KENT COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Lana

MAY 2023

Independent Chair and Author of Report: Shabana Kausar

Associate, Standing Together Against Domestic Abuse

MAY 2025

The abuse that Lana experienced caused her to become ground down, both mentally and physically, until she was a shadow of herself. Lana experienced significant trauma in her life and went through bouts of drug use, which she used as a coping mechanism when things got bad. But these experiences do not define Lana, who was a cherished daughter, sister, mum, aunt and friend to many. Lana was a larger-than-life character who meant everything to us, and I want to share some special memories of Lana and her personality here, so the world can see the beautiful person that Lana really was…

With nearly 9 years between us, Lana was always my baby sister – she clung to me like glue. When we were young, she would always want to go everywhere with me and be involved in what I was doing, and as we grew older, our bond remained close.

As a child, Lana was mischievous - when she was around 4 years old, Lana decided she wanted to make a cake and she pulled all the ingredients out of the cupboard and onto the floor, until our mum came in and found her. Lana was loved at nursery but every week she'd have a black dot next to her name because of her mischievous nature, for things like flicking her paintbrush at others.

Lana was a keen roller skater - as kids we would skate around the estate holding onto the back of bikes, and at around 18 months old Lana wanted to do it as well, so my dad went on to buy her some skates of her own. Lana was an absolute whiz in less than a week and had no fear – she was the youngest on the estate with skates and people admired how good she was, jumping and doing turns. Lana skated until she was around 7 - she'd come to teenage roller discos, often causing people to fall because she'd skate through their legs!

When Lana got to school, she continued to be well-loved - she was a bubbly person who enjoyed gymnastics and football, and people gravitated towards her. Lana had a stubborn nature, and it was easier to accept things (even if we did not agree with them) than fight against her because if you said she couldn't do something, then she would do it.

When Lana was in her early twenties, we began working together in a contact lens factory. Lana was very well liked there, and we had some good fun together – Lana was always pranking people and arranging lunchtime drinks with colleagues. We would frequently go out in the evenings together and be the last ones standing - we had some great nights out and everyone seemed to know her. Lana was fearlessly protective of me, especially against men who behaved inappropriately.

After her time at the contact lens factory, Lana went on to do some security work in pubs until she fell pregnant with her first-born. There were just 4-months between my son and Lana's first-born, so we started doing family things together. Lana adored everything about the seaside, and we would often visit – she loved the beach, the amusements, ice cream and chips. My son adored Lana and she was always the fun aunt – he had the best time ever during caravan holidays with Lana as she would take him swimming and to the amusements, and they would enjoy the entertainment in the evening.

Lana was loud and you always knew she was there - she liked to be the centre of attention (even though she'd probably say she didn't). Back when we did the school runs, she would dominate the playground with her laugh, and you could hear it from a mile away – sometimes her humour would get her (and those around her) in to trouble.

For over half of her life, Lana was an energetic and happy go lucky person. She would wear flip flops all year round unless it was snowing, adored animals and had a unique passion for apple Danish pastries. Lana was a social butterfly and had a circle of mum friends that she would always be off doing things with, including a monthly get together for games at each other's houses.

When Lana was in her mid-thirties, she started studying to become a Nurse. Against all odds, Lana managed to complete the course (albeit there was one exam she didn't pass but there were certain aspects to nursing that she would still be able to do). Lana didn't pursue nursing after her course, something our family never understood, but she did go on to become a phlebotomist – Lana was so happy when she was in her blues.

Lana was extremely supportive of others, including myself through difficult periods in my life. She would go to church, was caring by nature and was the first to help others - the Christmas before Lana died, she had been helping an elderly neighbour who was struggling with money, and even though Lana had no money herself she helped them with food. Lana always saw the best in people, including those who hurt her.

Lana would not have wanted her family to fall apart regardless of the toxicity and chaos – she would have wanted them to be together and having her children removed was her worst nightmare. Lana would always say that she needed to be here for her children, and she would get them back one day. Lana was the type of person who would fight to the ends of the earth for those she loved and would have done anything in her power to keep and protect her children. Up until she died, she fought hard for her kids.

Lana shouldn't be where she is today. At Lana's funeral, the crematorium was so full that they couldn't fit everyone in which is a testament to how many lives she touched. Only a handful of those present at Lana's funeral knew that she had an addiction and had experienced abuse – they just knew her as Lana, the person that was always there to help. My parents should never have received that devastating knock on the door from the police or have had to bury their daughter. Lana's loss has had a detrimental effect on our family.

I miss everything about Lana, including her questionable sisterly advice. She was, and will forever be, our lovable rogue.

Pen portrait provided by Lana's sister

1. Preface

1.1 The Incident

1.1.1 This review concerns the circumstances leading to the death of 43-year-old Lana, who died by suicide. At the time of her death, Lana lived alone in her home in Kent. She was in a relationship with Louis since 2020.

1.1.2 Lana has been described by her family as someone who was very sociable and had the best time when she was with friends. She was described as very confident in her opinions and would jokingly say *"we will have to agree to disagree, but I'm right."* She was described as strong and would put on a brave face when faced with challenges.

1.1.3 On the day of her death, police attended Lana's home to conduct a welfare check after they received a call from the Crisis Team. The Crisis Team informed the police that Lana had rang them in the early hours of the morning and reported having suicidal ideation. The police forced entry into the house and found Lana by the stairs, whereby attempts to revive her failed.

1.1.4 The day before Lana's death, her relationship with Louis ended, and she was considering going to a refuge as she *"did not want to be beaten."* An investigation into coercive and controlling behaviour was conducted by the police and submitted to the Crown Prosecution Service, who considered that there was insufficient evidence to support a charge.

1.1.5 The Review Panel expresses its sympathy to the family of Lana for their loss and thanks them for their contributions and support for this process.

1.2 Introduction

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and should be conducted in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the statutory guidance').

1.2.2 The *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (2016) states that: "Where the victim took their own life (suicide) and the circumstances give rise for concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken…Reviews are not about who is culpable" (Para 18). The CSP decided that the circumstances of Lana's death warranted the commissioning of a DHR.

1.2.3 This Domestic Homicide Review (hereafter 'the review') examined agency responses and support given to Lana,[1] a resident of Kent prior to the point of her death by suicide in May 2023.

1.2.4 The review considered agencies' contact/involvement with Lana and Louis[2] from September 2020 to May 2023.

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

1.2.6 The key purpose for undertaking DHRs is to enable lessons to be learned from a death by suicide where it is known or believed that they previously experienced domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2.7 This review process does not take the place of the criminal or coroners' courts, nor does it take the form of a disciplinary process.

1.3 Timescales

1.3.1 This review was commissioned by the Kent Community Safety Partnership. Having received notification from the Kent Police in June 2023, a decision was made to conduct a review in consultation with the Kent Community Safety Partnership (KCSP) in July 2023. Subsequently, the Home Office was notified of the decision in writing in August 2023.

1.3.2 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Longer was needed as there were multiple DHRs being undertaken in Kent at the same time, impacting capacity.

1.4 Confidentiality

1.4.1 The findings of this review are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. In the interim, information has been available only to participating officers/professionals and their line managers.

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[1] Not their real name.

[2] Not their real name.

1.4.2 This review has been anonymised in accordance with the 2016 statutory guidance. The specific date of death and the sex of the children has been removed (with anonymity further enhanced by the children being referred to as Child A, B and C). Only the independent Chair and Review Panel members are named.

1.4.3 As Lana appeared to have died as a result of suicide, the name of her partner and family have also been anonymised.

1.4.4 The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members, and the perpetrator:

Name	Relationship to victim
Lana	Victim
Louis	Alleged perpetrator
Child X	Eldest child
Jensen	Former partner
Child B	Louis' child

1.4.5 These pseudonyms were provided by Lana's family members.

1.5 Equality and Diversity

1.5.1 The Chair and the Review Panel have considered the protected characteristics under the Equality Act 2010 of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

1.5.2 Throughout the review, the Review Panel identified that the following protected characteristics required specific consideration:

- *Sex*: The impact of Lana's sex has been an enduring feature of domestic abuse related deaths. This characteristic was therefore relevant to this case as the deceased was female and alleged perpetrator of previous abuse is male. In considering the links between domestic abuse and suicide in women, it is estimated that more women take their own life as a result of domestic abuse than those that are killed by their intimate partner. Studies have shown that almost 30 women attempt suicide every day as a

result of experiencing domestic abuse. It is also estimated that that every week three women take their own lives.[3]

1.5.3 The following have also been identified as pertinent to the lived experiences of Lana and Louis:

- Substance use and mental health needs: Both Lana and Louis had a long history of substance use and mental health support needs. Lana used substances whilst in a relationship with an abusive person, her ex-partner, Jensen. The panel felt it was important to recognise the link between experiencing trauma and using substances as a coping mechanism[4] but also to recognise any impact Lana's substance use or mental health needs may have had on her access and engagement with services, as well as responses of services. For Louis, the panel were clear that neither substance use, nor mental health issues cause abusive behaviour but can compound existing abusive behaviour. The panel, did therefore, consider how Louis's substance use and mental health needs may have compounded pre-existing abusive behaviour.
- Children removed from parental care: The panel felt it was important to consider how placing Lana's children in her ex-partner's care would affect her. Evidence highlights the negative impact on a parent on having children removed, and the panel considered this in relation to Lana's perceptions of services, her substance use, and her mental health.
- *Socio-economic status:* Although the panel was clear that domestic abuse can affect anyone regardless of socioeconomic status, consideration was given in this review to the accessibility and professionalisation of services engaging with Lana, and any barriers she may have faced as a result.

1.5.4 The Review Panel took an intersectional and ecological analysis approach to better understand the lived experiences of both victim and the alleged perpetrator. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experience with local services and within their community. As stated by Kimberlé Crenshaw, "If you don't have a lens that's been trained to look at how various forms of discrimination come together, you're unlikely to develop a set of policies that will be as inclusive as they need to be."

[3] SafeLives, How widespread is domestic abuse and what is the impact? https://safelives.org.uk/policy-evidence/about-domestic-abuse/how-widespread-domestic-abuse-and-what-impact (accessed 16 February 2021)

[4] Herman, J *Trauma and Recovery: The aftermath of Violence from domestic abuse to political terror* Basic Books, 1992

- An ecological analysis considers someone's identity and lived experiences at an individual, relational, community, and societal level. It is about how individuals relate to those around them and to their broader environment.[5]
- An intersectional analysis considers the complex ways in which differing aspects of someone's identity and lived experience can combine or intersect in the context of structural discrimination to create heightened and persistent forms of inequality, marginalisation, disadvantage and powerlessness.[6]

1.5.5 Taking an ecological and intersectional approach can help identify the factors that create, sustain or exacerbate someone's risks and needs. An ecological and intersectional approach can also identify the barriers someone may have faced in recognising or reporting domestic abuse, their options for safety and protection available, and considers any conscious or unconscious bias or privileging by agencies and or society.

1.6 Terms of Reference

1.6.1 The Terms of Reference are included at **Appendix 1**. This review aims to identify the learning from this case, and for action to be taken in response to that learning with a view to preventing homicide and ensuring that individuals and families are better supported.

1.6.2 The Review Panel was comprised of agencies from Kent, as the victim and alleged perpetrator were living in that area at the time of the death. Agencies were contacted as soon as possible after the review was established to inform them of the review, invite their participation and request them to secure their records.

1.6.3 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from September 2020 to the date of the death in May 2023. This timeframe was chosen because, although Lana was known to services prior to this, it was in September 2020 that Lana lived through a suicide attempt. Agencies were asked to summarise any relevant contact they had had with Lana or Louis outside of these dates.

1.6.4 *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in the 2016 statutory guidance and identified and considered the following case specific issues:

5 Further information on this approach can be found online, such as in EVAW (2011) *A Different World is Possible: A call for long-term and targeted action to prevent violence against women and girls*, https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/a_different_world_is_possible_report_email_version.pdf:

6 Intersectionality is a term rooted in Black feminism and Critical Race Theory and coined by Kimberlé Williams Crenshaw in the 1989 landmark essay "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," and furthered this in 1992 with "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color., these, amongst her other work can be accessed online for further information regarding this approach to analysis.

a) Analyse the communication, procedures and discussions, which took place within and between agencies.
b) Analyse the co-operation between different agencies involved with Lana and Louis [and wider family].
c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
d) Analyse agency responses to any identification of domestic abuse issues.
e) Analyse organisations' access to specialist domestic abuse agencies.
f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
g) Analyse the impact on Lana of her children being taken from her care.
h) Analyse how previous responses to Lana's experiences of agencies, and her reports of abuse to them (concerning previous intimate partners), may have affected her confidence in agencies.
i) Analyse how did agencies consider Lana's multiple experiences of abuse from different perpetrators.
j) Analyse how did agencies consider adult child to parent abuse.
k) Analyse how did agencies respond to Lana's mental health.
l) Analyse how did agencies respond to Lana's substance use.
m) Analyse how agencies responded to concerns regarding Lana's suicidal ideation.
n) Analyse how agencies responded to Louis and understood the risk he posed.
o) Where a perpetrator assumes care for their victim, analyse how did agencies understand the relationship between domestic abuse and caring responsibilities.
p) Analyse how the experience of the child was included in agencies response to Lana and her children.
q) Analyse the impact of the COVID-19 pandemic.

1.7 Methodology

1.7.1 The review applies the statutory definition[7] of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

(i) physical or sexual abuse

(ii) violent or threatening behaviour

(iii) controlling or coercive behaviour

(iv) economic abuse

(v) psychological, emotional or other abuse

[7] The Domestic Abuse Act 2021 received Royal Assent on 29 April 2021: https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

1.7.2 Economic abuse is defined as “any behaviour that has a substantial adverse effect on a person’s ability to acquire, use, or maintain money or other property or obtain goods or services” (s.3: Domestic Abuse Act 2021).

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

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

1.7.5 This definition includes “so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.”

1.7.6 A total of 23 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, 6 had only limited contact and submitted a Short Report. However, 10 had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared.

1.7.7 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned.

1.7.8 Most IMRs/Short Reports received were comprehensive and enabled the Review Panel to analyse the contact with Lana and Louis and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses were received.

1.7.9 Some IMRs/Short Reports reported changes in practice and policies over time and 11 made single agency recommendations of their own (these are described in section 5). The IMR from the Integrated Care Board (ICB)needed further analysis, which was requested by the Chair and provided by the ICB after some communication.

1.7.10 *Documents Reviewed:* In addition to the above information, the Review Panel and/or Chair reviewed a number of other documents during the review. Where appropriate, these are referenced in the report.

1.8 Contributors to the Review

1.8.1 The following agencies were contacted, but recorded no involvement with victim or perpetrator:

- Probation
- Town & Country Housing

- The Chair would contact Pause (a charity that works with women who have experienced, or are at risk of, repeat removals of children from their care) to gather their input at the report writing stage.

1.8.2 The following agencies and their contributions to this review are:

Agency	Contribution
Victim Support	IMR
Rising Sun	IMR
Forward Trust	IMR
Department for Work and Pensions	Short Report
Kent Police	IMR
Fire & Rescue	Short Report
Southern Housing	IMR
Town A Council	Short Report
South East Coast Ambulance Service	IMR
Kent County Council Adult Social Care Services	Short Report
Kent Community Health NHS Foundation Trust	Short Report
Kent and Medway NHS and Social Care Partnership	IMR
East Kent Hospitals University Foundation NHS Trust	IMR
Children's Services Kent County Council	IMR
Children and Family Court Advisory and Support Service	Short Report
Education Safeguarding Service	IMR
Kent and Medway ICB	IMR

1.9 The Review Panel Members

1.9.1 The Review Panel members were:

Name	Job Title	Agency
Alison Oates	Safety and Wellbeing Manager, Designates Safeguarding Lead	Town A Council
Anna Bate	Contracts Manager and Safeguarding Lead	We Are With You
Brea Attrill	Safeguarding and Domestic Abuse Manager	Southern Housing
Catherine Collins	Adult Strategic Safeguarding Service Manager	Kent County Council (KCC) Adult Safeguarding
David Naylor	Area Manager	Victim Support
Della Young	Named Nurse for Safeguarding Children	Kent Community Health Foundation Trust (KCFHT)
Elanor Sahadow	Advanced Customer Support Senior Leader	Department for Work and Pensions (DWP)
Fran Ellis	CEO	The Rising Sun Domestic Abuse Service
Graeme Southern	Service Manager	KCC Children's Social Care
Katy McGrath	Safeguarding Manager	The Forward Trust
Jenny Churchyard	Specialist Safeguarding Practitioner	South East Coast Ambulance Service (SECAmb)
Nam Maredza	Designated Professional Safeguarding Adults	Kent and Medway Integrated Care Board (ICB)
Natalie Smitherman	Manager from Safe & Well Team	Kent Fire and Rescue Service (KFRS)

Mark Rolfe	Interim Head of Community Protection	KCC Community Protection
Martin Cripps	Named Nurse for MCA/DoLS	East Kent University Hospitals Foundation Trust
Richard Morris	Assistant Director	Child and Family Court Advisory and Support Service (CAFCASS) South East
Shafick Peerbux	Head of Community Safety	Kent Community Safety partnership
Sophie Kemsley	Senior Project Officer	Kent & Medway Suicide Prevention Programme
Zoe Traynor	Detective Chief Inspector	Kent Police

1.9.2 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.9.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 15 December 2023. There were subsequent meetings on 10 May, 28 June, and 29 November 2024. Delays to the report were caused by a number of DHRs being undertaken in the area, as well as complexities associated with this review which required additional meetings.

1.9.4 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.10 Involvement of the Victim's Family, Friends, Work Colleagues, Neighbours and Wider Community

1.10.1 The Review Panel sought to involve the family, friends, work colleagues, neighbours and the wider community.

Name[8]	Relationship to Victim	Means of Involvement
Samantha	Sister	Interview
Henry	Nephew	Interview

1.10.2 Once the decision to conduct the DHR had been confirmed in July 2023, KCSP notified Samantha of this decision in October 2023. A letter was sent via the police Family Liaison Officer (FLO), along with the Home Office leaflet, and information on Advocacy After Fatal Domestic Abuse (AAFDA).[9]

1.10.3 In October 2023, Samantha, Lana's sister contacted the Chair directly to enquire about the DHR process after receiving details from the CSP. The Chair followed up on this telephone call with an email, including additional information on the DHR process. Future correspondence was coordinated through the AAFDA advocate.

1.10.4 The Chair highlighted that any participation in the review was voluntary, and that Samantha could contribute in the way she found best. Samantha was keen to be able to take part and an in-person meeting was arranged to go through the draft Terms of Reference and key lines of enquiry in early April 2024. The meeting provided a valuable insight into who Lana was and has helped bring her voice to this report.

1.10.5 The draft Overview Report was shared with the family in February 2025.

Victim's Friends, Work Colleagues, Neighbours and Wider Community

1.10.6 Consideration was given to approaching Lana's friends, work colleagues, neighbours and wider community. The chair reached out to Lana's colleagues, but they chose not to be involved in the review.

1.11 Involvement of the Perpetrator and their Family, Friends, Work Colleagues, Neighbours and Wider Community

Perpetrator

1.11.1 The panel decided that it was not appropriate to contact Lana's most recent partner, their friends, work colleagues, neighbours and wider community.

[8] Not their real name

[9] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: https://aafda.org.uk.

1.12 Parallel Reviews

1.12.1 *Criminal trial:* A case file was submitted to the Crown Prosecution Service for review with consideration for controlling and coercive behaviour and malicious communications. This was reviewed, and a decision was made that there was insufficient evidence to progress these matters as there was undermining material and any statements taken from friends/family would be hearsay. Therefore, this did not meet the evidential threshold and did not progress to a criminal trial.

1.12.2 The Senior Investigation Officer (SIO) was invited to the first meeting of the Review Panel to share information about the criminal investigation and address issues in relation to disclosure.

1.12.3 *The Coroner's Inquest*: The death of Lana was referred to the HM Coroner, and an inquest was opened in May 2023 and adjourned in July 2023 at the Coroner's Court in Central and South East Kent.

1.13 Chair of the Review and Author of Overview Report

1.13.1 The Chair and author of this DHR is Shabana Kausar, an Associate of Standing Together. Shabana has received Domestic Homicide Review Chair's training from Standing Together. She has extensive experience in the domestic violence sector, having worked in both statutory and voluntary sector organisations. As a Violence against Women and Girls Strategic Lead, Shabana has commissioned and led reviews on behalf of three Local Authority areas in London. She is currently undertaking a PhD on Violence against Women at the University of London.

1.13.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR).[10] The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 100 reviews across England and Wales from 2013 until present day.

1.13.3 *Independence:* Shabana Kausar has no connection with the Kent area or Kent Community Safety Partnership, or any of the agencies involved in this case.

