Domestic Homicide Review

Patrick/2018

Executive Summary

Author: Paul Carroll CBE

Commissioned by:
Kent Community Safety Partnership Medway Community Safety Partnership

Review Completed: 17th September 2019

This page has been left blank intentionally.

CONTENTS

This page has been left blank intentionally.

On behalf of the members of the Domestic Homicide Review Panel, the individual organisations involved in this case and myself, as the author of this report, I would like to express my sincere condolences for the tragic events that led to the death of Patrick and the impact this has had on the wider family group.

1. The Review Process

1.1 This summary outlines the process undertaken by the Domestic Homicide Review Panel in reviewing the circumstances leading up to the death of Patrick Douglas who was a resident in their area.

1.2 The following pseudonyms listed in the table below have been used to protect the identities of those who have been involved/considered within this review.

Name	**Relationship to Patrick Douglas**
Mary Brown	Ex-Partner
Peter Douglas	Brother
Toni Pearson	Sister
Child A	Biological Child
Brian Pearson	Brother-In-Law
Child B	Stepchild

1.3 The process began with an initial meeting of the DHR Core Panel on 24th March 2018 and a decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Patrick Douglas (deceased) or the family, prior to the point of death were contacted and asked to confirm whether they had engagement with them.

1.4 All agencies contacted who confirmed engagement with the victim or the immediate family involved were asked to secure their files.

2. Contributors to the review

2.1 Each of the following organisations completed an IMR for this DHR:

- Kent Community Health NHS Foundation Trust (KCHFT)
- Canterbury Clinical Commissioning Group (CCCG)
- Kent Police
- Kent County Council (KCC) Adult Safeguarding
- Domestic Abuse Service Providers
- KCC Social Services including Children in Care, Fostering Service, LADO Service and Early Help
- Kent and Medway NHS and Social Care Partnership Trust (KMPT)

Short reports were additionally received from:

- East Kent University Hospital Foundation Trust (EKUHFT)
- South East Coast Ambulance Service (SECAmb)

2.2 Access to an internal NHS Trust Investigation was provided to the Chair of the Review Panel and also an IOPC investigation was also considered by him in the writing of this report.

2.3 Information from meetings with family members was included in the completion of this review.

2.4 Each IMR was written by an independent person from within the organisation concerned. It is a detailed examination of an organisations contact and involvement with Patrick and his immediate family. A member of staff from each relevant agency writes the IMR. That person will have had no previous involvement with anyone subject of the review. Once completed the review is signed off as approved by a Senior Manager of the organisation before being submitted to the DHR Review Panel.

3. The Review Panel

3.1 The Review Panel consisted of an Independent Chairman and senior representatives of the organisations that had relevant contact with Patrick Douglas and his immediate family. It also included a senior member from the Kent County Council Community Safety Team.

3.2 The Panel members are appropriately skilled members of their respective agencies, but with no direct involvement with Patrick Douglas or Mary Brown, neither are they an immediate line manager of any staff whose actions are, or may be, considered within the review.

3.3 The review panel met first on the 22nd June 2018, at which the Terms of Reference for the review were agreed. Further meetings were held on the 11th December 2018, 31st January 2019 and on the 22nd March 2019. Further review of the report was conducted by e mail where necessary to allow for clarification or change of the draft report.

3.4 The members of the panel were:

Agency	Name	Job Title
	Paul Carroll	Independent Chairman
KCC, Community Safety	Kathleen Dardry	Community Safety Practice Development Officer
Domestic Abuse Service Provider	Leigh Joyce	Locality Business Manager

Domestic Abuse Service Provider	Julie Grover	Project Manager
KCC, Children's Social Work	Pritpal Sodhi	IRO Team Manager
Kent Police	Suiling Chan	Detective Inspector
East Kent Clinical Commissioning Group (EKCCG)	Clare Bright	Head of Adult and Child Safeguarding
The Education People, Education Safeguarding – on behalf of KCC	Claire Ray	Principal Officer
Kent County Council, Adult Safeguarding	Catherine Collins	Adult Strategic Safeguarding Manager
Kent and Medway Partnership Trust	Alison Deakin	Head of Safeguarding
Kent CCG, Looked After Children	Nancy Sayer	Designated Nurse for Looked After Children

4. Author of the Overview Report

4.1 The Independent Chairman of the Review Panel is a retired Senior Civil Servant, having no association with any of the organisations represented. His career path was within HM Prison Service in which he served from1977 until retirement in March 2013. Roles undertaken during this period included being a Governing Governor, working closely with Ministers in a Prison Service Headquarters setting, before ending his career as an Assistant Director responsible for oversight of 12 Prison establishments. His experience and knowledge include issues relating to domestic abuse and surrounding legislation. He has a clear understanding of the roles and responsibilities of those involved in working within a multi-agency approach required to deal with domestic abuse. He has a background of conducting formal reviews, investigations and inspections, including the process of disciplinary enquiries. The Chair has no connection to the Community Safety Partnership (other than in the capacity of Independent Chair for DHRs) and has never worked for any of the agencies involved with this review.

