless of whether the patient has consented to details of their case being discussed with another person.	Kent and Medway CCGs
4.	11.3.46	CCGs in Kent and Medway must include the provisions of the Care Act 2014 relating to carer's assessments in local GP training.	Kent and Medway CCGs
5.	11.4.6	EHPS must remind staff of the importance of asking for consent from clients to allow information to be obtained from GPs and other relevant services, to better inform ongoing action.	EHPS



6.	11.4.21	EHPS should examine this case to identify the shortcomings and missed opportunities. It should then confirm that changes have been made to ensure the voice of the child is clearly heard under the transformed service.	EHPS
7.	11.5.14	In every initial assessment, the Thinkaction assessor should ask for the person being assessed to agree to a short time alone with the assessor.	Thinkaction
8.	11.5.15	Thinkaction should consider including a heading of 'Domestic Abuse' on its assessment form to prompt the assessor to consider this as a specific issue.	Thinkaction
9.	11.6.24	KMPT must ensure CMHTs participate in conference calls with the SPoA.	KMPT
10.	11.6.40	KMPT should review its use of fax as a method of communication and seek to phase it out as soon as possible.	KMPT
11.	11.6.43	KMPT must ensure that access to its Psychological Service is based on the needs of a patient, not on an administrative process.	KMPT
12.	11.6.49	KMPT must review its procedures to ensure that it is clear to their staff what action must be taken when a patient discloses information that causes their risk to be raised to High.	KMPT
13.	11.6.55	KMPT must ensure all its consultant psychiatrists have a clear understanding of how safeguarding should be incorporated into their assessments and the actions they should take if concerns arise.	KMPT

14.	11.6.69	KMPT must change its Single Point of Access webpage to ensure that it is immediately clear to those with urgent or emergency mental health needs, what number they can call or text to receive the help they need at that time.	KMPT
15.	11.6.78	KMPT must ensure that clinical professionals and public facing staff understand the Approved Mental Health Practitioner service referral criteria in order that they can advise patients and service users correctly.	KMPT
16.	11.6.94	KMPT must ensure that its staff understand and implement the provisions of the Care Act 2014 relating to carer's assessments.	KMPT
17.	11.6.95	KMPT must establish why the request for a carer's assessment was not actioned in this case and ensure that a robust process is put in place to ensure that future applications are correctly managed, and decisions recorded.	KMPT
18.	11.6.111	KMPT must consider how it will better manage its resilience in future to ensure that a Community Mental Health Team experiencing a temporary staffing crisis, that risks the shutdown of part of its service, can be supported and this action averted.	KMPT
19.	11.7.22	KERS must ensure that its staff who make decisions about referrals and case closures understand both the requirements of the operating protocols and the full circumstances of a case before making decisions.	KERS
20.	11.8.17	Porchlight should consider whether an appropriate prompt can be included in the initial screening for the call handler to consider domestic abuse.	Porchlight

# **Kent & Medway Domestic Homicide Review**

## **Victim – Emily Dale**

### **Terms of Reference**

*These terms of reference were agreed by the DHR Panel following their meeting on 22 September 2017.*

#### **Background**

In July 2017, Emily Dale, aged 19 years, was found dead in a house in Kent, which was the home of her father, Clive Dale. Clive had earlier been arrested on suspicion of the Emily's murder and the attempted murder of Emily's mother, who was his ex-partner. Clive was subsequently charged with these crimes.

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 6 September 2017. It agreed that the criteria for a DHR have been met and, the Chair of the Kent Community Safety Partnership confirmed that a DHR would be conducted.

That agreement has been ratified by the Chair of the Kent Community Safety Partnership 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 Emily Dale.

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, Emily Dale, and the alleged perpetrator, Clive Dale.

### **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 Emily and/or Clive in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. The DHR Panel will decide 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 Chairman.

IMRs and reports will be prepared by an appropriately skilled person who has not had any direct involvement with Emily or Clive, 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 Emily or Clive from 1 January 2014 to the date of Emily's death in July 2017. If any information relating to Emily being a victim, or Clive being a perpetrator, of domestic abuse before 1 January 2014 comes to light, that should also be included in the IMR.

Information held by an agency that has been required to complete an IMR, which 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 Emily and/or Clive. 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 2015, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, for example disability, sexual orientation, cultural and/or faith should also be considered by the authors of IMRs. If none are 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 in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Independent Chairman. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

### **Specific Issues to be Addressed**

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

- i. Were practitioners sensitive to the needs of the Emily and Clive, 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 Emily and Clive? 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

## Appendix A

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 MAPPAs? 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?