[10] For more information, go to: https://www.standingtogether.org.uk/ccr-network.

1.14 Dissemination

1.14.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Kent Community Safety Partnership for approval and thereafter will be sent to the Home Office for quality assurance.

1.14.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with the Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Integrated Care Board and the Office of the Kent Police and Crime Commissioner amongst others; The Kent and Medway Safeguarding Adults Board; The Kent Safeguarding Children Multi-Agency Partnership; Domestic Abuse Commissioner, and Additional agencies and professionals identified who would benefit from having the learning shared with them. Briefings are offered to the local CSPs by KCC's Community Safety Unit at the partnership meetings. A short briefing document highlighting key learning is circulated upon publication. Learning events are also held by the KCSP.

1.14.3 The recommendations will be owned by Kent Community Safety Partnership, with the Kent and Medway DHR/DARDR Steering Group Chaired by the Head of Community Safety for KCC being responsible for monitoring the recommendations and reporting on progress.

2. Background Information (The Facts)

The Principal People Referred to in this Report						
Referred to in report as	**Relationship to the victim**	**Age at time of V death**	**Ethnic Origin**	**Faith**	**Nationality & Immigration Status**	**Disability**
Lana	Victim	43	White British	Christian	British	None
Louis	Ex-partner	38	White British	Unknown	British	None
Jensen	Ex-husband	Not known	White British	Unknown	British	None
Child X	Eldest child	18	White British	Unknown	British	None
Child B	Louis's child	14	White British	Unknown	British	None

2.1 The Death

2.1.1 *Death:* Lana was found deceased in her home in May 2023 by the police after they were requested to undertake a welfare check by the Crisis Team. Lana had rung the Crisis Team in the early hours of that morning and had reported suicidal ideation. The Crisis Team were

unable to get back in touch with Lana, so the police were contacted to undertake an urgent welfare check.

2.1.2 Attempts were made to revive Lana, but sadly these were unsuccessful.

2.2 Background Information on Victim and Alleged Perpetrator

2.2.1 *Background Information Relating to Victim:* At the time of her death, Lana was a 43-year-old White British woman. She lived in Kent in a 4-bedroom house. She was unemployed but had previously worked in a local takeaway and before that, as a phlebotomist. Before her relationship with Louis, Lana had been in an relationship with an abusive person (Jensen) for approximately 14 years. They had 3 children together. Lana's fourth and eldest child, Child X, was from a previous relationship. In September 2020, Jensen made the decision to exercise his parental right and took the youngest two children into his care, removing them from school.

2.2.2 *Background Information Relating to Alleged Perpetrator:* At the time of Lana's death, Louis was 38 and is White British. He was unemployed and lived separately to Lana in Kent. He had a child from a previous relationship and was known extensively to the police in relation to criminal damage, possession of drugs, and domestic abuse against his previous partner which spanned from 2007 to 2019. He was also known to police for domestic abuse perpetrated against his parents. Louis had a criminal history dating back to 2000. These include investigations into criminal damage, assault Actual Bodily Harm (caution), domestic abuse investigations of assault Actual Bodily Harm (charged), breach of non-molestation order, harassment (filed), common assault (charged). The domestic abuse offences were with a previous partner.

2.2.3 *Synopsis of Relationship with the Perpetrator:* Lana and Louis met in 2020. They lived separately. Lana would often describe Louis as her carer. He was first known to police for perpetrating abuse against Lana in 2021.

3. Chronology

3.1 Overview

3.1.1 The following chronology describes the contact that Lana and Louis had with agencies. The time period under review is September 2020 to May 2023, which marks a significant incident where Lana lived through a suicide attempt, until the date of Lana's death in May 2023. However, there are some significant events prior to the time period under review which have been summarised in 3.2.

3.2 Summary of Significant Events Prior to the Time Period Under Review

3.2.1 The family first became known to services in relation to domestic abuse in 2016, when Jensen, Lana's then partner, sent abusive messages to Lana threatening to kill her by 'slitting her throat.' He refused to leave the family home and broke down the door to the bedroom, where Lana was hiding. He dragged Lana by the hair and pulled her across the bed, injuring her arm and hitting her across the face. He then attempted to suffocate her pulling the duvet over her head.

3.2.2 Once police arrived, Lana was visibly upset and said she wanted help. However, Lana then disengaged with the officers and did not want to support a police prosecution. Information provided at the time showed that Jensen had previously threatened to kill Lana and had made an attempt to kill her by strangulation, choking, suffocating and drowning. He had also made threats to burn the home down, with their children inside.

3.2.3 The family were referred to Kent Children's Services. An assessment was undertaken in June 2017, which concluded in no further action.

3.2.4 In March 2019, Kent Children's Services received a referral after Lana reached out, asking for support to manage Child X's behaviours. Child X's school also submitted a Request for Support Form for some support for Child X. At the time, Child X was staying with maternal grandparents and had alleged that their stepfather, Jensen, had assaulted them. The case was referred to a Multi-Agency Discussion and Planning Panel and stepped down to the Early Help team in September 2019.

3.2.5 In August 2018, Lana was referred from Victim Support to Rising Sun Domestic Abuse service. Lana was allocated an outreach worker who supported her from August 2019 until January 2020. Lana also self-referred to the Forward Trust for support with her alcohol use. At assessment, it was decided that there was no identified need for structured treatment and so she was signposted to Alcoholics Anonymous.

3.2.6 A strategy meeting was held in September 2019 after worries had been reported to NSPCC about physical abuse, emotional abuse, and the children being exposed to domestic abuse and substance use in the home. Along with the domestic abuse

perpetrated against Lana, the strategy discussion included reference to the children being left home alone, the home being visited by local drug dealers, and Lana being described as 'violent.' Lana disclosed to Kent Children's Services that she had been an on/off cocaine user for 20 years.

3.2.7 The children were made subject to child protection plans in October 2019. At this time Lana and Jensen separated.

3.3 Time Period Under Review

2020

3.3.1 The children were stepped down from child protections plans to Child in Need in June 2020. A deterioration in the family was noted by Children's Services. The children reported Lana was often absent from the home resulting in the older children caring for the younger two children. Jensen also disclosed to his stepdaughter, Child X, that Lana was a cocaine user, which resulted in a decline in the relationship with Lana. Lana and her elder child were both reported to be verbally abusing one another, and Child X was noted to have attempted to strangle Lana and bite her thumb. There is no evidence of referrals to specialist services.

3.3.2 Lana shared with Children's Services that Jensen was continuing to be controlling post-separation, including through child contact, where he was not turning up or changing plans, refused to pay maintenance or buy things for the children, and had sent abusive messages to her. The police undertook a risk assessment and referred Lana to a Multi-agency Risk Assessment Conference (MARAC) which was held in September. A panic alarm was fitted in Lana's home to assist in safeguarding her from Jensen.

3.3.3 In mid-September 2020, Jensen made the decision to exercise his parental right and took the youngest two children into his care, removing them from school. This had a significant impact on Lana's mental health, and she attempted suicide by a prescription drug overdose. This was in the presence of Child X on their 16th birthday, which would have had a profound effect on Child X.

3.3.4 Lana was admitted to hospital. Lana was assessed by the Liaison Psychiatry Service at Kent and Medway NHS and Social Care Partnership, where she told the mental health worker that she had been diagnosed with depression and anxiety for the last 15 years. She spoke about her relationship with Jensen, with her two eldest children, and with her parents, all of whom she considered to have been abusive to her in the past and present. Lana also spoke about her contact with Cocaine Anonymous. Lana reported that she was off sick from work and that they were very supportive. It was agreed that Lana did not need admission to an acute mental health ward. There is no documented support or signposting offered to Lana by the Liaison Psychiatry Service.

3.3.5 Whilst in hospital, Children's Services arranged a strategy meeting due to concerns about the children's welfare. The two eldest children refused to stay with Jensen or their maternal grandparents, so stayed in the family home, unsupervised but checked on by a neighbour. The outcome of the strategy assessment was for the two youngest children to remain in the care of their father, and the preferred contingency plan for the two elder children was to be looked after by Jensen or their maternal grandparents. It was at this time that services were made aware of Lana being in a relationship with Louis.

3.3.6 A few days later, Lana was discharged from hospital and returned home into the services of Kent and Medway NHS and Social Care Partnership's Crisis Resolution Home Treatment Team for daily contact and support for one week and later transferred to the Community Mental Health Team in October. Her two elder children had returned to the family home from their grandparent's home, whereby an argument broke out, and the police were called to the property by Lana. Lana informed the police that, since her break up from Jensen, her children do not like her and verbally abuse her. Lana stayed at a hotel and the family social worker informed the mental health crisis worker of this update.

3.3.7 Child X informed the police that they were neglected by their mother. Lana had a call with her social worker and informed her that she would 'not live out the day if the [children] remained living with her,' and that she 'felt suicidal because of the [children].' She expressed that she felt scared and unsafe with them in the home. During this call, she became upset that Jensen may be in the family home and was struggling to breath. The social worker heard the police reassure Lana that Jensen was not in the home. As the family were known to Social Services, the police case resulted in no further action against Child X.

3.3.8 In September, Louis came to the attention of the police. Louis's child, Child B, was staying with her grandparents, whereby Louis arrived at the property under the influence of substances and argued with his child's stepfather. He was asked to leave the property but became verbally abusive and the police were called.

3.3.9 Lana had calls with her mental health crisis worker every other day over September and informed them that she felt that Jensen was turning the children against her and 'poisoning their minds.' The crisis worker responded that the children had only been with Jensen for a short period, whereby Lana became upset and frustrated. She told the worker that she was liaising with a solicitor regarding access to her two younger children. She did not want to return to work as a phlebotomist as she felt embarrassed by her stay in hospital and how she was treated. She later stated that she wanted to make a complaint against the hospital security once things were settled.

3.3.10 Rising Sun provided ongoing support to Lana regarding the domestic abuse she experienced by Jensen. She shared details of her difficult relationship with her elder two children with her Independent Domestic Violence Advocate (IDVA). Louis was not mentioned.

3.3.11 Lana's IDVA informed her that she was not eligible for legal aid for her legal case against Jensen. Lana pursued a non-molestation order against Jensen. The social worker and IDVA regularly liaised during this period, where concerns about Jensen' influence on the children was identified, but the social worker highlighted that the children could not be removed from Jensen' care without concerns for their immediate safety. Lana informed her IDVA that she was finding it hard to work with social services as they could not see what Jensen was doing.

3.3.12 In September, the social worker informed staff at the Liaison Psychiatry Service with Kent and Medway NHS Foundation Trust that Lana "presented herself as the victim." This victim-blaming language was not challenged.

3.3.13 Lana continued to have regular check-ins with her mental health worker. She continued to describe her low mood and spoke of her partner who lived separately and was supportive. Louis was at a home visit in October and was noted as supportive. A plan was in place for Lana to be discharged and transferred into the care of the Community Mental Health Team (CMHT) at Kent and Medway NHS and Social Care Partnership (KMPT) in October where she was allocated a care coordinator.

3.3.14 In mid-October, the police were called to Lana's home after an argument broke out with her and her two older children, who were visiting to collect items before returning to their maternal grandparents' home. The children were collected by Jensen and taken to their maternal grandparents.

3.3.15 A few days later, Lana informed her care coordinator that she had attempted to take an overdose of tablets but was stopped by her partner, who was identified as a protective factor in the case notes.

3.3.16 Lana reported Jensen to the police for unwanted contact after he accused her new partner of having drug and alcohol issues. The police followed up, but Lana did not want to pursue the report. A few days later, Lana attended a child protection conference, where she refused to give the chair Louis's full name. All the children were made subject to child protection plans and the existing childcare arrangements remained in place. When checking in with her care coordinator, a few days later, Lana described that it was all going Jensen' way.

3.3.17 In November, Jensen contacted Children's Services to say that he had evidence that Lana was using drugs and wished to stop contact between her and the children. He went on to call the police later that month to report that Louis had made threats to burn down his home with the children in it. The police investigated and Louis was given words of advice over the threats and Jensen was given safeguarding advice.

3.3.18 Lana returned to work on a part-time basis in November. She explained to her care coordinator that she was able to maintain her professional role at work. She explained that Louis, her partner of 3 months, was being supportive and encouraged her to eat. However, she described her mood as up and down, saying she could manage one day and on

another day not feel like she ‘wanted to be here’. She went on to share that Louis had removed anything from the home which she could have used to harm herself. Lana confirmed that she had all the mental health support numbers she needed, but that she did not want to contact them in case it had a negative impact on regaining contact with her children.

3.3.19 Lana continued to describe ongoing post-separation abuse from Jensen through child contact. She was supported by Rising Sun during this period. Lana informed Rising Sun that she felt supported by them, but that she felt alone as no other agency understood what her ex-partner was doing or the impact of domestic abuse. The IDVA and social worker continued to liaise, as the social worker had concerns about the children being in Lana’s care. The social worker shared that she was mindful that Jensen could have been using the children against Lana, but that he was doing what was required to provide a stable home for the children.

3.3.20 In late-November, Lana is admitted into Accident and Emergency at East Kent Hospitals University Foundation NHS Trust after she had taken an overdose of prescription tablets. She described her strained relationship with her children and being harassed by her ex-partner, who had been hacking into her social media accounts. She told the Single Point of Access (SPOA) service that she wanted to be sectioned. Louis was with her when she was on the phone to the SPOA, where he described her as being in a ‘right state’ and that she was going through a breakdown due to her ex-husband taking the children. He described being afraid of leaving her. A carers assessment was not undertaken.

3.3.21 Lana reached out to the children’s school to know if she could come to the school to give the youngest children their birthday presents. The school informed her that she can bring the presents but not see the children.

3.3.22 In December, Lana shared with her care coordinator that she had been introduced to illicit substance use by her ex-husband, Jensen. She also shared that she was in debt and struggling with bills. She was living in a 4-bedroom house, but since the children were no longer living with her, she was impacted by the bedroom tax. Lana wanted to keep the house as she wanted the children to return and stay with her, so she did not want to downsize. She was advised to contact Citizen’s Advice Bureau. A decision was made by Town A Council in December to award Lana a discretionary housing payment.

3.3.23 Rising Sun supported Lana with the harassment allegations against Jensen, which she said had escalated after Jensen learnt about her new relationship with Louis. She shared with her IDVA that Jensen had found out that Louis had been to prison for fighting when he was 19 and that he had taken drugs, however, she stressed that Louis had not been in trouble with the police since then. After the first phone call with Lana, the IDVA raised concerns about her new partner in her call with the social worker and at MARAC because Lana did not want to provide his full name, and also because there was a known serial perpetrator of the same name who was known to Rising Sun. This was good practice to

be curious about the new partner and why Lana might be withholding information about him, and to share concerns with other agencies. This led to a DVDS disclosure for him.

3.3.24 Lana received ongoing support from her care coordinator. She mentioned to her care coordinator that she had reached out to her mother 'begging for help,' but that her mother felt she was just after money and so shut the door in her face. Lana made a referral to Forward Trust for support with substance use and was allocated a recovery worker.

3.3.25 In mid-December, Lana contacted the police with a request for a Clare's Law - Domestic Violence Disclosure Scheme (DVDS) check in relation to Louis. The police contacted agencies, and Rising Sun initially responded with details for Jensen before realising the request was in relation to Louis. Rising Sun continued to support Lana while she waited for the disclosure information.

3.3.26 The police are called to Lana's mother's home, after Child X called the police, claiming that 'mum was kicking off.' Lana had attended her mother's home to collect a phone. She was then reported to have become verbally abusive and started to scratch her face. A DARA risk assessment was undertaken by the police for Lana's mother, which was assessed as standard risk.

2021

3.3.27 In January, the DVDS information was shared with Lana by Rising Sun, which included detail of Louis having been abusive to two ex-partners, which she found hard hitting. Early warning signs were explored with Lana, which included a conversation that it may be harder for Lana to notice some signs because of her previous relationship with an abusive person. The IDVA encouraged Lana to be open with social services with this information, whereby Lana highlighted that she struggled to be open for fear of being judged and losing all contact with her children.

3.3.28 Louis was arrested at the end of January for a failure to appear warrant, which was unrelated to his relationship with Lana.

3.3.29 Lana continued to see her recovery worker at Forward Trust, who informed her social worker that Lana was reporting abstinence and so relapse prevention would be offered. At this time, Lana informed her care coordinator that she had stopped communicating with her two elder children due to their attitude towards her, which she described as abusive.

3.3.30 In February, Lana was informed by social services that she would be able to have contact with her children at her home as opposed to a contact centre. At this time, Lana informed her care coordinator that Louis was now living with her and was supportive. Lana's IDVA continued to support Lana over the phone due to COVID restrictions. The IDVA did not ask about Louis as she had heard a male voice in background. The IDVA continued to attend the children's service's core group meetings regarding the children's care, where Louis was discussed with no concerns disclosed at that time.

3.3.31 Jensen was cautioned for the offence of malicious communications in March 2021 for reported incidents from September 2020 to December 2020.

3.3.32 Lana continued to report abstinence and was closed to Forward Trust in April 2021. Her IDVA continued to provide support, where the focus was on her relationship with her children. Louis was discussed briefly, but Lana did not want to discuss him in depth and shared that social services were aware of the DVDS and had not said anything.

3.3.33 Lana's two older children's placement with their grandparent's broke down and Child X stayed with Jensen while the second child stayed with a friend. Child X was diagnosed with depression, and Lana asked Child X to stay with her, which Child X declined. An argument ensued and Lana told Child X that no one wanted them. The youngest children became aware of this and were reluctant to have contact with Lana over Easter. Lana received support from her IDVA regarding the reduced child contact.

3.3.34 In April, Lana shared with her GP that she had a difficult week as she had broken up with her partner, Louis.

3.3.35 Lana contacted the police to report that, whilst sleeping, a television had been moved to another room, and she woke with a bruise on her forehead. She explained that she thought that her ex-partner, Louis, had entered with a key and moved it. The police attended the following day and found no evidence of a criminal offence. Lana was advised by the police that she had been sleeping under the influence of alcohol and prescription medication. It was considered by the police that Lana had moved the television herself and not had any recollection of doing so.

3.3.36 At the end of April, Lana contacted the police to disclose that Louis had threatened to burn her house down. A DARA risk assessment was undertaken and assessed as standard risk. Lana did not want to engage with the police further and there was no further action. There was no referral to MARAC based on professional judgement.

3.3.37 Lana was supported by her IDVA, who she informed that she was no longer with Louis as he had stolen money from her and was taking more drugs, leading to Lana relapsing. A referral to Forward Trust was made. The IDVA informed the social worker about Lana's concerns of the children being in Jensen' care. The social worker acknowledged that Lana was doing everything she could do to see her children but that Lana 'had been increasingly difficult to work with.' The IDVA informed the social worker that she was happy to advocate for Lana at the next meeting, but that Lana's case was due to be closed with Rising Sun because there had been no physical abuse disclosed in the last 3-4 months. Louis was not discussed in this conversation.

3.3.38 Forward Trust provided support for Lana in May where she reported a cocaine use relapse triggered by loss of contact with her children. She was told she would be unable to access counselling because of her active cocaine use, but Lana reported that she had an assessment booked with The Priory for one-to-one support which was funded by her

father. Lana was asked to be transparent with the Forward Trust about her substance use to be able to access the right support.

3.3.39 In mid-May, Lana was admitted to Accident and Emergency at East Kent Hospitals University Foundation NHS Trust after making superficial cuts to her wrists. Louis was reported to have found her at home with a knife. He was noted as her current partner. The patient record stated that her family were concerned about her reduced food and fluid intake. In the ambulance on the way to the hospital, Lana became increasingly anxious and did not want to attend A&E after her previous bad experience. The ambulance stopped several times on route to support Lana to remain calm. At the hospital, Lana did not wait for the Liaison Psychiatry Team and left with Louis, who agreed to observe her at home and contact the Crisis Team.

3.3.40 The IDVA called Lana to check-in and moved to close her case. Lana shared she was upset at not having seen her children in 6 weeks. Lana stated that she had a better relationship with her family and that her father was paying for her to access counselling. Louis was discussed, and Lana mentioned that it was okay but that he was in the house and took drugs in front of her which caused her to relapse. The IDVA informed Lana the case with them would be closed and for Lana to get in contact when needed. Lana was upset that the IDVA would not be able to attend case conference meetings.

3.3.41 Lana continued to access Forward Trust over this period. An urgent referral was made to the GP at the end of May, due to an increase in anxiety and depression in relation to an impending court case. Triage was completed and Lana was referred to CMHT for a routine appointment. CMHT contacted Lana and explained that as she was getting support from The Priory and Forward Trust, they can only support her if she transferred over. Lana replied that ‘you cannot help me then,’ and hung up. CMHT contacted Lana on 3 further occasions. Louis was heard in the background speaking to Lana on one occasion, and on another, the mental health workers asked Louis to speak to Lana, whereby Louis responded that ‘she don’t want to speak…you sound like you have mental health as well,’ before hanging up. An offer of a further appointment was sent out via post.

3.3.42 In June, the police were contacted by Lana’s employer, who were concerned for her welfare. The employer had received concerning text messages indicating suicidal behaviours. Lana was contacted via telephone by the Police, who stated she had no idea what the call was about and had not sent any messages to her employer. The police contacted the Crisis Team who said they would get the community team to contact her.

3.3.43 CMHT contacted Lana and Louis answered the phone. He expressed that she was a threat to herself and had been scratching her face screaming and shouting and said she was trying to walk in front of moving cars. He reported that he felt she needed to be admitted. He was provided with support numbers and advised to take her to A&E if needed.

3.3.44 In early June, Lana and Louis make a joint claim for Universal Credit, and an advance was approved and issued to Louis’s bank account.

3.3.45 In mid-June, Lana contacted Southern Housing after reporting that her front door had been kicked in. When asked, she reported she did not know who had done it. She was advised to speak to her family for support, but she said that she didn't want them to know. Security measures were offered but declined.

3.3.46 The children were stepped down to a child in need plan as they had settled into their father's home and the risk of harm was considered by Children's Services to have been reduced significantly.

3.3.47 In July, Lana was in rent arrears and informed Southern Housing that she struggled to cover the costs of being in a 4-bedroom home. She was signposted to debt support services.

3.3.48 In August, Lana was reviewed by Forward Trust, and her case was closed. An email was sent to the children's social worker informing them of the case closure.

3.3.49 Child B was arrested for Common Assault against her mother. She was taken to the police station and a search for a placement was undertaken.

3.3.50 In September, Lana reported to her GP that she still had suicidal thoughts and was aware that she was approaching the anniversary date her children were no longer in her care. She handed in her notice to her employer where she worked as a phlebotomist.

3.3.51 Jensen contacted the police stating that Lana was attempting to find out where he and the children were living. A DARA risk assessment was undertaken for Jensen, which was assessed as medium risk. He was given advice on civil orders, and no further referrals were made.

3.3.52 In October, Lana's children are closed to children's services. In December, Lana called the children's school asking to drop off presents for the children. The school agreed to the presents being dropped off, but not to Lana seeing the children. The school noted that Louis was with Lana when the presents were dropped off. Lana was noted as being 'unpleasant with her partner' who was 'also nasty in the background.' The school record stated that contact with Lana could be aggressive.

3.3.53 A few days later, neighbours called the police due to hearing shouting and screaming from Lana's home. On arrival, the police spoke to both Lana and Louis. Lana did not want to speak to the police, and a DARA risk assessment was completed for Louis which was assessed as medium risk. Louis agreed to leave the home for a period of time for things to calm down. He explained to the police that Lana suffered from poor mental health. No other referrals were made.

2022

3.3.54 In January, Louis and Lana are stopped by Cumbria police whilst on holiday. Lana had scratches on her face, which were reported by both as being self-inflicted. Louis was noted

by the police as being ‘compliant and cooperative’ and ‘incredibly effective at calming Lana down when she became hysterical.’ Mental health services were contacted, but Lana did not want to engage with them.

3.3.55 A few days later, Lana went to A&E with a sprained wrist. She told the hospital that she ‘fell over the dog.’ A previous MARAC flag was on her case notes, but she was not asked about domestic abuse. In February, Lana visited her GP due to irregular periods and post-coital bleeding. She was referred for an ultrasound scan and colposcopy.

3.3.56 Lana informed Southern Housing that she could no longer afford to stay in the 4-bedroom property and needed to downsize. She was noted as being very upset on the phone. Lana requested a place where she could take her pets as they provided her with support. She was informed that she would be added to a waiting list.

3.3.57 In mid-January, Lana’s second eldest child alleged that their father, Jensen, had assaulted them by pinning them to the stairs by both of their arms, which had injured their back and right arm. A strategy discussion was held, and joint enquiries were carried out by Children’s Services. The outcome was that the concerns were not substantiated due to inconsistencies in the allegations that the child had made. A child and family assessment was completed which highlighted that the child appeared happy in their father’s care and was not raising any worries. The assessment concluded with no further action taken.

3.3.58 In March, neighbours again reported shouting at Lana’s home. Police arrived to find Louis and Lana in a car outside. Louis stated that they had argued, and that Lana had mental health issues. Lana was noted as being aggressive to police officers and walking away from them. An officer followed Lana, whereby she assaulted him and was subsequently arrested, whereby she assaulted a second officer. During interview, Lana did not engage with the questions and was charged with assaulting emergency workers. A DARA risk assessment was completed based on professional judgement and assessed as medium risk. No onward referrals were made.

3.3.59 A few days later, Lana’s father called 999 as he had concerns about Lana’s mental health. She had drunk a bottle of wine, was picked up by police and spent a night in Folkestone Police Station. On release, she returned home, where she was found by her parents wrapped in a duvet on the floor. She described feeling depressed and embarrassed about the previous day. She was left in the care of her parents and Louis, with the agreement that she would follow up with her GP. Her partner was noted as being very caring.

3.3.60 Lana was successful in her claim for an award under the discretionary housing payment scheme and her priority move request was approved for a smaller property. Lana requested for Louis to be given third party authorisation with Southern Housing. She also provided Louis’s email address on her online application on the housing register.

3.3.61 In April, Jensen contacted the police stating that Lana was contacting her eldest child despite being told not to make contact. Lana was messaging with attempts to reconcile. A

DARA assessment was undertaken and assessed as standard risk. It resulted in no further action as it was assessed not to be in the public interest.

3.3.62 The following week, 999 were called by the Mental Health team due to concerns for Lana's mental health and suicidal ideation. Lana did not engage with the ambulance clinicians and stated that they were not needed. Lana was left in the care of Louis. Lana was referred to SPOA by her GP due to concerns of her suicidal thoughts and self-harm. She was noted to have told the GP that she had attempted to walk in front of a car the previous week. She was triaged and placed in the care of Town A CMHT for home treatment. She was noted to tell mental health professionals that 'I don't want to wake up. Every day is a struggle. I'm so scared of me because I don't know what is going to happen next. I just don't want to be here anymore.'

3.3.63 During a home visit, Lana was under the influence of cannabis. She was informed that the visit could not be conducted because of this. Lana was described as upset that she was being blamed for cannabis use when she had told CMHT about her use. Louis was noted to apologise to the mental health workers, and an agreement was made to return the next day.

3.3.64 On their return, Louis left to walk the dog. Lana wanted him to stay, but he insisted on leaving. During the visit, the worker's described attempts to build a rapport as difficult, with Lana stating that she was 'mental,' and that she needed help and wanted to be sectioned. She also reported that her home was pelted with eggs, and that over the last few months these events had escalated where she felt unable to leave the home. She described police previously forcing entry into her home and restraining her whilst laughing at her. She believed she was wrongfully arrested and described not having access to her medication whilst in custody. Lana shared that she knew she could present as aggressive and irritable, but that this was because she was overwhelmed by her situation. A medication review was arranged, risk was assessed, and a visit arranged for the next day for ongoing support. Louis was noted as being supportive.

3.3.65 Due to Lana's suicidal ideation, she was triaged and placed in the temporary care of the Crisis Resolution and Home Treatment (CRHT) team between late April and the first two weeks of May. The CRHT team workers found Lana and Louis in the middle of the argument. They asked if they should return later, but Lana insisted they remain and shared with them that Louis had called her lazy. Lana and Louis were described as 'both being highly expressed.' The CRHT workers asked Lana if she could visit her family, at which Lana was described as being verbally abusive to staff and saying that she 'has no one.' The staff were noted to explore with Lana the pressure Louis may be feeling in supporting her, which Lana described as 'dismissing,' and she went on to explain that he did not show her affection and that she had 'been attempting to get a cuddle from him the past three days and he has not even done that.' Lana went on to ask to be sectioned after claiming that she may harm others. As they were leaving the property, Louis apologised to the

CRHT workers for the argument and reported he would contact services if he had concerns about Lana.

3.3.66 At the end of May, Lana was discharged from CRHT back to CMHT, whereby Lana contacted the duty team to explain that she was not happy she was being discharged from the Crisis Team. In the care of CMHT, Lana asked for a diagnosis as she did not believe she just had depression. In July, Lana contacted the duty team upset that no further outpatient appointment had been booked and that she was going to jump from a bridge. Attempts were made to call Lana back but there was no response.

3.3.67 At the end of July, Lana contacted Southern Housing to report a stone being thrown through Lana's front door glass and her back door being boarded up due to a similar incident. Lana shared that she regularly gets bottles, cans, and eggs thrown at her home. Lana was advised to contact the police for a crime reference number, but Lana was described as being upset and not wanting to involve the police. The housing officer contacted CMHT to follow up with Lana.

3.3.68 On the same day, the police received an anonymous call that they could hear a 'male voice beating up a woman.' On arrival, the police found broken window glass, and Lana did not want to engage with them, swearing at them and not wanting to open the door to them. She was heard to be on the phone at the time with Louis's mother, where she told her that Louis had hit her several hours earlier. The police ask Lana about the comment, but she denied it. The police contacted Louis's mother who confirmed the comment. Louis was later located at his mother's home and arrested for assault and damage. On his arrest, he was described as being obstructive and aggressive, threatening to murder himself, bite his tongue off, and started hitting his head on the floor. He was screened in custody by the Criminal Justice Liaison and Diversion Service where he did not engage and was provided a leaflet to signpost for support should he require this in the future. During interview, he denied causing damage but admitted to arguing with Lana. A DARA risk assessment was completed for Lana, which was assessed as being at medium risk and the case was referred to Victim Support. However, the DARA was sent to Victim Support with a "standard risk" indicator.

3.3.69 A few days later, Southern Housing contacted Lana regarding her request for a smaller property. She was upset on the phone, and the officer suggested that she got in touch with mental health services. She explained to the officer that Louis was back at the property and that it was a row and nothing more. Lana told the officer that her life would improve once she was able to move. The officer offered support around domestic abuse, but this was not taken up.

3.3.70 CMHT followed up with Lana with a phone call in August, where she was described as being angry, shouting, and swearing on the phone. She was upset that she did not have a diagnosis. Shortly after, an active review team meeting was held and the decision was made to discharge Lana back her GP due to Lana being aggressive/abusive towards staff

on four occasions, as per their zero-tolerance policy. The GP re-referred Lana via the Mental Health Helpline later in August, but the referral was declined.

3.3.71 At the end of August, Lana rang the police to report that her children verbally assaulted her after seeing her in the street. She alleged that they called her a 'crackhead' and had informed others with them that she used to abuse them. The police informed Lana that the behaviour would not amount to harassment, whereby Lana hung up on the call. A DARA assessment was assessed as standard risk.

3.3.72 In September, Southern Housing continued to liaise with Lana. Their records show that Lana was in rental arrears which would impact her request to downsize. The records also showed that Louis was in receipt of a carers allowance for Lana. Lana was provided details of the Homeless Prevention Team but was upset stating that she 'would be stuck in the property' before hanging up on the call.

3.3.73 The GP continued to support Lana but flagged that she was not suitable to be treated within their service and that she would benefit from a re-referral to secondary care for appropriate assessment and support. In October, Lana contacted 111 asking to be sectioned. The GP referred Lana to the Mental Health Crisis Team, and an ambulance was called to attend to Lana. On the ambulance arrival, Lana did not want to open the door. She told ambulance staff that she wanted to be sectioned but did not want to discuss it further. The ambulance made no further contact and informed the GP, who subsequently made a referral to the Mental Health Helpline Team, who agreed to contact Lana within 72 hours.

3.3.74 Two days later, Lana was taken to William Harvey Hospital A&E after self-harming with knife cuts to her wrists, sides of face, and neck because Louis was threatening to leave her. When Lana was enroute to home, she was noted to argue with Louis, and was brought back to the hospital, where she claimed that she was now in another relationship with an abusive person. No risk assessment or referral to MARAC was made. Lana was referred for a psychiatry assessment where she told the psychiatrist that she did not have support and was 'let down' by services. She was referred to CMHT for further assessments of her mental health needs and was accepted back into their services in November.

3.3.75 In late October, Lana contacted the police to report that, after texting one of her children for their birthday, her child had sent an angry message back stating that Lana should be in prison for abusing the children and their father, and that she deserved to die. Threats to kill were also made. Lana did not want to support a prosecution. An Operation Encompass[11] referral was made to the school, and a DARA risk assessment was undertaken and assessed as medium risk and a referral to Victim Support was made.

[11] Operation Encompass is a police and education early information safeguarding partnership enabling schools to offer immediate support to children experiencing domestic abuse. https://www.operationencompass.org/

3.3.76 In early November, Victim Support contacted Lana, but Lana said it was not a convenient time, so a text was sent to arrange a more suitable time, which was not responded to. No further attempts to contact Lana are made.

3.3.77 At the end of November, Lana called the police to report that something had been thrown at her house and broken the window while she was in the lounge. Lana contacted Victim Support following this incident stating she believed her child was involved. Lana was noted to have declined a referral to a domestic abuse service and was provided details of other support services as well as home security assistance. She was not referred to a MARAC based on professional judgement, where consent would not have been needed.

3.3.78 Following this, Lana contacted Southern Housing regarding repairs. Repairs were made to the property, and additional calls were made to support Lana's move. Southern Housing also followed up with the police to arrange a joint visit to Lana's home. Lana was noted to tell housing staff that she felt 'the police were not interested or bothered.'

3.3.79 In late November, Child B was placed to stay with Louis and Lana on weekends on a temporary basis by Children's services.

3.3.80 In early December, Louis was arrested for drug driving. At his arrest, Lana was reported to be abusive to officers. Subsequently, Lana contacted the police to report that she had been assaulted by an officer. The police attempt to follow up for further information of the allegations but were unable to contact Lana. Body worn video of the incident was reviewed, and the police deemed the allegation to be untrue, and the case was closed after being reviewed by two supervisory officers.

3.3.81 A few days later, Lana contacted the police to report that her dog had been stolen from her front garden. He was found 20 minutes later. Over December, Lana continued to liaise with Southern Housing, her GP, and mental health support workers. She was noted to have told CMHT that 'none of you care and you all think I am horrible.' Lana was referred to Adult Safeguarding at Kent County Council who deemed that Lana did not meet the criteria for a care needs assessment and closed the case.

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3.3.82 In early January, Lana contacted Children's Services to inform them that Child B had been involved with the police over the weekend. The social worker spoke to Lana about boundaries, which Lana was noted to find difficult to hear.

3.3.83 In late January, Lana contacted the Urgent Mental Health Helpline and was referred to CMHT. On screening, she was noted to state that she felt she was suffering from Post Traumatic Stress Disorder (PTSD) after experiencing domestic abuse.

3.3.84 In February, Southern Housing closed their case with Lana after not being able to make contact with Lana on three occasions.

3.3.85 Child B had an argument with Lana and Louis and returned to live with her mother, Louis's ex-partner.

3.3.86 In March, Lana contacted the police stating that the neighbours were accusing Louis of killing their cat. During follow up queries, neither Louis nor Lana wanted to pursue a prosecution. It is unclear from police records if the neighbours were spoken to on this occasion. Southern Housing contacted Lana regarding Anti-Social Behaviour. A few days later Louis contacted the police to report that the neighbours had threatened to kill him for running over their cat. An email offering support was sent by Kent police.

3.3.87 In April, Lana contacted the police to state that she wanted Child B to be removed from her property as they had been arguing after she came to collect some items. Safeguarding advice was offered when officers attended. Child B was not spoken to in relation to this incident, and the report was filed with no further action due to lack of evidence.

3.3.88 Lana continued to access support from her GP, explaining that she had low mood, particularly after Mother's Day and after the school was not returning her calls. On a phone call, Lana told them that she had attempted to take her own life the previous week. The GP asked to make a referral to CMHT, which Lana was reluctant to agree to. Louis was then heard in the background raising his voice expressing his annoyance that Lana was being negative and not accepting any support. After this, Lana's tone was noted to have changed abruptly, and she consented to the referral being made. She was asked if everything was okay to which Lana did not respond. The GP then heard Louis say, "domestic abuse" and stated that he was leaving.

3.3.89 The GP spoke to Lana the following week over the phone and asked whether she was safe in her current relationship. Lana was noted to state that her mental health problem gets to her partner and that he does not have any support. Lana was referred to CMHT. During an assessment, Lana disclosed to CMHT that that she had attempted to run over her partner, Louis, with a car during a previous "meltdown". No referral for a carers assessment was undertaken for Louis.

3.3.90 CMHT made an appointment to see Lana at the end of April. They asked Lana to consider a referral to Forward Trust for support with her substance use.

3.3.91 At the end of April, Lana called 999, whereby the call handler heard a man and woman arguing. The police were dispatched and spoke to both Lana and Louis. Lana reported that Louis had accused her of being unfaithful and she wanted him out of the house. Louis was escorted out of the house to go for a walk to calm the situation, where, after 30 minutes, Lana cryingly stated she wanted Louis back. She expressed that she was worried Louis would kill himself. Louis was taken to the station, and Lana called the police on a number of occasions over the day saying that Louis was missing. A DARA was completed which was assessed as medium risk. No referral to MARAC was made or onward referral for mental health support.

3.3.92 A few days later, in early May, Lana spoke to CMHT and explained what had happened. She told the duty worker that she did not feel safe around Louis. She went on to say that Louis was a nice person and that she was horrible to him. She was noted to be very distressed on the call, sobbing to the point of retching. An outpatient appointment was made, and a care plan was developed, which included four sessions of CBT. The domestic abuse was not explored.

3.3.93 A week after the call, Lana called the Mental Health Crisis Helpline in the early hours of the morning, stating that she had thoughts of ending her life as she had broken up with her partner the day before. A referral was made to the Rapid Response service who were unable to contact Lana. The police were contacted to conduct a welfare check, where, sadly, despite a full resuscitation attempt, Lana's life could not be saved.

3.3.94 The chronology demonstrates extensive involvement from a range of services. This review will analyse this involvement and explore missed opportunities and learning for future practice.

4. Overview

4.1 Summary of Information from Family

4.1.1 The Chair interviewed Samantha and Henry, Lana's sister and nephew, in April 2024. They spoke about Lana's experience of services, the barriers Lana faced in accessing support, and the missed opportunities. Samantha highlighted that she felt that Lana was stereotyped by services which impacted the support she was offered:

'It feels like the police looked at it and thought "oh it's just another call from that house" and the mental health team thought "oh just another call from this crazy person". Nobody appeared to see how serious this was.'

4.1.2 Samantha went on to share that she felt there needed to be more professional understanding of how someone who has experienced trauma presents.

'*The mental health team did not like the way Lana spoke to them. However, they should be trained properly, because you are dealing with people in crisis… not everyone will be quiet and sad, some might be angry and shout…they said they had a zero-tolerance policy, but how can you have this with people who are unstable – why did they not think to look into why she was feeling like this?'*

4.1.3 Samantha and Henry also felt that a barrier to Lana not getting the support she needed was because it was mostly offered over the phone and not face to face. Although there was a recognition of COVID and lockdown impacting services, Samantha still highlighted,

'Lana wanted to see someone face-to-face, and for some reason they were not allowing this. This was during the pandemic, but they were seeing people, as I went to the Memory Clinic and saw someone face-to-face and that was during lockdown.'

4.1.4 They felt this also had an impact on how Lana was able to engage with services and how open she could be.

'She would not have been able to talk. She only had it [support] over the phone, and he [Louis] was in the background. In one case, they said to her if she was not safe, she should go to the police, and he was in the background and he said, "do you think this is actually domestic abuse" and he left. It is unclear if they even asked if she was alone. There are ways to ask someone something without increasing the risk.'

4.1.5 Samantha also felt that a trauma informed approach was needed to support Lana. She felt that her experience of abuse with Jensen was manipulated by Louis and impacted how she viewed Louis. More needed to be done around supporting someone who experiences abuse from multiple perpetrators and how they understand their abuse.

'*This was used quite a lot – the type of person Jensen was. Louis tried to make himself look better. He tried to shift the blame back onto Jensen for his own behaviour.'*

4.1.6 Samantha felt that more needed to be done by professionals to understand how Louis was impacting Lana's access to support and seeing beyond the façade of him being her carer.

'*He [Louis] used to say he did so much for her…that he is the one who takes her to hospital every time she tried to end her life. But Lana never attempted suicide before, even with Jensen, until she met Louis.'*

4.1.7 Samantha felt that Louis interrupted Lana's journey to recovery and support.

'Lana was doing really well. I know this because I have a friend at the Forward Trust who said that she was getting herself back on track and wanted to get her children back. Then all of a sudden, she started dropping out of meetings. The friend shared that she saw Lana around with Louis and, from his reputation, I knew this was why she had stopped going to meetings.'