## Appendix A

- 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 the Emily and Clive?

## GLOSSARY

Abbreviation/Acronym	Expansion
A&E	Accident & Emergency
AMHP	Approved Mental Health Practitioner
CBT	Cognitive Behaviour Therapy
CCG	(NHS) Clinical Commissioning Group
CMHT	(KMPT) Community Mental Health Team
CP	Consultant Psychiatrist
CPN	Community Psychiatric Nurse
CRHTT	(KMPT) Crisis Resolution and Home Treatment Team
CRU	Central Referral Unit
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
EHCP	Education Help and Care Plan
EHPS	(KCC) Early Help and Preventative Services
GP	General Practitioner
GPP	General Practitioner Practice
HCA	Healthcare Assistant
IAPT	Improving Access to Psychological Therapies
IMR	Independent Management Report
IOPC	Independent Office for Police Conduct
KCC	Kent County Council
KERS	Kent Enablement and Recovery Services
KMPT	Kent & Medway NHS & Social Care Partnership Trust
KMDASG	Kent and Medway Domestic Abuse Steering Group
KW	KERS Worker
MHA	Mental Health Act



NHS	National Health Service
OOH	(GP) Out of Hours
OT	Occupation Therapist
PCMHT	(KCC) Primary Care Mental Health Team
PW	Porchlight Worker
SKW	Senior KERS Worker
SPoA	(KMPT) Single Point of Access
SW	Social Worker
YM	(EHPS) Detached Youth Work Manager

This glossary contains explanations of terms that are used in the main body of the Overview Report. The terms are listed in the order that they first appear in the report.

### **Education’ Health and Care Plan**

An education, health and care plan (EHCP) is for children and young people aged up to 25 who need more support than is available through special educational needs support.

EHCPs identify educational, health and social needs and set out the additional support to meet those needs.

A parent can ask their local authority to carry out an assessment if they think their child needs an EHCP. A young person can request an assessment themselves if they’re aged 16 to 25. A request can also be made by anyone else who thinks an assessment may be necessary, including doctors, health visitors, teachers, parents and family friends.

If the local authority decides to carry out an assessment it may ask for:

- any reports from the child’s school, nursery or childminder;
- doctors’ assessments of the child; and
- a letter from the applicant about the child’s needs

The local authority will tell the applicant within 16 weeks whether an EHC plan is going to be made for the child.

### **Community Mental Health Team (CMHT)**

CMHTs deliver mental health services to people with long term mental in the community health conditions, rather than at inpatient facilities. As with CRHTs, CMHTs in Kent and Medway cover geographical areas.

More information about CMHTs can be found by clicking [here](#) or at:

<https://www.rethink.org/diagnosis-treatment/treatment-and-support/cmhts>

### **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 which could otherwise lead to an inpatient admission to a psychiatric hospital.

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

More information about CRHTTs can be found by clicking [here](#) or at:

[https://www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/crht-crisis-teams/#.W3\\_UMehKiUk](https://www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/crht-crisis-teams/#.W3_UMehKiUk)

### **Single Point of Access (SPoA)**

KMPT provide an SPoA for those suffering from mental health condition and who are in urgent or emergency need of help and support. The criteria for calling the SPoA are set out on a webpage:

#### Webpage Text

If you are under the care and treatment of one of our mental health services already please see our 'Need Help?' page to find the appropriate contact details.

If you have concerns about your mental health and you are **NOT** currently under the care and treatment of one of our Community Mental Health Teams or any other of our mental health services within the trust please make an appointment to see your GP, where you can discuss your concerns and they will advise and signpost you to the most appropriate service.

If, however you need **urgent** or **emergency** mental health help and support and you are not currently receiving care and treatment from one of our Community Mental Health Teams, please call our 24/7 Single Point of Access on **0300 222 0123** or text **07860 022819**.

Our Mental Health Single Point of Access (SPoA) provides a single route to obtain Urgent advice to all **new** patients to our Kent and Medway mental health services in urgent situations. When calling our SPoA you will be speaking to someone who can ensure you are put through to the right person or service.

**Central Referral Unit (CRU)**

The CRU contains staff from Kent Police, Kent Social Services, Health and Education. Its main purpose is to manage safeguarding referrals, facilitate the sharing of information with partner agencies and to conduct initial strategy discussions relating to child and adult safeguarding.

Kent Police staff in the CRU examine crime reports and secondary incident reports relating to domestic abuse and assess the DASH risk classification to ensure that it is appropriate and that there is a protection plan in place.