4.1.8 Samantha also felt that everyone around Louis believed the role he played of Lana's carer. As well as by professionals, Samantha highlighted how friends and family were manipulated by Louis.

'*Louis would ring our parents and say she was trying to take her life and having an" episode." I used to ask my parents how they knew it was not him putting her into that frenzy, and they would say that he was really good with her. From my job, I could tell straight away what he was like.'*

4.1.9 Samantha recalled speaking to both her parents and Lana about her concerns with Louis's criminal background. She recalled Lana saying *'it was for something small,'* and when asking their parents if they knew that Louis had gone to prison, they also said *'it was for something silly,'* At the time, Samantha flagged that you do not go to prison for something silly, but her parents told her *'how brilliant he was with Lana and that he did not take drugs'.*

4.1.10 Both Samantha and Henry felt very strongly that they did not believe that Lana had died by suicide. They questioned the method Lana was found to have used as well as Louis's influence on Lana. Henry felt that if Lana did attempt to end her life *'it would have been through an overdose'.* Samantha also felt that Lana *'would never end her life by hanging, because she hated things touching her neck – she never wore scarves.'* Instead, Samantha felt that Lana was *'getting herself together, she was working as a phlebotomist, and then she met Louis and the job and everything went…she may have been chaotic and want a way out, but I believe that she was pushed to it'.* Samantha shared that she felt that Louis had killed Lana and staged it.

4.1.11 Samantha also wanted to highlight the findings of the toxicology report undertaken by the coroner, which did not detect anything of toxicological significance. Samantha felt this was particularly significant given Lana's history of drug use, but also because this is something that Louis would use to undermine Lana.

4.1.12 After Lana's death, Samantha spoke about how they went to clear Lana's home and found a number of items which indicated that Lana was planning for the future. They found a book hidden on top of a kitchen cupboard on *'how to get out of violent*

relationships. Some of the pages were folded and notes had been made. She had got all the way up to "getting out.' Samantha shared with the chair that she later found out from Lana's next-door neighbour that Lana had approached the neighbour and asked them not to call the police anymore as she felt it was making things worse.

4.1.13 Samantha highlighted that she felt Lana was being abused economically by Louis and she was concerned that Louis was getting Lana into debt. Samantha described that their father would take Lana to do her food shopping. After Lana met Louis, the trips ended and instead Lana would phone for her father requesting him to send her £300. Henry added that this phone call *'turned into just a text asking for the money.'* They felt that this reflected the control that Louis had over Lana and her finances. They also believed that Louis had control over Lana's phone and was likely the one who was sending the text messages.

4.1.14 Samantha explained that their father had taken out an equity release on their property and given all of their children £60,000 each, of which Lana's share was gone within three months. Samantha later learnt that Louis had told the police that the money had gone on drugs.

4.1.15 When discussing Lana's relationship with her ex-partner Jensen, Samantha shared that Lana never mentioned anything about the domestic abuse she was experiencing: 's*he would only say "oh Jenson has the hump" or something.'* Samantha went on to explain that someone experiencing domestic abuse does not want to share the detail and that they can blame themselves, and that she felt that this was the case with Lana also: *'she would say that she "annoyed him" or was "doing his head in."*

4.1.16 Samantha shared that the extent of abuse that Lana experienced only surfaced after Lana's death and that she felt Jensen's *'hatred'* for Lana was likely a factor in her death, either directly or indirectly. Further, Samantha shared that, in 2022, Child X had told Samantha that *'her dad had planned on getting a hit man to ger rid of Lana as it would be a lot less hassle.'*

4.1.17 When discussing Lana's children, both Samantha and Henry explained that Lana was very determined to get her children back, but that Jensen was continuing to abuse Lana through their children: *'The youngest children have sort of been brainwashed into thinking that their mother was or was not certain things.'* They also spoke about occasions where the two eldest children spoke about displaying abusive behaviours towards Lana. Henry explained that one of the eldest children had told him that *'they [sic] beat up her mum several times and it was quite hard to hear as they [sic] seemed proud of it.'* Samantha also shared that Child X lived quite near to Lana at the time that something was thrown through Lana's window.

4.1.18 When asked to describe who Lana was as a person, Samantha and Henry described her as a vocal person with a bubbly personality, *'if she had an opinion, you would know about it! She would say "we will have to agree to disagree, but I'm right."* They shared that she was very sociable, and, before Louis, she was always with her friends and had the best time with them. At Lana's funeral, the crematorium held around 100 people,

and it was completely full. They described her as *'now being at peace,'* but powerfully shared that *'she is not here to tell her side, she is not here.'*

4.2 Summary of Information from alleged Perpetrator

4.2.1 As there had been no conviction in relation to Lana's death by suicide, the panel agreed not to reach out to either of Lana's ex-partners as part of the review.

4.3 Summary of Information Known to the Agencies and Professionals Involved

4.3.1 A range of agencies had contact with Lana. Broadly this contact related to the following services:

- Health services
- Police and fire services
- Children's services
- Housing
- Support services: domestic abuse services, substance use services, and debt services.

Health services:

4.3.2 Lana had extensive contact with a number of health services in relation to her own physical and mental health needs. Lana was registered with a local GP Practice and had frequent contact with them. Whilst the medical care provided was appropriate, and good practice was demonstrated in liaising with mental health services, there were missed opportunities where safe routine enquiry could have been undertaken to explore Lana's experience of abuse from Louis and the abusive behaviours displayed by her children. Lana's experience of abuse displayed by her children was well documented in her notes, but this did not result in a referral for support for Lana. In April 2022, Lana spoke about her relationship with Louis and how she was upset that it had ended, but there was no exploration of the impact or risk associated with this.

4.3.3 Lana had a number of visits at East Kent Hospitals University Foundation Trust (EKHUFT). Lana was appropriately supported with her presenting needs, but there were missed opportunities to identify domestic abuse, and when disclosed, to appropriately respond. In October 2022, Lana told the assessing clinician that she had been in a relationship with an abusive person and was now in another one and did not feel safe to go home. No risk assessment or referral to MARAC was made. There also appears to be a lack of consideration around assessing Lana's mental capacity when she left the department prior to completion of treatment. In September 2020 there was a missed opportunity to explore Lana's suicide attempt and her reference to experiencing abuse from her two children. There was also a missed opportunity to support Child X after witnessing Lana's suicide attempt on their birthday. Significantly, Lana also described being judged by ward staff in September 2020.

4.3.4 Lana had the most significant contact with Kent and Medway NHS and Social Care Partnership (KMPT) where she received support with her mental health, predominantly through the Community Mental Health Team (CMHT). Lana had a strained relationship

with the service where she felt that she was not given the diagnosis or support that she needed. Lana was recorded as being verbally abusive to staff on a number of occasions and was discharged from the service back to her GP in August 2022 as a result of this. A re-referral into the service was refused at the end of August 2022 but Lana was accepted in April 2023. Whilst in the care of KMPT, Lana shared many insights into her experiences of abuse, but there was limited follow up or understanding of risk. When they did ask Lana about abuse, it was in April 2023, whilst on the phone with her and with Louis shouting in the background. This was not safe practice and could have increased the risk to Lana. Louis was often referred to as being 'supportive' of Lana, but no carers assessment was undertaken or exploration of risk he posed. No DASH assessment was undertaken, and Lana was not offered an adult safeguarding referral despite her care and support needs.

4.3.5 Lana came to the attention of Adult Safeguarding in December 2022 after a referral was received from the GP. A desktop triage was undertaken which found that Lana had no appearance of care or support needs. There are limitations to desktop triages whereby referrals can be limited in information, which can present a gap in seeing the needs of the person being referred.

4.3.6 The ambulance service visited Lana a number of times during the scope of the review. Lana was provided with care and there were good practice examples of support, such as stopping the ambulance when Lana grew anxious, providing her with time to calm before continuing to the hospital. However, there is no evidence that the ambulance service asked Lana about domestic abuse. Louis was repeatedly seen as helpful without any professional curiosity of his role. Good practice was shown when a referral was made for the eldest child after Lana had attempted suicide, but no ongoing supportive referrals were made for Lana. It was highlighted to the panel that the ambulance service was not aware of local referral pathways. Recommendations have been made to address this.

<u>Police and Fire services:</u>

4.3.7 Lana was known extensively to the police in relation to the abuse she experienced from Jensen and the abusive behaviour displayed by her elder two children. The police showed good practice by providing security items to her home, including a panic alarm. They also appropriately followed up with Lana's allegations against Jensen of malicious communications by cautioning him in March 2021. However, there were missed opportunities to support Lana, particularly as the police were one of the few agencies who were sighted on Louis's abusive behaviour against Lana. In April 2021, after contacting the police with concerns that Louis may have broken into her property and that she had an unexplained injury, no risk assessment was undertaken and the police assumed that the injury was self-inflicted. Two days later, after Louis threatened to burn Lana's home, a risk assessment was undertaken, but it was marked as medium risk on the police system but sent to Victim Support as standard risk and resulted in no further action.

4.3.8 In March 2022, the police did undertake a risk assessment after neighbours reported hearing shouting from the home. This was undertaken for both Lana and Louis and was risked as medium risk, but there was no evidence of a referral to MARAC. On this occasion, Lana was also arrested for assaulting a police officer, and Louis was noted to reference Lana's mental health issues. In June 2022, the police did arrest Louis for assault and damage, but Lana was again risked as medium risk with no referral to MARAC. These were missed opportunities to holistically see the risk Louis posed to Lana and to make appropriate referrals to specialist services. Lana also made allegations of being assaulted by police in December 2022, which was reviewed by two supervisory officers as being untrue prior to being closed. It is unclear what engagement was had with Lana during this review or what support was offered to her.

4.3.9 The police were also called to see Lana in relation to abusive behaviours displayed against her from her children. None of these interactions resulted in a referral to specialist services for Lana or her children.

4.3.10 The Fire and Rescue Service provided Lana with security measures and showed good practice in being led by Lana's needs when she declined an offer for a letterbox seal as she was worried about Jensen taking mail from an external mailbox, so they fitted a flap lock which allowed Lana to lock the letterbox. They also appropriately reported back to Rising Sun with an update.

Children's Services:

4.3.11 Lana was known extensively to Children's Services in relation to her previous relationship with Jensen and her four children. Children's Services showed good practice in centring the needs of the children and also made attempts to link Lana with mental health support. However, Children's Services were aware of the domestic abuse that Lana was experiencing from both Louis and Jensen. As well as how the children were being manipulated by Jensen, to display abusive behaviours against Lana as a continuation of his abuse post-separation, but space was not made to consider the risk this posed to Lana, nor the impact this had on her mental health. Jensen's behaviours i.e. not allowing contact, often went unchallenged and not understood in the context of domestic abuse. Lana's presentation as 'challenging to work with,' was not considered by professionals as trauma responses to abuse, and on occasion resulted in her being excluded from key meetings and discussions, e.g. not being invited to a core group meeting in April 2021 due to a prior difficult conversation. This resulted in Lana believing that Children's Services were 'taking sides.'

4.3.12 Lana expressed difficulty in her relationship with her two eldest children, but this did not result in any support for Lana. In September 2020, Child X had strangled Lana and bit her thumb and there were ongoing police calls outs over the timeframe of this review. Adolescent to parent abuse was not considered or explored as a form of domestic abuse by Children's Services, and the focus predominantly remained on how Lana's behaviours impacted the children. There was a missed opportunity to understand the impact of abuse and trauma on the children and how this may have

had an impact on their relationship with their mother. The children had expressed a preference to stay with Jenson or their maternal parents. Professional understanding of the ways in which the children may have been impacted by the traumatic events they witnessed, could have helped build a picture of the reasons why the children distanced themselves from their mother. Situating this in an understanding of domestic abuse would have also showed why the children appeared to aligned themselves with Jenson. The Review Panel also considered how children can be manipulated by an abuser to further perpetrate abuse against a victim. This is further explored in the analysis in section 5.

4.3.13 Knowledge of Louis's abusive history was known to Children's Services in September 2020 at a MARAC discussion on Lana's current partner. This was a missed opportunity to understand whether Lana continued to be a victim of domestic abuse during her relationship with Louis and how this may have impacted on her mental health. Further, in June 2021, when Rising Sun ended their involvement due to no further incidents of domestic abuse being recorded, this did not appear to be challenged by Children Services.

4.3.14 Kent Education Services demonstrated some good practice, such as agreeing to meet with Lana every two weeks from December 2020 to provide her with updates on the progress of her two younger children. In March 2021, good practice was also shown in a referral being made for Child X for supported housing through the adolescent team. However, contact ceased when the children had limited contact with Lana. Although a school's duty of care to an adult carer is limited, there was an opportunity to consider the impact of this on Lana, as no onward support was offered.

4.3.15 Children and Family Court Advisory and Support Service (CAFCASS) received an application from HMCTS regarding child arrangements between Lana and Jensen. In February 2023, the Court directed CAFCASS to prepare a Section 7 report by June 2023. There was no information provided to CAFCASS which indicated any immediate concerns relating to the children or to either of the parents whilst this awaited allocation. In addition, no interim arrangements were made for the children to spend time with their mother. Lana died before the Section 7 report could be completed and CAFCASS had no contact with Lana or her children.

<u>Housing:</u>

4.3.16 Southern Housing had limited contact with Lana, where she was a resident from 2013 to 2023, but this significantly increased from September 2020 onward. Southern Housing demonstrated best practice on a number of occasions through a needs-led and flexible approach. This included timely responses to repairs needing to be made, check-in calls to see how Lana was coping, signposting to debt services, support in downsizing, and offering to make referrals to domestic abuse and mental health services. In June 2021, Lana requested Southern Housing repair a door that had been kicked in. Safety planning was offered in a follow up call, but there was a missed opportunity to follow up with the police to see if they attended or if it was reported to them. There was also an opportunity from the Financial Inclusion Team to explore a

face-to-face meeting to discuss rental arrears with Lana in September 2022. A further missed opportunity was to have a discussion with Lana when she made an application to put Louis down as someone Southern Housing could speak to on her behalf in March 2022, in light of this wider context.

4.3.17 Town A Council's housing team supported Lana when she was struggling to pay her council tax in December 2020 and when she needed to submit an application to downsize to a smaller property in early 2023. There was an opportunity to query Louis's details, which were added to her online application to join the housing register in February 2022.

Support services:

4.3.18 Rising Sun provided Lana with support for the post-separation abuse she was experiencing from Jensen. The IDVA appropriately advocated for Lana with Children's Services and signposted Lana onto specialist support. Some work was also done to support Lana to understand warning signs with her new partner, Louis. There was a missed opportunity to advocate for Lana at the first two Children's Services core meetings due to the IDVA not being admitted into the first online meeting and being on annual leave for the second. Had the IDVA been able to represent and/or support Lana at these meetings, there may have been a way for agencies to work together to see if they could come up with a solution for Lana to have more contact with her children. The IDVA should have asked for a copy of the minutes and followed up with the various professionals after the meeting, to introduce herself if not already known and to discuss how best to support Lana.

4.3.19 Rising Sun decided not to refer Lana to their High Support Needs team due to her rapport with her IDVA. But this could have provided Lana with more in-depth support and for longer. Although there was no indication of high support needs on Lana's referral form into Rising Sun, there was no evidence that a transfer to the specialist IDVA team was discussed in case management. Rising Sun have informed the panel that they now have more robust case management processes and have also embedded better communication between teams.

4.3.20 Rising Sun also did not provide Lana with support around her experience of adolescent to parent abuse from her two elder children. Lana's second eldest child was receiving support by a Rising Sun Mentor, but the IDVA did not liaise with the mentor resulting in a missed opportunity to provide holistic support to the family, share learning within the team and think about how best the IDVA and mentor could work together to support and advocate for their clients. Child X was not known to Rising Sun, which was a further missed opportunity to understand the impact of abuse on Child X and the support that could have been offered in the context of domestic abuse.

4.3.21 In terms of the risk posed from Louis, a Clares Law was suggested, and check-in conversations were had, but a risk assessment was not completed as the IDVA was concerned that this would have suggested she did not believe Lana when she said that

Louis was supportive. Further, Lana's case with Rising Sun was closed without a risk assessment done regarding Louis, but with Jensen only.

4.3.22 Victim Support had contact with Lana in August 2022 and November 2022 where they followed up after police visits. In August, a text was sent to Lana with details of support and in November, Lana declined a referral to a domestic abuse service, so was offered support services options. There was no follow up or liaison with other services.

4.3.23 Forward Trust provided Lana with support for her substance use after she self-referred at Children's Services request. Her support was primarily telephone keywork sessions. There is no evidence that Forward Trust conducted routine enquiry of domestic abuse from Louis. Although it is noted that updates were provided to the IDVA, there are no details of these conversations, and it could be suggested that these conversations were not as effective as they could have been. Stronger communication may have supported Forward Trust to better understand Lana's substance use as a coping mechanism and response to trauma. There were also missed opportunities to explore support for Lana's mental health, especially at a meeting in May 2021 where Lana presented as confused and experiencing memory loss. It was agreed that Lana's case would remain opened until there were assurances of mental health support being in place, however this was not in place at the point of actual discharge from their service in August 2021.

4.3.24 The Department for Work and Pensions supported Lana with her Personal Independence Payment claim in November 2020 and June 2021. In her first application, she referenced Louis as providing her with extensive care and support and in June 2021, Universal Credit was paid into Louis's account. There was a missed opportunity to identify abuse and to link with other agencies in understanding Louis's caring responsibilities.

4.3.25 **Agencies' contact with Louis**

4.3.26 The following services had contact with Louis:

- Health
- Police
- Children's Services
- Support services

Health services:

4.3.27 Louis was registered with the same GP as Lana, but he had limited contact and never attended with Lana. He was known to Kent and Medway NHS and Social Care Partnership on a number of occasions. There were missed opportunities to understand the role he played in his care for Lana, especially after Lana disclosed in April 2023 that she had previously attempted to run him over. There was also a missed opportunity to refer him into specialist support after he was arrested and screened in July 2022, following an arrest for alleged domestic abuse assault.

Police:

4.3.28 Louis was known to the police both in relation to his abuse against Lana, his abuse of a former partner, threats made against Jensen, and threats against the neighbours. Although he was appropriately arrested and removed in July 2022 and April 2023, as a known repeat perpetrator, there were missed opportunities to understand the risk that Louis posed to others, and to refer him onto Multi-Agency Tasking and Coordination (MATAC) and appropriate perpetrator programmes.

Children's Services:

4.3.29 Louis was known to Children's Services as the alleged abusive partner of Lana and also in relation to the care of his child. There was a missed opportunity to flag the risk Louis posed to Lana, when Rising Sun were considering closing her case.

Support services:

4.3.30 Louis was known to Department for Work and Pensions where it was recorded in notes that Louis had declared that he was Lana's carer. No further queries were made and there was a missed opportunity to link with other agencies to understand the role Louis played in Lana's care.

5. Analysis

5.1 Domestic Abuse

5.1.1 Taking into account the government definition, information gathered by the police as part of the suicide investigation, information provided by agencies, and by Lana's family, it is clear that Lana experienced domestic abuse by both Jensen and then by Louis during the timeframe of this review. She also experienced adolescent to parent abuse from her two oldest children. The Review Panel also noted the significant impact of the domestic abuse on Lana's children.

5.1.2 Tragically, it will never be possible to know the full extent of Lana's experiences. However, as a minimum it appears Lana experienced the following:

- **Physical abuse:** In July 2022, police overheard Lana on the telephone telling Louis's mother that he had hit her. In September 2020, Child X was noted by Children's Services to have attempted to strangle Lana and bite her thumb.
- **Coercion, threats and intimidation**: Lana had extensive experience of coercive and controlling behaviour perpetrated by Jensen post-separation, which resulted in him being cautioned for malicious communications in March 2021. Louis also demonstrated these behaviours on a number of occasions, one of which was overheard on the phone by mental health services in November 2020 and by her GP in April 2023. As a result of Jensen' manipulation and post-separation abuse, Lana also received threats from her two elder children and was noted in September 2020 to tell the social worker that she felt scared and unsafe with them in the home.
- **Emotional abuse and isolation:** Lana's experience of isolation was compounded by her mental health support needs and by lockdowns associated with COVID-19. Describing himself as her carer, Louis would often act as an intermediary between Lana and support services, compounding her isolation and access to services.
- **Children:** Jensen used their children to exert power and abusive control over Lana, often described by Lana as manipulating the children and turning them against her. This was also noted by the IDVA and social worker. Sadly, Lana's older two children also displayed abusive behaviours against Lana during the timeframe of this review. Lana's children had also been exposed to extensive abuse and trauma, including allegation of abuse perpetrated against them from Jenson and Child X witnessing their mother's suicide attempt on their 16th birthday.
- **Economic abuse:** Louis was noted to have taken control of Lana's DWP payments. Samantha, Lana's sister, also highlighted that Louis controlled Lana's weekly shop payments from her father and that he was responsible for the loss of a significant sum gifted to Lana after her father released equity from his property.
- **Potential Abuse of Animals:** Lana had pets, including a dog. On one occasion, a dog was stolen from the front garden, and on another, a neighbour accused Louis of killing their cat. Abuse of animals can be a recognised indicator of coercive and controlling behaviour and escalation of risk.

Experiencing trauma, substance use, and mental ill-health:

5.1.3 The relationship between trauma, substance use, and mental health is well documented and has a significant impact on a victim being able to access support. Research shows that there is a direct relationship between being a victim of domestic abuse and experiencing mental distress; with depression, anxiety and PTSD being most identified, followed by self-harm and suicidal behaviour.[12] Further, research highlights that domestic abuse victims often use substances as a means to cope with the trauma that they are experiencing.[13] For example, victims may use alcohol to detach from painful experiences when their ability to spontaneously dissociate has been eroded[14] or use substances to moderate symptoms of PTSD.[15] We see this with Lana, when, after her children were taken by their father in September 2020, her mental health was severally impacted resulting in a suicide attempt, she started using substances as a coping mechanism, and a deterioration in her mental well-being was noted over the next few years. Lana herself was noted to tell CMHT on a screening in January 2023 that she felt she was suffering from PTSD after experiencing domestic abuse.

5.1.4 We also know from research that victims are not only at risk of further abuse from a current partner but may also be at risk of abuse in future relationships. Both substance use and serious mental illness influence the likelihood of being in unsafe environments and increase vulnerability to violence victimisation.[16] Perpetrators are well documented to use a victim's mental ill-health or substance use as a means of abusing them. Research[17] has found that:

- Perpetrators may blame their infliction of abuse on the victim's substance use or mental ill-health.
- They may use a victim's mental ill-health as an excuse to isolate the victim, saying she is unable to cope going out by herself, or discouraging her from participating in social activities such as seeing friends or family because she is an "embarrassment."
- They are known to prevent access to substance use or mental health services.

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[12]Golding, Jacqueline M. "Intimate partner violence as a risk factor for mental disorders: A meta-analysis." Journal of family violence 14 (1999): 99-132.

[13] Humphreys, Cathy, Ravi K. Thiara, and L. Regan. "Domestic violence and substance use: overlapping issues in separate services." Final Report, University of Warwick and London Metropolitan University (2005).

[14] Herman, Judith Lewis. "Complex PTSD: A syndrome in survivors of prolonged and repeated trauma." Journal of traumatic stress 5.3 (1992): 377-391.

[15] Hien, Denise, Lisa Cohen, and Aimee Campbell. "Is traumatic stress a vulnerability factor for women with substance use disorders?." *Clinical psychology review* 25.6 (2005): 813-823.

[16] Howard, Louise M., et al. "Domestic violence and severe psychiatric disorders: prevalence and interventions." Psychological medicine 40.6 (2010): 881-893.

[17] O'Brien, Kate, and Michael Daffern. "The impact of pre-treatment responsivity and treatment participation on violent recidivism in a violent offender sample." *Psychology, Crime & Law* 22.8 (2016): 777-797 and Fox, Bryanna, and David P. Farrington. "What have we learned from offender profiling? A systematic review and meta-analysis of 40 years of research." Psychological Bulletin 144.12 (2018): 1247.

- They may use verbal insults relating to mental health or substance use to damage a victim's self-esteem such as "junkie" or "nutter."
- They may excuse their own behaviour because of the victim's mental health or substance use problems by accusing the victim of causing the abuse by their own erratic behaviour.

5.1.5 Sadly, this research speaks directly to much of Lana's experience of abuse. The Review Panel considered the complex relationship between mental health, substance use, and domestic abuse and the need for a more nuanced understanding of how they intersect.

5.1.6 The Review Panel welcomed news Kent County Council's Domestic Abuse Project and Partnership (DAPP) Team have requested updates to be made to the Joint Working Protocol Co-occurring Conditions to include domestic abuse.

5.1.7 Further, Kent and Medway Safeguarding Adults Board (KMSAB) is also developing a Multi-Agency Risk Management Framework. This framework has been designed to improve practice for services working with an adult where there is a high level of risk of harm, and where the circumstances sit outside the statutory adult safeguarding framework, but where a multi-agency approach would be beneficial. It also enables a proactive approach which helps to identify and respond to risks before crisis point is reached. KMSAB is also undertaking surveys with people experiencing multiple disadvantage, to better understand the barriers people face in accessing services as part of their 'Making Every Adult Matter' work.

Learning Point: It is important to raise awareness of the relationship between substance use, trauma, and domestic abuse, and to address the barriers facing victims in accessing support. In adopting an approach which focuses on the way that victims use substances as a coping mechanism, the way that perpetrators use a victim's substance use and/or mental ill-health to control their victims, and the barriers substance use creates in the accessibility of support, it is possible to challenge any victim blaming and hold perpetrators to account.

Recommendation 1: Kent and Medway Safeguarding Adults Board and the Domestic Abuse and Sexual Abuse Executive Group to identify how it can better raise awareness and improve a trauma-informed response to people impacted by multiple disadvantage who have experienced domestic abuse**.**

Domestic abuse and caring responsibilities:

5.1.8 Although no formal assessment was undertaken by agencies, when speaking to professionals, both Lana and Louis referred to Louis as Lana's carer. He was noted by many agencies to play an active role in Lana's care and was often described as helpful. His role as Lana's carer went unquestioned and no assessment was undertaken to

understand his role and any associated risk he may have posed to Lana. The issue of perpetrators as carers of domestic abuse is considered to be overlooked by statutory organisations but are a feature of an increasing number of domestic homicide reviews.[18] There is a need, therefore, for agencies to understand the links between care and domestic abuse.

5.1.9 This is particularly true when considering the relationship between caring responsibilities and economic abuse. We know that perpetrators may insist on controlling a victim's finances citing the victim as mentally incompetent or suggesting the victim will spend it all on drugs or alcohol.[19] We see this in Louis taking control of Lana's DWP payments as well as the funds provided by her father.

5.1.10 The Review Panel welcomed news that Kent Community Safety Partnership has held a number of awareness raising events on the links between domestic abuse and caring responsibility. Further, a multi-agency protocol has been published focusing on safeguarding adults with care and support needs for those who are impacted by domestic abuse.

Learning Point: Caring responsibilities are varied, and it is important that professionals recognise the impact of supporting someone with mental ill-health. Further, the issue of carers as perpetrators of domestic abuse is being overlooked by statutory organisations because they often do not fit the traditional patterns of being in a relation with an abusive person, and the complexities of the caring role can make typical safety options unsuitable.[20]

Recommendation 2: Kent and Medway NHS and Social Care Partnership Trust to review their processes in relation to their responsibility in identifying and supporting carers.

Recommendation 3: Kent and Medway Safeguarding Adults Board to embed their multi-agency protocol to safeguard adults with care and support needs who are impacted by domestic abuse, particularly circulating this to agencies who sit outside of their membership.

[18] Amanda Warburton-Wynn, "Carers and domestic abuse – the elephant in the room?" The journal of adult protection, 2023, 25:1, pp. 14-19.

[19] O'Brien, Kate, and Michael Daffern. "The impact of pre-treatment responsivity and treatment participation on violent recidivism in a violent offender sample." *Psychology, Crime & Law* 22.8 (2016): 777-797 and Fox, Bryanna, and David P. Farrington. "What have we learned from offender profiling? A systematic review and meta-analysis of 40 years of research." Psychological Bulletin 144.12 (2018): 1247.

[20] Amanda Warburton-Wynn, "Carers and domestic abuse – the elephant in the room?" The journal of adult protection, 2023, 25:1, pp. 14-19.

Domestic abuse and the impact on children:

5.1.11 Lana had a challenging relationship with her two elder children which was compounded by their exposure to domestic abuse and by Jensen' post-separation abuse tactics. In addition, Lana described her social worker as 'taking sides' with Jensen and she frequently raised that she felt her voice was unheard by Children's Services, further alienating her from her children. Research highlights the comparative lack of accountability attributed to fathers who perpetrate domestic abuse in child protection settings, and the parallel, routine responsibilisation of mothers within this same frame.[21] We also know that children represent a significant risk factor for continued abuse post-separation,[22] and the threat of court proceedings produces a relationship between mothers and services which is often fractured and distrustful.[23]

5.1.12 In addition, we know that a victim's parenting abilities may be affected by experiencing domestic abuse, substance use, and mental ill-health. It was important that Lana's children's safety and well-being was taken into consideration, but the greatest risk of harm comes from the perpetrator.[24] The panel considered the strained relationship with Children's Services and the impact this had on Lana reaching out for support. For example, Lana was noted to downplay her relationship with an abusive person (Louis) as she was worried how this would be viewed by Children's Services.

5.1.13 The panel also considered the impact of the domestic abuse and trauma on Lana's children. In 2021, the Domestic Abuse Act formally recognised children as victims of domestic abuse through witnessing it, but research by the Domestic Abuse Commissioner has found that only 29% of victims of domestic abuse reported that they were able to access the specialist support they wanted for their children. Further, we know that exposure to domestic abuse has a profound impact on children, including impacting their mental well-being, physical health, and emotional and behavioural development.[25] Sadly, we see this with Lana's children, but particularly with Child X who had additional support needs identified by the school and Kent Education Services. Child X was also diagnosed with depression in 2021. The panel considered the adverse impact of the domestic abuse on the children and the need for specialist support for them.

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[21] Wild, J. Gendered Discourses of Responsibility and Domestic Abuse Victim-Blame in the English Children's Social Care System. J Fam Viol 38, 1391–1403 (2023)

[22] Katz, E., Nikupeteri, A., & Laitinen, M. (2020). When Coercive Control Continues to Harm Children: Post-Separation Fathering, Stalking and Domestic Violence. Child Abuse Review, 29(4), 310–324

[23] Robbins, R., & Cook, K. (2018). 'Don't Even Get Us Started on Social Workers': Domestic Violence, Social Work and Trust—An Anecdote from Research. The British Journal of Social Work, 48(6), 1664–1681.

[24] Against Violence & abuse: Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health: 2013. PP. 25

[25] Cleaver, H (2025) Domestic abuse and the impact on young children: A UK perspective. Children and Youth Services Review Volume 172,

5.1.14 Research also shows that women who experience domestic abuse are three times more likely to develop mental illness, resulting in apathy and impaired concentration.[26] The impact of the domestic abuse on Lana's mental health has been discussed in this review, but it is important to highlight the result of apathy and impaired concentration and the impact of this on her children. The Review Panel discussed Lana's prescription overdose in the presence of Child X in 2020, as well as the argument in 2021 where Lana told Child X that no one wanted them, after Child X refused to stay with Lana. Research by Mahase goes on to state that a young child's emotions and behaviours are to a great extent dependent on the moods and actions of those caring for them. The apathy and despair many abused parents feel may leave them unable to respond to their children, in turn leaving the child feeling unloved, unlovable and unwanted. Sadly, we see this with Lana and her children.

5.1.15 The Review Panel also discussed the abusive behaviours that Lana experienced from her two eldest children, and how they were not picked up and addressed by either Children's Services, the Police, Lana's GP, or Rising Sun. The responses from Lana's children towards her were not considered as part of Jensen' control and manipulation (discussed further in section 5.2) nor were they seen as a triggering event for Lana given her past trauma. These behaviours were often considered as part of Lana's parenting strategies or a result of her behaviours i.e. her substance use.

5.1.16 The panel considered the Safe and Together Model, which improves professional competencies and collaboration in cases involving children exposed to the behaviour of a domestic violence perpetrator. The model aims to shift traditional assumptions made in child welfare interventions, as these hamper the ability to fully assess the impact of the perpetrator's pattern of behaviour on family functioning and safety. These assumptions include:

- seeing the perpetrator's pattern of behaviour towards his adult partner separately from his behaviour towards his children
- focusing on the family's living arrangements and the couple's relationship status as proxies for safety, particularly child safety, instead of assessing his pattern of behaviours regardless of family living arrangements and relationship status
- ignoring or minimising the perpetrator's role as a parent and co-parent, and holding him to a lower standard of parenting than his female partner

Learning Point: The impact of domestic abuse on children, and the ongoing role of abusive fathers' post-separation needs to be better understood by services. It has been highlighted that the notion that violent men should address their fathering in the context of domestic abuse has been even "slower to emerge" in child protection practice.[27]

[26] E. Mahase (2019) Women who experience domestic abuse are three times as likely to develop mental illness. British Medical Journal

[27] Smith, J., & Humphreys, C. (2019). Child protection and fathering where there is domestic violence: Contradictions and consequences. Child and Family Social Work, 24(1), 156–163

It is also important that an understanding of domestic abuse is not just limited to that which takes place in an intimate relationship. The Domestic Abuse Act 2021 created a statutory definition of domestic abuse and recognises abuse between relatives, including adolescent child against parent. More needs to be done to broaden understanding to ensure that professionals are able to identify and respond to wider forms of domestic abuse.

Recommendation 4: Kent Children's Services to ensure staff are trained in understanding post-separation perpetration of domestic abuse in the family context.

Recommendation 5: Kent Children's Services to look to adopt the Safe and Together best practice model.[28]

Recommendation 6: Kent Community Safety Partnership to identify how to raise awareness of domestic abuse experienced within a broader familial context of adolescent child to parent abuse.

A trauma-informed approach:

5.1.17 A number of services highlighted the challenge in supporting Lana, often describing her as "aggressive" and "hostile." As a result of her behaviour, Lana was discharged from CMHT to her GP in August 2022, and a re-referral into their service was declined later that month due to their zero-tolerance policy. Although staff safety is paramount, it is important to recognise that victims of domestic abuse and mental ill-health may, and often do, present as challenging and "difficult." It is vital that services understand how to identify and be led by the needs of victims, understanding that their response is a normal response to abnormal circumstances.

5.1.18 Research has found that survivors of abuse and multiple disadvantage find that statutory mental health services are the most difficult to access.[29] It is vital, therefore, that a trauma-informed approach is adopted by services to better respond to and meet the needs of survivors. Trauma-informed care is defined as a "strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense

[28] https://safeandtogetherinstitute.com/the-sti-model/model-overview/ (accessed September 2024)

[29] https://safelives.org.uk/news-views/trauma-informed-work-the-key-to-supporting-women/ (accessed September 2024)

of control and empowerment"[30] It is based on five core principles of safety, trustworthiness, choice, collaboration, and empowerment.

5.1.19 Services that embrace 'resilience over pathology' are ones that women are much more likely to use and feel supported by. A shift from 'what's wrong with this person?' to 'what happened to this person?' is the essence of this approach.[31] This approach would have benefitted Lana who had often communicated that she felt unheard and sometimes judged by services.

Understanding who does what to whom:

5.1.20 Lana's presentation also led to her being considered by the police as a perpetrator against Louis in March 2022. In instances where a couple are seen "to be as bad as each other," research by Hester shows that a more nuanced understanding is needed of who does what to whom.[32] Hester's analysis in 2009 of 96 police cases of domestic abuse perpetration found that where alcohol is involved, it is more likely to arrest both parties as the circumstances appear "chaotic." However, the research also found that violence by men was more likely to involve fear and control of victims and be a repeat pattern. In contrast, women were more likely to use violence in self-defence and had lower records of repeat incidents, indicating that they were not instigating a pattern of coercive control.

5.1.21 Further, Johnson distinguishes between different forms of conflict and control and highlights that "mutual violence" is often assumed rather than an understanding of "violent resistance," whereby an individual is violent, but not controlling, and is responding to the power and controlling behaviour of the abuser.[33] The panel considered how understanding who does what to whom can support agencies to understand how to identify and appropriately respond to risk and need. It also ensures that abusers are held to account.

Learning Point: Domestic abuse victims come from all walks of life and present in a myriad of ways. It is important that agencies do not hold a stereotypical view of what a victim looks and behaves like. Understanding that domestic abuse is the result of the misuse of power and control ensures that professionals recognise who does what to whom and that the right response is adopted.

[30] Hopper, E.K., E.L. Bassuk, and Olivet, J. 2010. Shelter from the storm: Trauma-informed care in homelessness services settings. The Open Health Services and Policy Journal, 3, pp 80-100.

[31] https://safelives.org.uk/news-views/trauma-informed-work-the-key-to-supporting-women/ (accessed September 2024)

[32] Hester, M. (2013). Who does what to whom? Gender and domestic violence perpetrators in English police records. European Journal of Criminology, 10(5), 623-637. https://doi.org/10.1177/1477370813479078

[33] Johnson MP (2006) Conflict and control: Gender symmetry and asymmetry in domestic violence. Violence Against Women 12(11): 1003–1018.

Recommendation 7: The police to ensure officers are trained in understanding who does what to whom and link with a Respect accredited service for domestic abuse perpetrator training in order for appropriate referrals to be made into perpetrator programmes.

Multiple perpetrators:

5.1.22 Lastly, it is clear that Lana was experiencing abuse from multiple perpetrators, but the impact of this was not fully explored or understood by agencies, resulting in missed opportunities to respond to risk. Although abuse from Jensen was recognised and Lana was referred to support from Rising Sun, the abuse from Louis was not fully understood, and the adolescent to parent abuse was not explored. Lana would downplay the abuse from Louis, partly because of her involvement with Children's Services, but also because we know that victims who have been in a previous relationship with an abusive person may not identify the new relationship as abusive based on tactics adopted by the new partner.

5.1.23 Although Rising Sun did undertake some work with Lana on domestic abuse warning signs, Lana's case was closed to them without a fuller understanding of the impact of Louis's behaviour, as well as the abuse displayed by her two elder children.

Learning Point: Experiencing abuse from multiple perpetrators can have a profound impact on victims and affect how they are able to access support. It is important that professionals have a dynamic understanding of risk and respond with a needs led approach.

Recommendation 8: The Domestic Abuse and Sexual Abuse Executive Group to identify how to raise awareness of domestic abuse perpetrated by multiple abusers.

Recommendation 9: Rising Sun to review their policy on risk assessment at case closure in relation to a new partner of the client due to be closed, and under what circumstances a DASH RIC might be appropriate.

5.2 Analysis of Agency Involvement / Responding to the Terms of Reference

5.2.1 The following section responds to the lines of enquiry as set out in the Terms of Reference in section 1.6.

Analyse the communication, procedures and discussions, which took place within and between agencies. The co-operation between different agencies involved with Lana and Louis.

5.2.2 There were a significant number of services who were supporting Lana and who held key information regarding her experiences, but this review has highlighted that this information was not often shared with other agencies to better coordinate support for Lana. This is despite Lana being discussed at MARAC in 2019 and 2020, which should have presented an opportunity for communication between agencies. By focusing on Jensen as the sole perpetrator, however, there were missed opportunities to see Lana's holistic experience and provide wrap-around support for her.

Between Children's Services, Rising Sun and Forward Trust

5.2.3 In particular, the information held by Children's Services in relation to the children displaying abusive behaviours were not followed up by Rising Sun. This could have supported Rising Sun to develop a support package which considered multiple forms of domestic abuse and could have reinforced the need for Lana to be referred to the specialist provision that could have been provided by the High Support Needs team. A more joined up approach between the two services could have resulted in a better understanding of the risk that Louis also posed, and why Lana may have wanted to downplay his abuse due to her concerns of the impact this would have regarding access to her children. In addition, when Rising Sun were making plans to withdraw Lana from their service in June 2021, there was a missed opportunity for Children's Services to flag the ongoing risk that Louis posed to Lana.

5.2.4 Lana was in the care of Forward Trust until April 2021. During this time, they were sighted on her history of domestic abuse, and they were in contact with Children's Services. She also had contact with Rising Sun. The IDVA did not judge Lana's history of drug use, or her partner's, recognising her drug use as a coping strategy for the trauma caused by domestic abuse. When Lana relapsed, the IDVA discussed a referral to Forward Trust with her and completed the referral on her behalf. She also called the Forward Trust to discuss the referral. This conversation informed the IDVA that Lana was already engaging with the Forward Trust and was intending to access support through the Priory. The IDVA was then able to discuss this with Lana in her next call and learn that she was accessing counselling sessions from the Priory as well as receiving support from the Forward Trust. The IDVA praised Lana for her accessing support around drugs and having a plan for moving forward. As discussed earlier, there are strong links between substance use and domestic abuse, with victims often using substances as a way to manage their trauma. It is important to note that, during the timeframe of this review, Forward Trust did not have a domestic abuse policy. The Review Panel welcomes the news that a new domestic abuse policy is in place as part of Forward Trust's wider Domestic Abuse Strategy. It is important that multi-agency working is captured in this policy.

Between the police and key agencies

5.2.5 The police had responded to a number of call outs regarding abusive behaviours displayed against Lana from her two elder children as well as domestic abuse perpetrated by Louis. However, none of these resulted in onward referrals, except to Victim Support in August 2022 and November 2022. The support from Victim Support was limited, as Lana did not want to engage, and no follow up support was offered. Referrals into MARAC would have likely yielded better results as Lana's experience would have been flagged with Children's Services, Health Services, and resulted in a dedicated IDVA support and access to a substance use service.

5.2.6 Despite both Jensen and Louis being known as repeat offenders, neither were known to MATAC or Multi-Agency Public Protection Arrangements (MAPPA). It is important that the police focus on holding perpetrators to account and using established multi-agency frameworks to support them to do so.

Within health services, and between health services and other key agencies

5.2.7 Lana had extensive contact with a number of services offered by different teams at Kent and Medway NHS Trust, who all held information into Lana's experience. It is important to highlight that the IMR Author met with the CMHT Service Manager for the purpose of this review, and they confirmed that the team were under resourced during the timeframe of the review. Despite this, there were good practice examples of inter-agency working, such as referrals to drug addiction support services and undertaking checks in respect of safeguarding of the children. However, despite knowledge of domestic abuse being raised with professionals, no onward referrals were made to domestic abuse services.

5.2.8 It is also important to note that Kent and Medway NHS and Social Care Partnership were asked to provide research for Lana at two MARAC meetings (both in relation to Jensen) in September 2019 and September 2020, yet no actions were identified for them. The Panel considered the way the MARAC was working during this period, especially as research highlights that staff do not have the time to devote to MARAC nor given enough resources to support the initiative.[34]

5.2.9 When Lana was discharged from their service back to the GP in August 2022, the Review Panel found that there was limited partnership working to consider the additional support that could have been offered to Lana once she was no longer in their care.

5.2.10 EKHUFT has an established Hospital Independent Domestic Violence Advisor (HIDVA) service, which consists of domestic abuse specialist workers employed through honorary contracts to work across the Trust. This is clear evidence of best practice in terms of co-located support. However, despite Lana's disclosure to the Trust, there is no documentation to determine whether a referral to the HIDVA was discussed or

[34] Robbins, Rachel;McLaughlin, Hugh;Banks, Concetta;Bellamy, Claire;Thackray, 'Domestic violence and multi-agency risk assessment conferences (MARACs): a scoping review.' The journal of adult protection (2014) 16:6, PP 389 - 398

made. There is a need, therefore, to ensure that internal referral processes are robust, and staff are trained to follow them.

5.2.11 However, the Review Panel welcomed plans for a new service level agreement that will be in place between KMPT Mental health and EKHUFT to improve joint working and supporting service users. This provides a good opportunity to strengthen a whole health approach to domestic abuse. This agreement must include guidance on domestic abuse and can draw on the learning of the Whole Health Pathfinder Programme. The Pathfinder Programme is a whole-system approach to health and domestic abuse. Its ambition is to create an innovative, comprehensive and sustainable model responding to domestic abuse across the health economy. [35]

5.2.12 Collaboration, teamwork, joint working, partnership working, multi-agency practice, and integrated responses are all terms to describe the ways in which professionals and agencies can work together to support victims and their families. Partnership working can range from informal sharing of information about a service user (with their consent) between two professionals, to service level agreements between organisations that formalise interagency referral pathways. Working collaboratively can be beneficial for professionals and service users. For clients, effective partnership working is vital in reducing:[36]

- the number of inappropriate referrals between agencies.
- the number of times someone has to 'tell their story'.
- the number of appointments with and phone calls/letters from professionals to deal with which can feel overwhelming.
- the time and stress of coordinating different professionals.
- the feeling of being "passed from pillar to post" without getting anywhere.
- the likelihood of getting lost in the gaps between services.
- better understanding of the client as a whole person and how different parts of their life can impact on the area that you specialise in.
- more opportunity to intervene early and prevent crisis from arising or escalating.
- greater engagement with service users who feel more supported.
- ability to learn from colleagues and see things from a different perspective.
- inspire innovation and creativity in the development and delivery of services.

5.2.13 The Review Panel welcomed news that the Domestic Abuse and Sexual Abuse Executive Group is undertaking a review of their MARAC processes which will include setting up a joint funding model with contributions from various agencies, a new resourcing structure, updating operating protocols and training, and introducing a new

[35] https://www.standingtogether.org.uk/health

[36] Against Violence & abuse: Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health: 2013. PP. 206-207.

case management system in 2025 to better support information sharing and management of actions.

Learning point: Ensuring internal and external referral processes are robust are vital to creating a coordinated community response to domestic abuse. We know that no one agency can single handily tackle domestic abuse and therefore a joined-up approach is needed to effectively share information and provide victims with the support they need.

Recommendation 10: Forward Trust to review their multi-agency working arrangements and ensure that they have a joined approach to supporting service users who experience multiple disadvantages.

Recommendation 11: Police to review how they undertake domestic abuse risk assessments to ensure that officers are correctly making referrals based on assessment outcome and professional judgement. Police should also ensure that domestic abuse risk assessments include an assessment of a pattern or history of abuse in order to avoid responding to incidents in isolation.

Recommendation 12: The Domestic Abuse and Sexual Abuse Executive Group to monitor and review impact of their changes to their MARAC process to ensure it effectively responds to high-risk cases.

Recommendation 13: EKHUFT to review internal processes to ensure effective referrals into established Hospital Independent Domestic Violence Advisor (HIDVA) service.

Recommendation 14: Health partners to adopt a Whole Health Approach to domestic abuse.[37]

The opportunity for agencies to identify and assess domestic abuse risk and agency responses to any identification of domestic abuse issues.

[37] https://www.standingtogether.org.uk/pathfinder

Health services

5.2.14 As discussed elsewhere in this report, there were a number of missed opportunities to identify and appropriately ask about domestic abuse by a number of health agencies. Some services did not broach the subject despite clear indicators/disclosure made by Lana. As stated previously, in October 2022, Lana told the assessing clinician at EKHUFT that she had been in a relationship with an abusive person and was now in another one and did not feel safe to go home. No risk assessment, referral to the HIDVA, or referral to MARAC was made. The Review Panel recognised this as a clear missed opportunity to engage with Lana and respond to her clear disclosure. Since this, EKHUFT has embedded a new Domestic Abuse policy in May 2023 which includes routine domestic abuse enquiry at all attendances. This will support the Trust to better identify domestic abuse, but this policy must include guidance and training on how to appropriately respond once a disclosure is made.

5.2.15 With Kent and Medway, Lana was not asked about domestic abuse, but when she did share information, a safe approach was not adopted. For example, in April 2023, Lana was asked about her experience of abuse from Louis whilst on the phone with Louis shouting in the background. This was not safe practice and could have increased risk to Lana. Despite Lana being engaged with a number of different Kent and Medway teams, she was not asked about domestic abuse. Enquiries made by Kent and Medway NHS and Social Care Partnership for the purposes of this review found that Service Managers identified a "grey area" in terms of which team was responsible for undertaking DASH risk assessments. It is important that teams work in a coordinated way and understand the roles and responsibilities they all play in identification, safe enquiry, and appropriate follow-up.

5.2.16 Lana's GP provided her with a range of support and referred her to specialist mental health support, but her experiences of domestic abuse were not fully explored by the GP. It was noted in the ICB IMR that the GP found 'no significant presentations which would have led to suspecting domestic abuse'. As discussed earlier, the Review Panel discussed the importance of not making assumptions about how a victim may or may not present and instead introduce routine enquiry to best support victims of abuse. It was shared with the panel that funding has been provided in Maidstone and Canterbury to pilot the IRIS programme but the GPs in this review are not part of this pilot. IRIS is a specialist domestic abuse training, support and referral programme for GPs that has been positively evaluated in a randomised controlled trial. [38] It is a partnership between health and the specialist domestic abuse sector and provides in-house domestic abuse training for general practice teams and a named advocate to whom patients can be referred for support. The IRIS programme can support GPs to better identify and respond to domestic abuse and is a programme which Lana's GP would benefit from

[38] Feder, Gene et al, 'Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial.' The Lancet, Volume 378, Issue 9805, 1788 - 1795

in supporting victims. The panel welcomed that attempts to secure funding for IRIS remain ongoing.

5.2.17 Lana first came into contact with South East Coast Ambulance Service in February 2020 regarding abdominal pain and was then seen a further 10 times until their final visit where Lana was sadly found deceased in May 2023. The majority of these visits were related to Lana's mental ill-health. The ambulance service provided Lana with appropriate support with her presenting needs; however, she was not asked about domestic abuse during her engagement with them. Lana was noted to have disclosed to the ambulance service that her ex-husband was the cause of much of her stress and anxiety, but no direct enquiry was undertaken. The National Institute for Health and Care Excellence (NICE Guidance) recommend that ambulance staff should be trained to ask about domestic abuse in a way that makes it easier for people to disclose it. This involves an understanding of the epidemiology of domestic violence and abuse, how it affects people's lives and the role of professionals in intervening safely. Staff should also be able to respond with empathy and understanding, assess someone's immediate safety and offer referral to specialist services.[39]

Support services

5.2.18 Rising Sun provided Lana with extensive support and advocacy, and she had a good relationship with her IDVA. The IDVA provided a range of support in relation to Jensen, and some safety planning with Louis. However, the opportunity to further explore the domestic abuse perpetrated by Louis was limited. The IDVA explained that she was cautious about asking further questions about Louis because Lana said he was not abusive and the IDVA did not want to give the impression that she did not believe Lana. However, we know from research that both substance use, and serious mental illness influence the likelihood of being in unsafe environments and increase vulnerability to violence victimisation, meaning that victims are not only at risk of further abuse from a current partner but may also be at risk of abuse in future relationships.[40] This should have supported the IDVA to routinely revisit the issue of domestic abuse whilst Lana was in their service, and influenced the exit assessment. In addition, there was a missed opportunity to adopt a holistic approach to supporting the family by the IDVA linking up with the mentor supporting Lana's second eldest child between November 2020 and March 2021.

5.2.19 It was highlighted that at this time Rising Sun's policy was for an IDVA to have a case management meeting with the Line Manager once a month to review all their cases. This did not happen monthly on this case for a number of reasons, including:

[39] https://www.nice.org.uk/guidance/ph50/chapter/Recommendations Recommendation 15

[40] O'Brien, Kate, and Michael Daffern. "The impact of pre-treatment responsivity and treatment participation on violent recidivism in a violent offender sample." *Psychology, Crime & Law* 22.8 (2016): 777-797 and Fox, Bryanna, and David P. Farrington. "What have we learned from offender profiling? A systematic review and meta-analysis of 40 years of research." Psychological Bulletin 144.12 (2018): 1247.

a) it was a particularly busy period for referrals (whereby services nationally saw an increase in referrals following the COVID-19 pandemic).

b) the Line Manager felt that the IDVA was very experienced and would come to her if there was a problem.

c) on one occasion the Line Manager had taken Lana off her list of cases to be reviewed because the case had previously been discussed as closing and so was missed.

The Review Panel have since been informed that Rising Sun have reviewed their management structure to ensure that there is a better ratio of service managers to IDVAs and that there is an improved system of downloading all open and pending cases from the case management system at the start of a case management meeting so that none get missed. This is good practice and ensure that service users do not slip through the net.

5.2.20 Victim Support had contact with Lana in August 2022 and November 2022. In August, the responses included a text to Lana, which follows their standard procedural response to a standard risk case. In November, a phone call was made to Lana, as this is the standard procedural response to a medium risk case. Lana was noted to have declined a referral to a domestic abuse support agency stating that completing a needs assessment would be too emotional for her, however she did accept the offer of security items. There was no follow up by Victim Support or attempt to connect with Rising Sun to build a picture of need or to share information.

Police

5.2.21 The police responded to a number of calls made by Lana and also, on occasion, by Lana's neighbours. The review has found that the police did undertake risk assessments in March 2022 and in June 2022, showing that processes were followed in identifying domestic abuse and in ascertaining risk. Attempts were also made to remove Louis from the property in order to manage any escalation. This is good practice. However, the review has found that the assessments did not result in support for Lana or a referral to MARAC, although referrals were made to Victim Support as discussed above. The review also found inconsistencies in how risk was identified which impacted ongoing referrals. The police held information of a pattern of abuse from multiple abusers, yet it appears that each incident was viewed in isolation. As discussed earlier, there was also some confusion as to ascertaining who was the primary perpetrator and who does what to whom.

5.2.22 The police were asked to review decision making in regards to the incident where Louis threatened to burn down Jensen's home and words of advice / safeguarding advice given. The review found that extensive safeguarding was undertaken. Support from the fire service was offered but felt by the victim to be unnecessary due to the limited access to his flat; conviction and court orders were considered but not feasible; there were limited lines of enquiry. The victim was content with the outcome and the case was reviewed by a supervisor who agreed with the steps taken. The report was taken seriously from the outset and this is clear from the investigation; all reasonable lines of

enquiry were carried out very quickly; rationale and thought process is clearly documented. The report was reviewed by a temporary Sergeant and another PC who was acting as Supervisor. In relation to safeguarding for Lana around this incident, this was the first incident where Lana and Louis are noted as being in a relationship. She was not the victim of this crime and little was known about Louis at the time. A MARAC at a similar time for Lana and Jensen considered a DVDS for the new partner, but Lana would not provide his name. Two days after the report a hidden harm check was made for Lana and safeguarding offered in relation to Jensen. After this Lana made a Claire's Law request in relation to Louis and she was offered safeguarding as a result of this too.

Housing

5.2.23 Southern Housing provided Lana with a range of support and demonstrated best practice by going further to check in with Lana and signposting her to mental health support. There was an opportunity for Southern Housing to identify domestic abuse and refer Lana onto specialist support. The Review Panel welcomed news that Southern Housing has signed up to the Kent Safer Protocol to support them to work in a more coordinated and multi-agency way. They are also looking to recruit to their new specialist safeguarding team and work towards achieving Domestic Abuse Housing Alliance (DAHA) accreditation.

Learning point: People need encouragement to disclose domestic abuse, and disclosures need to be followed by action.[41] There is no point in routinely enquiring if there is no action afterwards. In fact, research shows that certainly in the case of domestic abuse, asking and taking no action can be more detrimental than not asking at all.[42] It is vital that professionals are appropriately trained to ask and respond to domestic abuse.

Recommendation 15: Kent and Medway NHS and Social Care Partnership to ensure staff are trained to identify and safely ask about domestic abuse, and, once disclosure is made, to appropriately refer onto support.

Recommendation 16: Continued efforts to be made to secure funding for the IRIS Programme to be delivered across GPs involved in this review.

[41] Against Violence & abuse: Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health: 2013. PP. 50.

[42] Parnitzke Smith, C. & Freyd, J.J. (2013). Dangerous Safe Havens: Institutional Betrayal Exacerbates Sexual Trauma. Journal of Traumatic Stress, 26, 119-124

Recommendation 17: South East Coast Ambulance Service to ensure that staff are proactively enquiring about domestic abuse and have knowledge of local referral pathways.

Recommendation 18: Victim Support to review their processes to ensure that repeat referrals, where escalation of risk has been identified, are appropriately risk assessed, and victims are provided with support.

The policies, procedures and training available to the agencies involved in domestic abuse issues.

5.2.24 Agencies involved in this review have a range of policy, procedures, and training in place in relation to domestic violence and abuse and these were described in each agency's IMR/short report.

5.2.25 A summary of the agencies with domestic abuse policies and their training is outlined in the table below:

Agency	Domestic Abuse Policy and review date at time of this report	Domestic Abuse Training
Kent Children's Services	Yes, last reviewed February 2024	KCS offer a range of non-mandatory domestic abuse training to staff on topics including Working with perpetrators; Child to Parent Violence and Abuse; Trauma Informed Responses; Gender privilege and father inclusive practice; and Parental Substance Misuse, Parental Mental Ill-Health and Domestic Abuse.
CAFCASS	Yes, last reviewed March 2023	Mandatory domestic abuse training package which includes: 1) Domestic Abuse Learning and Development Programme module 2) Mental Health and the Abuse of Power in Domestic Abuse module (launched in 2023)
Kent Maintained Schools and Academies	Child Protection Policy. No standalone domestic abuse policy.	All staff are also expected to read and understand Part One of Keeping Children Safe in Education which defines domestic abuse. Designated Safeguarding Leads in Schools are also expected to be updated at least annually and have training on their role and responsibilities at least every two years. Further details of what should be included can be found in KCSIE. Whilst the ESS provide DSL training for school staff, as noted above, it is not a mandatory

		requirement for schools to access training from specific providers
NHS Kent and Medway Integrated Care Board	Yes, last reviewed June 2024.	Regular domestic abuse and safeguarding training offered to all constituent primary care teams and is mandatory within each practice. Additional training was arranged for January 2025 to primary care staff by an external provider.
East Kent Hospitals University Foundation NHS Trust	Yes, next review due in February 2026	Mandatory Level 3 Safeguarding Training includes section on domestic abuse delivered by the Hospital IDVA team. The team also provide monthly updates for community midwives. Additional ad hoc training is offered.
Kent and Medway NHS and Social Care Partnership	Yes, last reviewed November 2023	Mandatory Safeguarding training in place. Domestic Abuse is covered as a topic in all levels of safeguarding training with increased depth of discussion at level 3. Also offer DASH RIC training which is not mandatory.
Kent Community Health NHS Foundation Trust	Yes, last reviewed May 2023	Domestic abuse is included in safeguarding training. All staff are expected to complete suicide awareness training. In addition, Health Visitors receive domestic abuse training from the institute of health visiting.
Adult Social Care Services	Multi-agency domestic abuse protocol in place	Staff have access to Safeguarding Training and Domestic Abuse as part of their roles.
South-East Coast Ambulance Service	Safeguarding Policy in place. No standalone domestic abuse policy.	Included within Level 2 Safeguarding training for all staff and within Level 3 training for registrants
Town A Housing	No standalone domestic abuse policy.	Mandatory safeguarding training includes a section on domestic abuse. All managers and front-line staff, including housing staff must complete additional face-to-face safeguarding training when they join Town A Council and on a three-year refresher cycle.
Southern Housing	Yes, last reviewed in March 2024	Domestic Abuse E-Learning – All Staff (Mandatory) Domestic Abuse – Level 1 & 2 (Every 3 years incorporated in department training plan) DASH Training – Case Holder/Case Officers (Every 3 years incorporated in department training plan)
Kent Police	Yes, last reviewed February 2023	Domestic abuse training is included within probationer police officer training. Training is mandatory for all new police officers, for new

		PCSO's, new Special Constables, and for trainee detectives. Additional mandatory training for all officers up to and including Chief Inspectors within the 'Protecting Vulnerable People.' Advanced domestic abuse courses are delivered to domestic abuse specialist personnel.
Kent Fire and Rescue Service	Safeguarding Policy in place. No standalone domestic abuse policy.	All staff are trained to Level 1 Safeguarding standard which includes domestic abuse. Fire crews and Safe and Well Officers are trained to level 2 safeguarding – which also includes domestic abuse. Managers and supervisors of the Safe and Well team are trained to level 3 safeguarding.
DWP	Domestic abuse and violence guidance in place	DWP Work Coaches undergo learning to support customers with additional or complex needs, including domestic abuse. Work Coaches are trained to identify signs of domestic abuse, provide empathetic support and signpost to specialist domestic abuse support.
Forward Trust	Adult Safeguarding Policy No standalone domestic abuse policy in place, but in is development.	Domestic abuse is included in Safeguarding training mandated to all Forward Trust staff. All Forward Trust staff have access to central training resources for their CPD including a Domestic Abuse and Violence Against Women and Girls module (not mandatory).
Rising Sun	Yes, last reviewed in October 2021	Mandatory induction training including: Introduction to DA and the Rising Sun Framework Understanding the context of DA/Introduction to Domestic Abuse/Power and Control/Victim Blaming/ Coercive Control/Post Separation Abuse/DA and Children/Barriers to Action/Trauma Informed Response Additional non-mandatory DA training includes: Shadowing and case management/Reflective practice in supervision/Specialist courses/Safe lives IDVA training
Victim Support	Yes, last reviewed August 2023	Domestic abuse included in mandatory Safeguarding training.

5.2.26 Having a clear and robust standalone domestic abuse policy in place which is regularly reviewed can provide an organisation with the support and guidance to best respond to domestic abuse. It is also important that this policy is accompanied by regular and stand-alone domestic abuse training, which is mandatory for any appropriate professional to attend.

Learning point: Domestic abuse policies must be kept up to date and utilised by staff. Staff also need to be regularly trained on all forms of domestic abuse, including adolescent child to parent abuse, domestic abuse and multiple disadvantage, and domestic abuse and mental health**.**

Recommendation 19: Kent Community Safety Partnership DHR Steering Group to ensure that all agencies have policies and training which include detail of adolescent to parent abuse, multiple disadvantage, suicide awareness, and abuse perpetrated by multiple perpetrators.

Analyse how previous responses to Lana's experiences of agencies, and her reports of abuse to them (concerning previous intimate partners), may have affected her confidence in agencies. Analyse the organisations' access to specialist domestic abuse agencies

5.2.27 This review has found that Lana regularly did not feel supported by a number of statutory services. Lana also had negative experiences with statutory services from previously being arrested by the police through to her relationship with Children's Services after Jensen took their children into his own care, which may have negatively impacted her feeling safe to access statutory services.

5.2.28 Although Lana's children were not formally removed by Children's Services, Lana did view Children's Services 'taking sides' with Jensen. Research has highlighted the impact of this on mothers, which includes mothers being silenced through the stigma and shame of being judged to be a deeply flawed mother, the justifiable fear of children being removed, and court-ordered reporting restrictions.[43] Lana did not feel included by Children's Services or her children's schools and often felt that she did not have a voice or support in relation to her children. Significantly, research by Morris highlights that:

'…m*others are effectively abandoned by the state. They are left to deal with the trauma and loss of a child on their own, particularly as they may be ostracised by family and friends due to the stigma and shame of removal.*[44]

5.2.29 Further, Morris highlights that:

'Once their child is removed from their care, the mothers also lose any child related benefits. Women living in social housing are at risk of losing their home once their child or children are removed due to the under-occupancy penalty (also known as the

[43] Morris L. Haunted futures: The stigma of being a mother living apart from her child(ren) as a result of state-ordered court removal. The Sociological Review. 2018

[44] Ibid, p.818.

'bedroom tax'). In these dire circumstances, it is perhaps understandable that the women (re)turn to drugs and alcohol or remain in violent relationships.[45]

5.2.30 The panel considered the impact this had on Lana's confidence in accessing statutory services. In addition, Rising Sun highlighted that in order for Lana to obtain Legal Aid, the agency required her to share her experiences of domestic abuse. The IDVA shared that this was too traumatising for Lana to do, but that the agency would not accept the information from the IDVA on Lana's behalf. Therefore, Lana did not get legal aid to support her in obtaining a non-molestation or child arrangement order.

5.2.31 Sadly, we are unable to hear directly from Lana on her relationship with services, but we do know that victims of domestic abuse have a mistrust of statutory services.[46] Barriers to disclosing can be based on lack of trust around confidentiality and the potential misuse of information.[47] As Lana often withdrew from statutory service support or did not fully disclose her experiences, it can be strongly suggested that she too had these concerns.

5.2.32 It is also important to note that Lana did disclose to statutory services of abuse from her ex-partner, Jensen, and was active in pursuing justice, but this did not result in the difference that Lana was hoping to see. This experience would have further compounded her mistrust of services.

5.2.33 In cases where victims face barriers in accessing statutory services, the role of specialist support is key in enabling victims to feel safer and more in control of their lives following abuse.[48] Research by the Domestic Abuse Commissioner's Office in 2023 found that:

- The independence of services is critical to build trust and is highly valued by victims and survivors accessing support.
- Victims and survivors need a range of types of support to help them find safety and to cope and recover from abuse.
- Support varies by whether a victim or survivor was experiencing multiple disadvantage or had additional needs.[49]

5.2.34 Lana was known to many statutory services, but her access to specialist support was limited. She was supported by Forward Trust, who focused solely on her substance use until April 2021, and by Rising Sun until June 2021. For much of the timeframe of this review, Lana's support was received solely by statutory services. Referrals made by statutory services were often, if not exclusively, to other statutory services. Given Lana's needs, her historic experience of statutory services, and her experience of

[45] Ibid.
[46] Evans, M and Feder, G.S Help-seeking amongst women survivors of domestic violence: A qualitative study of pathways towards formal and informal support Health Expectations, 19 (1) (2014), pp. 62-73
[47] Ibid.
[48] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://domesticabusecommissioner.uk/wp-content/uploads/2023/02/DAC_Mapping-Abuse-Suvivors_Summary-Report_Feb-2023_Digital.pdf
[49] Ibid.

multiple disadvantage, it is clear that she needed more specialist and wrap-around support to best meet her needs.

Learning point: It is important that statutory agencies recognise the barriers that victims face in accessing support from their services. Concerns about judgement, victim-blaming, and general mistrust in services can mean that victims fall through the net.

Recommendation 20: The Domestic Abuse and Sexual Abuse Executive Group to review their offer for specialist domestic abuse services and Kent Community Safety Partnership to ensure that statutory services are appropriately referring into specialist services.

Analyse how agencies consider Lana's multiple experiences of abuse from different perpetrators.

5.2.35 This is addressed elsewhere in the analysis.

Analyse how agencies responded to Lana's mental health and substance use.

5.2.36 This is addressed elsewhere in the analysis.

Analyse how the experience of the child was included in agencies response to Lana and her children.

5.2.37 The panel has found that Lana had a difficult relationship with her two older children over the course of this review, however, there was limited understanding of the way in which the children were being manipulated and controlled by Jensen to further perpetrate abuse against Lana.

5.2.38 Research highlights that abusive men use their children to control their partners and ex-partners. A case study of 156 women found that a majority of women (88%) reported that their assailants had used their children to control them in various ways and to varying degrees. Most women reported that their assailants had used their children to stay in their lives (70%), keep track of them (69%), harass them (58%), or intimidate them (58%). Significantly, almost half (47%) of women reported that their assailants had tried to turn their children against them. Further, 48% stated that their assailants had tried to use their children to frighten them.[50]

[50] Beeble, Marisa L, Deborah Bybee, and Cris M Sullivan, 'Abusive Men's Use of Children to Control Their Partners and Ex-Partners', *European Psychologist*, 12.1 (2007), 54–61

5.2.39 Sadly, these findings are relevant to Lana's experience of abuse via the use of her children. She was noted to have shared with social services that she was 'afraid' of her two older children. She also expressed concern that Jensen was manipulating them. We see this when Jensen informed their eldest child that Lana was using drugs. The panel were clear that this was not shared out of concern for the children's welfare, but as a way to manipulate and control them.

5.2.40 The panel also considered how support for Lana's children was provided by services without a wider understanding of this context and the impact of the children being in contact with a father who had previously exposed them to the domestic abuse of their mother. Research highlights that the emphasis on maintaining the father-child relationship is driven by a presumption that contact is invariably in the child's best interests, providing a ''blind-spot'' against the dangers involved for women and children post-separation.[51]

5.2.41 This report has earlier examined Lana's experience of abusive behaviours displayed by her older children. It is important to understand these behaviours in the context of Jensen control and manipulation of the children. A large proportion of children and adolescents who display abusive behaviours against their parent have witnessed domestic abuse.[52] Indeed, research has also found that adolescents who display abusive behaviours often start to abuse the victimised parent (typically mother) soon after the violent parent (typically father) leaves the family home. The behaviour is influenced by ''a combination of direct male role modelling, idealisation of the abuser, and anger at the mother for failing to protect the family.[53]

5.2.42 The Review Panel discussed the impact of this on the children and their experiences of services as well as their relationship with their mother. As discussed earlier, unstable interpersonal relationships may influence a child's mental and emotional development, which may cause mental health problems later in life.[54] Services needed to do more to understand the responses of the children to Lana within the context of their experience of domestic abuse.

5.2.43 Services who work with families affected by domestic abuse must understand the nuanced impact of domestic abuse and adopt a whole family approach to best support victims and their children, and to hold abusers to account.

Learning point: It is important that statutory agencies recognise the way that children are used by abusers to further perpetrate harm against their victims. They

[51] Stephanie Holt (2011) Domestic Abuse and Child Contact: Positioning Children in the Decision-making Process, Child Care in Practice, 17:4, 327-346

[52] Kennair, N., & Mellor, D. (2007). Parent abuse: A review. *Child psychiatry and human development*, *38*, 203-219.

[53] Ibid.

[54] Cilar Budler, L., Stricevic, J., Kegl, B., Pevec, M., & Klanjsek, P. (2022). Caring for children and adolescents victims of domestic violence: A qualitative study. *Journal of Nursing Management*, 30(6), 1667–1676.

must also understand the impact of the father's abuse on children going on to display abusive behaviours.

Recommendation 21: Children's Services to raise awareness of the impact of domestic abuse on children and the role that perpetrators play in influencing adolescent to parent abuse.

Where a perpetrator assumes care for their victim, analyse how agencies understand the relationship between domestic abuse and caring responsibilities and how agencies understood the risk Louis posed.

5.2.44 This is addressed elsewhere in the analysis.

The impact of the COVID-19 pandemic.

5.2.45 Agencies involved in this DHR were asked to consider the impact of COVID-19 and lockdown on service delivery. Over September 2020 to May 2023, the timeframe of this review, there were national lockdowns between January 2021 to July 2021, and local lockdowns from September 2020 to November 2020. It is important to note that Kent was also a county that had additional lock downs in regard to Covid and staff were adapting to new ways of working within an untested period of time.

5.2.46 Further research on the impact of COVID-19 is still very much needed, but initial studies have found that existing mental health difficulties were exacerbated for many people, that there was inadequate access to mental health services, and that new remote ways to access mental health care, including digital solutions, presented substantial barriers to access.[55]

5.2.47 The Review Panel considered the impact of moving to digital solutions, particularly for Kent and Medway NHS and Social Care Partnership, who moved all their appointments over the telephone unless deemed to be at high risk. In addition, as Lana had a no lone working policy in place, practitioners were unable to see her on their own. Although the Review Panel recognised good practice whereby Lana was consistently seen in person by Kent and Medway practitioners when risk was identified as high, consideration was still given to the change in service and its accessibility for Lana.

5.2.48 Findings have also highlighted the changing patterns of domestic abuse during the Covid-19 lockdown. Abuse by current partners as well as family members increased on average by 8.1% and 17.1% respectively over the lockdown period.[56] Although an important caveat is that this increase was also due to an increase in third party

[55] Gillard, S., Dare, C., Hardy, J. et al. Experiences of living with mental health problems during the COVID-19 pandemic in the UK: a coproduced, participatory qualitative interview study. Soc Psychiatry Epidemiology 56, 1447–1457 (2021)

[56] Ivandic, Ria, Kirchmaier, Thomas and Linton, Ben (2020) Changing patterns of domestic abuse during Covid-19 lockdown. CEP Discussion Papers (1729). London School of Economics and Political Science. Centre for Economic Performance, London, UK.

reporting,[57] it is still noted that locking down with a perpetrator increased risk by limiting opportunities for support.

5.2.49 The Review Panel considered this period of heightened risk and how this should have resulted in an increase of awareness of domestic abuse and use of DASH risk assessments.

Learning point: The COVID pandemic forced a change in how frontline services were delivered.

As we return to life beyond the pandemic, it is necessary to review the impact of the lockdown on current service delivery.

Recommendation 22: Kent and Medway NHS Partnership Trust to ensure they do not rely on digital solutions when offering support but instead offer a range of support contacts which include face-to-face appointments.

Recommendation 23: Domestic Abuse and Sexual Abuse Executive Group to review the impact of lockdown on the work of their member agencies.

[57] Ibid.

6. Conclusions and Lessons to be Learnt

6.1 Conclusions

6.1.1 Lana tragically died by suicide in May 2023 after experiencing abuse by her partner Louis, her ex-partner Jensen, and abusive behaviours from her two elder children.

6.1.2 But this tragic incident must not be allowed to overshadow Lana's life. Conversations with Lana's family have shed a light on her colourful character. Despite her own experiences of abuse, Lana has been described as very sociable and popular and had the best time when she was with her friends. She was described as strong and would put on a brave face when faced with challenges. It is this memory of Lana which endures and will be missed.

6.1.3 The Review Panel extends its sympathy to all those affected by Lana's death and thanks all those who have participated in the review.

6.1.4 There has been significant learning identified during the course of this review, which the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships, to further develop their response to domestic abuse. This learning is summarised below.

6.2 Key Themes and Learning Identified

6.2.1 The most substantive learning of this case has related to seven key areas: 1) lack of awareness of the impact of multiple perpetrators, 2) the limited understanding of multiple disadvantage, 3) Perpetrators use of children to further abuse victim 4) lack of identification of adolescent child to parent abuse, 5) limited multi-agency working, 6) limited understanding on what it means to be a carer, and 7) limited understanding what a victim 'looks like' and who does what to whom.

<u>Lack of awareness of the impact of multiple perpetrators</u>

6.2.2 This review has found that Lana experienced abuse and abusive behaviours from a number of individuals, but her victimisation was seen by services in relation to Jensen almost solely. The agency response to her experience of domestic abuse from Jensen did see some support, mainly from Rising Sun and somewhat from the Police, but was not a feature in the support she was offered by other agencies. Indeed, Lana's experience with services was influenced by how she was viewed as a mother, how she presented to agencies, her mental health and her coping mechanisms.

6.2.3 The impact of this was that Lana was reluctant to disclose abuse perpetrated by Louis and that services did not join the dots on her wider experience. There was a lack of professional curiosity on how Lana's history of abuse may have made her vulnerable to further perpetration of harm from others and the impact this may have had on her engagement with services. This is especially the case as agencies were aware of Louis's history of perpetration against former partners, so were sighted on the risk he posed to Lana.

6.2.4 Domestic abuse can be experienced in a myriad of ways and professionals need to be aware that perpetrators move from one relationship with an abusive person to the next. Having a holistic understanding of someone's experience and the risk they can experience from multiple individuals must be considered by agencies. Recommendations have been made to address these points.

Limited understanding of multiple disadvantage

6.2.5 This review has also found that there was limited professional awareness of the intersection of experiencing abuse, substance use, and mental health. As discussed earlier, experiencing abuse can have a significant impact on the mental wellbeing of victims and can result in them using substances as a coping mechanism for managing the trauma. This is particularly true for women who have been separated from their children as Lana had been.

6.2.6 Instead, Lana's needs were addressed in isolation by mental health services, substances services, and other statutory services. Dissecting these issues and not seeing how they were compounding each other, meant that Lana was not fully supported in the way she needed. As we know that domestic abuse is the most common cause of depression and other mental health difficulties in women, and results in self-harm and suicide rates among survivors. Which are at least four times higher than the general female population,[58] it is important that agencies adopt a multi-agency approach which centres the needs of survivor.

6.2.7 The panel welcomed news of a service level agreement between KMPT Mental health and EKHUFT to improve joint working and supporting service users. However, addressing multiple disadvantage must go further, and the response must include an understanding of domestic abuse and the relationship between mental health and substance use. Recommendations have been made to address these points.

Perpetrator's use of children to further abuse victim

6.2.8 Jensen's abuse of Lana was further compounded by his manipulation of their children and using them to further perpetrate abuse against Lana. Lana highlighted her concerns to services, but this did not result in support for her or her children.

6.2.9 This review has found that perpetrators often use children in their abuse of their victims, and that services must have a wider understanding of the family context and the impact of the children being in contact with a father who has previously exposed them to the domestic abuse of their mother.

6.2.10 Recognising that children can be used to further abuse the victim must be central to child safeguarding and domestic abuse responses. It is important to understand the relationship between perpetrator's use of the children and the relationship between

[58] Against Violence & abuse: Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health: 2013. PP. 24

children going on to display abusive behaviours against the victim. Recommendations have been made to address these points.

Lack of identification of adolescent child to parent abuse

6.2.11 Whilst experiencing domestic abuse from both Jensen and Louis, Lana's two elder children also displayed abusive behaviours towards her. As discussed earlier, this was in the context of manipulation and control by their father. However, of all the agencies involved in supporting Lana, no agency focused on providing support for Lana in relation to adolescent child to parent abuse.

6.2.12 The review has found that agencies had limited awareness of domestic abuse when being perpetrated by an adolescent child to a parent. Usually, parents themselves are not able to identify this as domestic abuse, but with Lana we see that she clearly explained her fears to social services. Despite this, neither Lana nor her children were referred to support to address this. In light of this, there is a need for professionals to understand and to raise awareness of the different forms of domestic abuse and the support that is available. Identifying and responding to risk in a broader domestic abuse context can support myth busting and ensure that survivors are able to access the right support at the right time.

6.2.13 Although agencies are recognising the need to respond to domestic abuse, and to have policies and processes in place, this is still mainly limited to intimate partner violence. Agencies need to be confident that their level of awareness is in line with the statutory definition of domestic abuse as defined in the Domestic Abuse Act 2021. Recommendations have been made in this report to address these points.

Limited multi-agency working:

6.2.14 A number of different agencies held information on Lana, but this information was either not shared, not shared appropriately, or there was no follow up after an onward referral was made. This meant that agencies had a patchy picture of the situation and therefore a limited understanding of risk. If information was shared effectively through a broader partnership working approach, and through the use of MARAC, agencies could have put the pieces together to build a clearer picture of Lana and her needs.

6.2.15 Where good multi-agency practice was identified in this review, this was reliant on individual initiative rather than being embedded in processes and procedures. Individual good practice is commendable but can result in inconsistencies and missed opportunities. It is important that Kent Community Safety Partnership take a wider collaborative and multi-agency approach whereby their systems and processes are robust and fit for practice, ensuring joined up and appropriate information sharing.

6.2.16 We know that no one agency can single-handedly tackle domestic abuse and that a coordinated community response is needed to provide victims with the support they need. Recommendations have been made to address these points.

Limited understanding of what it means to be a carer

6.2.17 The review has found that there are extensive links between domestic abuse and perpetrators in caregiving roles. The power and control a perpetrator has is compounded by the caregiving responsibilities that they are given. In addition, professionals often only see the 'caring' side of their behaviour, especially when caring for a 'challenging' person, and do not see the wider risk that they pose.

6.2.18 Being a carer can give somebody complete control over another person's day-to-day activities and resources. Caring can include taking over tasks such as managing finances or medication if the cared for person is unable to do these themselves, as well as carrying out personal care, including practical support and management of incontinence. A carer who supports somebody who relies on them for everyday tasks is also in a position of power, and assuming power and control are the precursors for domestic abuse.

6.2.19 This was very much the case with Louis, where a significant number of services only saw him as helpful and providing support for Lana. This was despite his history of domestic abuse perpetration and police call outs for his current abuse against Lana. It is clear, therefore, that scrutiny needed to be applied to Louis and the role he played.

6.2.20 Carers assessments can play an important part of identifying risk but also in identifying any specific support for either the carer or cared for person. Assessments include discussions on what the care looks like, how caring affects someone's life, including their physical, mental, and emotional needs. A carers assessment could have supported Lana to articulate her needs and highlighted the role that Louis played in her care.

6.2.21 There is a growing awareness of the relationship between domestic abuse and caring responsibilities. It is vital that agencies better understand this intersection to ensure that victims' needs are recognised, and appropriate support is offered where needed.

Understanding what a victim 'looks like' and who does what to whom

6.2.22 How Lana presented to agencies had an impact on how she was or wasn't supported. We know that victims come from all parts of society and all walks of life. People who have combined experiences of domestic and sexual violence, mental ill-health and problematic substance often only come to the attention of services when the difficulties become so problematic that an intervention is needed. By this point, agencies can end up working with people who are traumatised, who use coping strategies which they consider dangerous or unhelpful, who are seemingly stuck at a certain point in their life. They can be some of the most challenging clients to work with, so remembering where they have come from and that they still deserve support is vital.[59]

[59] Against Violence & abuse: Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health: 2013. PP. 23

6.2.23 Lana was often deemed by agencies to be challenging. There was also confusion around her experience of domestic abuse, and she was known to the police as being abusive towards Louis. The review has found that it is important that professionals understand that domestic abuse is the misuse of power and control and that there needs to be an awareness of who does what to whom in order to better identify the primary aggressor. This ensures that the right people are referred to support and held to account.

6.2.24 Agencies were noted to not have recognised Lana's presentation as trauma response and so her experience of domestic abuse was not fully explored. Professionals must understand that victims present in a myriad of ways and must receive trauma-informed support to best meet their needs. The review has also found that Lana had concerns about access to her children and about how Jensen was manipulating services to demonise her. This would have placed additional barriers in her help-seeking options. Recommendations have been made to address these points.

7. Recommendations

7.1 Single Agency Recommendations (Identified by Individual Agencies)

7.1.1 The following single agency recommendations were made by the agencies in their IMRs.

7.1.2 These recommendations were supported by individual action plans developed by each agency. These recommendations should be acted on through the development of an action plan, and are the responsibility of each agency. Where actions have been completed before the conclusion of the review, the updates are included in section 5, and the recommendations not listed here.

Children's Services

7.1.3 Better pathways for perpetrator programmes especially in CP but also for CIN & EH, resources are extremely limited, when working with perpetrators of domestic abuse.

7.1.4 Greater recognition from professionals in relation to the impact that domestic abuse has on the victim experiencing this and the understanding that domestic abuse can continue to occur even after the relationship has ended through use of the children and emotional abuse. Training in relation to domestic abuse to be made mandatory across the county.

7.1.5 Professionals responding to domestic abuse need specialist domestic abuse training that strengthens their understanding of perpetrator tactics in weaponising mental ill health.

7.1.6 Greater partnership work between health services and specialist domestic abuse services. Particularly with mental health services there should be a more open line of communication and more streamlined referral pathways, which professionals can access. Better and more effective links between Children services and mental health services.

Education Services

7.1.7 Education providers to be reminded of their responsibilities towards vulnerable adults where there are safeguarding concerns.

7.1.8 Education providers to be reminded of their statutory responsibilities towards non-resident parents, to include information regarding father inclusive practice.

Integrated Care Board

7.1.9 NHS KMICB Safeguarding should arrange resources and training that will share best practice discussed in this IMR to enable primary care staff provide effective responses to DA.

7.1.10 K&M ICB should devise a toolkit for domestic abuse and identify policy/practice gaps in Primary Care through audit to identify improvements areas and actions.

East Kent Hospital NHS Trust

7.1.11 Increase staff knowledge of ACE's and Trauma Informed practice.

7.1.12 Increase staff knowledge of Domestic Abuse Act 2021.

7.1.13 Increase staff knowledge of statutory responsibilities (Homelessness reduction Act 2017) when identifying individual whom are Homeless or at risk of becoming Homeless.

7.1.14 Increase staff knowledge of Mental Capacity Act 2005.

7.1.15 Increase staff knowledge in relation to Alcohol Substance issues and the impact that can have on delivering health care.

7.1.16 ED staff to receive bespoke Mental Health training.

7.1.17 To increase staff knowledge of the importance of wellbeing and the impact of wellbeing on mental and physical health.

7.1.18 Increase staff knowledge of statutory responsibility re Adult Safeguarding Care Act 2014.

Kent and Medway NHS Trust

7.1.19 Support the CJLDS team and Shepway CMHT with some bitesize learning in regard to safe routine enquiry, and utilising history when considering risks and safeguarding and undertaking DASH, when someone is in police custody.

7.1.20 The LPS practitioners to utilise the DASH RIC training offered by the KMPT safeguarding team.

7.1.21 The LPS team to follow the KMPT domestic abuse policy.

7.1.22 Share SafeLives presentation for managing counter allegations of domestic abuse and "reactive" abuse with front line services in order to support victims effectively.

7.1.23 The KMPT Safeguarding team and KMPT HIDVA to provide additional domestic abuse training regarding safe routine enquiry and support and signposting to KMHCL team.

7.1.24 Promote the Victim Blaming Language training commissioned by Kent Community Safety Partnership within their organisations.

Adult Social Care

7.1.25 For practitioners to be reminded of the importance of information sharing within Safeguarding by referencing the relevant information in the Kent and Medway Safeguarding Adults Board Policy Procedures document and KCC ASC Safeguarding Operational Guidance document and sharing in a Strategic Safeguarding SWAY Newsletter circulated to ASC operational colleagues

7.1.26 Safeguarding Closure Domestic Abuse dip test to take place, which will support understanding of any gaps in learning.

Town A Council

7.1.27 Key officers such as Housing options officers and Welfare Intervention officers to attend the Mid Kent Mind Adult Suicide Prevention training.

7.1.28 To update our internal safeguarding training to cover suicide prevention and understanding the links with Domestic Abuse.

7.1.29 To ensure there is a robust internal mechanism for dealing with threats or concerns of suicide.

Southern Housing

7.1.30 Escalation of 'make safe' repair requests. Build into new operating safeguarding and domestic abuse procedures at next review in January 2025, an escalation that 'make safe' or 'emergency repairs' have a follow up with residents by the relevant case officer. If cases have been reported or requested by police, recorded crime reference numbers and requested an in person visit to property.

7.1.31 Make requests for information from police to support any safeguarding concerns or when contacted by police requesting information about residents. This will form part of operating procedures, reflected in case management and added to case audits forms. The specialist roles who manage safeguarding concerns will be in place by January 2025. Having specialist roles within boundary areas, will build on engagement and attendance at MARAC and other coordinated community safety programmes.

7.1.32 Work is being undertaken to improve engagement and training for repairs call centre, contractors and supply chain; a training and development project for safeguarding training for all people who work for Southern Housing or on their behalf within the repairs and maintenance sector. The project is in development and will be launching in April 2025. Work is being undertaken with the procurement team to ensure policies and procedures are shared and followed. Requests are made to ensure safeguarding training has been completed for organisations who are providing direct services to people living in their homes.

Police

7.1.33 In incidents of domestic abuse where the victim's mental health is of concern, positive action should be considered in relation to referrals to mental health services. If declined this should be clearly recorded.

7.1.34 In incidents of suspected domestic abuse involving a reluctant victim, officers to consider referrals to IDVA service.

Forward Trust

7.1.35 Risk assessment of those reporting experience of domestic abuse to include specific reference to impact on mental health

7.1.36 Advanced Safeguarding training module to specifically reference Critical assessment and analysis of cross agency information sharing to ensure the contact results in more effective; care, support and protection of those identified as at risk/in receipt of services.

7.1.37 Review of processes in substance misuse treatment providers with regards to liaison with privately funded substance misuse treatment to assess if there is any scope for a more robust approach to this.

Rising Sun

7.1.38 The following recommendations were set forward by Rising Sun who confirmed these are now complete:

- To discuss the need to take a holistic view at the MARAC Steering Group and consider with partners how to ensure this is embedded in the process.
- to review their case management process to ensure IDVAs are routinely considering and capturing clients' strengths and needs, as well as physical risk from the perpetrator.
- to provide Mental Health Awareness training for the team.
- to review their case management process to ensure IDVAs are routinely considering how to strengthen wraparound support for survivors by working in partnership with other agencies and services.

7.2 Multi Agency Recommendations (Developed by the Review Panel)

7.2.1 The Review Panel has made the following recommendations during this review in response to learning identified. These are described in section 5 as part of the analysis.

7.2.2 These recommendations are also presented in the multi-agency recommendation action plan template. The Kent Community Safety Partnership is responsible for overseeing then development and monitoring of an action plan.

Recommendation 1: Kent and Medway Safeguarding Adults Board and the Domestic Abuse and Sexual Abuse Executive Group to identify how it can better raise awareness and improve a trauma-informed response to people impacted by multiple disadvantage who have experienced domestic abuse.

Recommendation 2: Kent and Medway NHS and Social Care Partnership Trust to review their processes in relation to their responsibility in identifying and supporting carers.

Recommendation 3: Kent and Medway Safeguarding Adults Board to embed their multi-agency protocol to safeguard adults with care and support needs who are impacted by domestic abuse, particularly circulating this to agencies who sit outside of their membership.

Recommendation 4: Kent Children's Services to ensure staff are trained in understanding post-separation perpetration of domestic abuse in the family context.

Recommendation 5: Kent Children's Services to look to adopt some of the principles and ways of working relating to the Safe and Together best practice model.

Recommendation 6: Kent Community Safety Partnership to identify how to raise awareness of domestic abuse experienced within a broader familial context of adolescent child to parent abuse.

Recommendation 7: The police to ensure officers are trained in understanding who does what to whom and link with a Respect accredited service for domestic abuse perpetrator training in order for appropriate referrals to be made into perpetrator programmes.

Recommendation 8: The Domestic Abuse and Sexual Abuse Executive Group to identify how to raise awareness of domestic abuse perpetrated by multiple abusers.

Recommendation 9: Rising Sun to review their policy on risk assessment at case closure in relation to a new partner of the client due to be closed, and under what circumstances a DASH RIC might be appropriate.

Recommendation 10: Forward Trust to review their multi-agency working arrangements and ensure that they have a joined approach to supporting service users who experience multiple disadvantages.

Recommendation 11: Police to review how they undertake domestic abuse risk assessments to ensure that officers are correctly making referrals based on assessment outcome and professional judgement. Police should also ensure that domestic abuse risk assessments include an assessment of a pattern or history of abuse in order to avoid responding to incidents in isolation.

Recommendation 12: The Domestic Abuse and Sexual Abuse Executive Group to monitor and review impact of their changes to their MARAC process to ensure it effectively responds to high-risk cases.

Recommendation 13: EKHUFT to review internal processes to ensure effective referrals into established Hospital Independent Domestic Violence Advisor (HIDVA) service.

Recommendation 14: Health partners to adopt a Whole Health Approach to domestic abuse.

Recommendation 15: Kent and Medway NHS and Social Care Partnership to ensure staff are trained to identify and safely ask about domestic abuse, and, once disclosure is made, to appropriately refer onto support.

Recommendation 16: Continued efforts to be made to secure funding for the IRIS Programme to be delivered across GPs involved in this review.

Recommendation 17: South East Coast Ambulance Service to ensure that staff are proactively enquiring about domestic abuse and have knowledge of local referral pathways.

Recommendation 18: Victim Support to review their processes to ensure that repeat referrals, where escalation of risk has been identified, are appropriately risk assessed, and victims are provided with support.

Recommendation 19: Kent Community Safety Partnership DHR Steering Group to ensure that all agencies have policies and training which include detail of adolescent to parent abuse, multiple disadvantage, suicide awareness, and abuse perpetrated by multiple perpetrators.

Recommendation 20: The Domestic Abuse and Sexual Abuse Executive Group to review their offer for specialist domestic abuse services and Kent Community Safety Partnership to ensure that statutory services are appropriately referring into specialist services.

Recommendation 21: Children's Services to raise awareness of the impact of domestic abuse on children and the role that perpetrators play in influencing adolescent to parent abuse.

Recommendation 22: Kent and Medway NHS Partnership Trust to ensure they do not rely on digital solutions when offering support but instead offer a range of support contacts which include face-to-face appointments.

Recommendation 23: Domestic Abuse and Sexual Abuse Executive Group to review the impact of lockdown on the work of their member agencies.

Appendix 1: Glossary

A&E	Accident and Emergency
AAFDA	Advocacy After Fatal Domestic Abuse
AFV	Adult Family Violence
BAMER	Black, Asian, Minority Ethnic and Refugee
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CCR	Coordinated Community Response
CPS	Crown Prosecution Service
CPV	Child to Parent Violence
CSP	Community Safety Partnership
CSU	Community Safety Unit
DAHA	Domestic Abuse Housing Alliance
DASH RIC	Domestic Abuse Stalking, Honour Based Abuse and Harassment Risk Indicator Checklist
DHR	Domestic Homicide Review
DI	Detective Inspector
FSW	Family Support Worker
FLO	Family Liaison Officer
GP	General Practitioner / Practice
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
IO	Investigating Officer
LAS	London Ambulance Service
LGBT	Lesbian, Gay, Bisexual and Trans
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MERLIN PAC	(MPS) report completed by police officer when they encounter a child in circumstances that cause a concern
MPS	Metropolitan Police Service
OIC	Officer in the Case

SIO	Senior Investigating Officer
SPOC	Single Point of Contact
VAWG	Violence against Women and Girls
VSHS	Victim Support Homicide Service

Appendix 2: Terms of Reference

This Domestic Homicide Review ('the review') is being completed to consider agency involvement with Lana and Louis following the death by suicide of Lana in May 2023. This review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004 but will be described as a 'Domestic Abuse-Related Death Review'.

Purpose of the Review

1. To review the involvement of each individual agency, statutory and non-statutory, with Lana and Louis during the relevant period of time September 2020 to May 2023 (inclusive). To summarise agency involvement prior to 1st September 2020.
2. To establish what lessons are to be learned regarding the way in which local professionals and organisations work individually and together to safeguard victims.
3. To identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
5. To prevent domestic violence and abuse and domestic abuse-related deaths 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.
6. To contribute to a better understanding of the nature of domestic violence and abuse.
7. To highlight good practice.

Role of the Review Panel, Independent Chair and the CSP

8. *The Independent Chair of the Review will:*
    a) Chair the review panel.
    b) Co-ordinate the review process.
    c) Quality assure the approach and challenge agencies where necessary.
    d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
9. *The Review Panel:*
    a) Agree robust terms of reference.
    b) Ensure appropriate representation of your agency at the review panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a review panel meeting.
    c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.

d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
e) Agree and promptly act on recommendations in the IMR Action Plan.
f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
    - The purpose of the review has been met as set out in the Terms of Reference.
    - The report provides an accurate description of the circumstances surrounding the case; and
    - The analysis builds on the work of the IMRs, and the findings can be substantiated.
h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) On completion present the full report to the Kent Safer Community Partnership
j) Implement your agency's actions from the Overview Report Action Plan.

Kent Community Safety Partnership:

a) Translate recommendations from Overview Report into a SMART Action Plan.
b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
c) Forward Home Office feedback to the family, Review Panel and Standing Together Against Domestic Abuse ('Standing Together').
d) Agree publication date and method of the Executive Summary and Overview Report.
e) Notify the family, Review Panel and Standing Together of publication.

Definitions: Domestic Violence and Coercive Control

10. The Overview Report will refer to the terms domestic abuse and coercive control. The Review applies the statutory definition[60] of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

    (a) physical or sexual abuse

    (b) violent or threatening behaviour

    (c) controlling or coercive behaviour

[60] The Domestic Abuse Act 2021 received Royal Assent on 29 April 2021: https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

(d) economic abuse

(e) psychological, emotional or other abuse

11. Economic abuse is defined as “any behaviour that has a substantial adverse effect on a person’s ability to acquire, use, or maintain money or other property or obtain goods or services” (s.3: Domestic Abuse Act 2021).
12. Controlling behaviour is: “a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.”
13. Coercive behaviour is: “an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”
14. This definition includes “so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.”

Equality and Diversity

15. The review panel will consider all protected characteristics (as defined by the Equality Act 2010) of Lana and Louis (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g., armed forces, carer status and looked after child).
16. The review panel identified the following protected characteristics of Lana and Louis as requiring specific consideration for this case: sex. The following were discussed and deemed not appropriate for this review: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief.
17. The following issues have also been identified as particularly pertinent to this death: substance, mental health, children removed from mother’s care, class, trauma linked to historic domestic abuse.
18. Consideration has been given by the Review Panel as to whether either the victim or the alleged perpetrator was an ‘Adult at Risk’ Definition in Section 42 the Care Act 2014: “An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.”

    Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity. If it is the case that any party is an adult at risk, the review panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning

Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.

The Care Act 2014 states; “Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.”

The panel will keep this under review throughout the DHR process.

19. *Expertise:* The review panel will therefore invite Pause to the panel as an expert/advisory panel member on the lives of women who have more than one child removed from their care to help understand crucial aspects of the death.
The review panel have also invited Kent & Medway Suicide Prevention Programme as an expert/advisory panel member to help understand aspects of the suicide.

    The review panel agrees it is important to have an intersectional framework to review Lana and Louis life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one’s experience with local services/agencies and within their community.

Parallel Reviews

There are no parallel reviews.

Membership

20. It is critical to the effectiveness of the meeting and the review that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

21. The following agencies are to be on the Review Panel:
    a) Kent Community Health Foundation Trust
    b) East Kent Hospitals University Foundation NHS Trust
    c) Integrated Care Board (ICB) (covering: *Ivy Court Surgery, Mote Medical Practice, Kingsnorth Medical Practice and Sydenham House Medical Centre)*
    d) Kent County Council Adult Social Care Services
    e) Kent County Council Children’s Social Care Services
    f) Kent County Council Community Safety Partnership
    g) Kent County Council Education Services
    h) Kent & Medway Suicide Prevention Programme

i) Kent & Medway NHS and Social Care Partnership Trust
j) The Rising Sun Domestic Abuse Service
k) Kent Police (Borough Commander or representative, Senior Investigating Officer (for first meeting only) and IMR author)
l) The Forward Trust
m) Victim Support
n) Town A Council
o) Porchlight
p) South East Coast Ambulance Service
q) Fire & Rescue
r) Cafcass (to be confirmed)
s) DWP (to be confirmed)
t) The Priory (to be confirmed)
u) Southern Housing (to be confirmed)

22. As set out in paragraph 19 the following will contribute to the review as experts:
    a) Pause

Role of Standing Together and the Panel

23. Standing Together have been commissioned by the Kent Community Safety Partnership to independently chair this review. Standing Together have in turn appointed their DHR Associate Shabana Kausar to chair the review. The review team consists of three Coordinators and a review Manager. The review Coordinator will coordinate and have oversight of the review. The manager will quality assure the review process and Overview Report. The contact details for the Standing Together review team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

24. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.
25. Chronologies and Short Reports/Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Lana and Louis during the relevant time period:
    a) Kent Police (IMR and Chronology)
    b) Kent County Council Education Services (IMR and Chronology)
    c) Victim Support (IMR and Chronology)
    d) Integrated Care Board (IMR and Chronology)
    e) Kent County Council Children's Social Care Services (IMR and Chronology)
    f) The Rising Sun Domestic Abuse Service (IMR and Chronology)
    g) East Kent Hospitals University Foundation NHS Trust (IMR and Chronology)
    h) Kent & Medway NHS and Social Care Partnership Trust (IMR and Chronology)
    i) The Forward Trust (IMR and Chronology)
    j) Kent Community Health Foundation Trust (Short Report and Chronology)
    k) Town A Council (Short Report and Chronology)
    l) Fire & Rescue (Short Report and Chronology)

m) Kent County Council Adult Social Care Services (Short Report and Chronology)

26. Further agencies may be asked to completed chronologies and Short Reports/IMRs if their involvement with Lana and Louis becomes apparent through the information received as part of the review.

27. Each Short Report / IMR will:
    - Set out the facts of their involvement with Lana and Louis.
    - Critically analyse the service they provided in line with the specific terms of reference
    - Identify any recommendations for practice or policy in relation to their agency.
    - Consider issues of agency activity in other areas and review the impact in this specific case.

Key Lines of Inquiry

28. In order to critically analyse the incident and the agencies' responses to Lana and Louis this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Lana and Louis [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
    g) Analyse the impact on Lana of her children being taken from her care.
    h) Analyse how previous responses to Lana's experiences of agencies, and her reports of abuse to them (concerning previous intimate partners), may have affected her confidence in agencies.
    i) Analyse how did agencies consider Lana's multiple experiences of abuse from different perpetrators.
    j) Analyse how did agencies consider adult child to parent abuse.
    k) Analyse how did agencies respond to Lana's mental health.
    l) Analyse how did agencies respond to Lana's substance use.
    m) Analyse how agencies responded to concerns regarding Lana's suicidal ideation.
    n) Analyse how agencies responded to Lana's and understand the risk Louis posed.
    o) Where a perpetrator assumes care for their victim, analyse how did agencies understand the relationship between domestic abuse and caring responsibilities.

p) Analyse how the experience of the child was included in agencies response to Lana and her children.
q) Analyse the impact of the COVID-19 pandemic.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

29. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Kent CSP on their action plans within six months of the Review being completed.
30. The Kent CSP to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

31. The review will sensitively attempt to involve the family of Lana in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The independent chair will lead on family engagement with the support of AAFDA.
32. The Review Panel discussed the involvement of children in the review and have decided it is not appropriate for this review. The panel has considered the following factors: age, proximity to the homicide and view of Children's Social Care of child/children's needs.
33. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
34. The Review Panel will consider the involvement of other informal networks of Lana and Louis.

Media handling

35. Any enquiries from the media and family should be forwarded to the Kent CSP who will liaise with the independent chair. Panel members are asked not to comment if requested. The Kent CSP will make no comment apart from stating that a review is underway and will report in due course.
36. The Kent CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

37. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

38. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this review and for the secure retention and disposal of that information in a confidential manner.
39. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.
40. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the password provided to you by the Standing Together team. They should be reminded that they should remove the password and only share appropriate information to appropriate frontline staff in line with the review Confidentiality Statement and the specific Terms of Reference.
41. If you are sending password protected document to a non-secure email address, it must be a recognisable work email address for the professional receiving information. Information from review should not be sent to a gmail / hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.
42. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at review.

Disclosure

43. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.
44. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
    a) The Data Protection Act 2018 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of reviews (Guidance) outlines data protection issues in relation to reviews (Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a review should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.
    b) The Guidance and the Explanatory Notes to the Domestic Violence, Crime and Victims Act 2004 paragraph 7 of Section 2, states that the purpose of a review is to safeguard victims (see Section 2, paragraph 7(a)) and to prevent domestic violence and homicide (see Section 2, paragraph 7 (d). Therefore, the legal power to share with the Review is created by Section 7(2) of Part 2 of Schedule 2 of the Data Protection Act 2018.
    c) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the [alleged] perpetrator, the obligations do apply.

However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:

- The review team should be informed about the existence of information relevant to an inquiry in all cases; and
- The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
- partial redaction of record content.

d) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).
e) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
   a) It is needed to prevent serious crime.
   b) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)