5. Terms of Reference for the Review

5.1 The terms of reference for this review are set out in Appendix A of the Overview report. However, the specific issues and purpose of a Review are set out below.

5.2 Purpose of the Review:

- Establish what lessons are to be learned from the domestic homicide, regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- 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;

- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

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

- Contribute to a better understanding of the nature of domestic violence and abuse; and

- Highlight good practice.

5.3 Focus of the Review:

- The review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Patrick Douglas.

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

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

6. Summary of Chronology

6.1 This section sets out a summary of the key facts associated with the death of Patrick Douglas who took his own life near his home in March 2018. At the time of his death Patrick was a 46 year old living with his estranged partner, Mary Brown, despite their relationship ending in December 2016. Also, in the home was their biological child, Child A, and an older child from Mary's previous relationship, Child B, who latterly spent time living with his father.

6.2 Patrick had a difficult early life and witnessed domestic abuse within the family setting. Patrick suffered from Crohn's disease and also suffered from depression, though he was able to build a normal life with Mary and two children. Patrick had limited contact with the agencies contributing to this review, except significant inter-action between himself and Fostering Services, Children's Services and Early Help relating to his role as both a foster carer to children with challenging behaviour and additional medical needs, and as a father to a child who also required support. In terms of contact with other agencies, there is no history of contact with either Kent Police or unusually high contact with medical professionals until such time as he and his partner decided to end their relationship in late 2016.

6.3 As seen in the following chronology, the events leading to the death of Patrick Douglas occurred as a culmination of events, with which Patrick found it difficult to cope. However, Patrick was described by family as being very capable of giving the impression of coping, even when he was under stress. The breakdown of his relationship, the challenging nature of the foster placement, conflict with his ex-partner and involvement of the police appears to have increased Patrick's drinking, added to his depressive mindset and led to several overdose attempts requiring medical treatment.

6.4 In 2012, Patrick and Mary who had applied to become Foster Carers, were given their first placement, which lasted until 2013, when the child was found a permanent placement. It is recorded that Patrick had formed an attachment to the child and found it difficult to come to terms with the child's removal to adoption. In December 2013, Patrick and Mary agreed to a further placement, which was significantly demanding with the demands of the placement soon becoming evident. Together with meeting the needs of the foster children, Patrick's birth child was, in 2015, also diagnosed with additional needs, placing further stress upon Patrick.

6.5 In June 2016, Patrick requested the required 28 - day notice period to end the placement of one child with particularly challenging behaviour. A Fostering Stability Core Group meeting convened to discuss the concerns and Patrick and Mary agreed to continue with the placement after receiving an assurance that an assessment would be carried out to look at the individual needs of the foster children. It is recorded in the Child in Care

Team case supervision notes (some eight months later) that due to lack of continuity amongst staff, this assessment had still not been completed, with Patrick and Mary effectively having no substantive support following the request for removal of the one child, leaving them to continue to cope with the issues raised.

6.6. The assessment for the children was delayed. A case discussion held on 30th January 2017 is recorded where a decision was made to place the assessment on hold due to so many changes taking place for the children, mainly around securing an Education, Health and Care Plan for one of the children and appropriate school provision. Effectively this individual child was often at home during the day or on a part-time school timetable. Ultimately these assessments were finally completed following the appointment of a permanent children's social worker in September/October 2017.

6.7 During 2016, Mary had been unwell for a lengthy period and towards the end of 2016, she indicated to Patrick that she no longer wished to continue in the relationship. Initially, there appeared to be accord around this decision, with the couple agreeing to remain in the family home together until a suitable sale could be agreed and domestic issues resolved in terms of the children.

However, it was later in December 2016 that Patrick is recorded as taking an overdose of medicine and alcohol. Patrick was assessed by the Psychiatric Liaison Team, where a wide number of issues relating to Child A's condition and the death of his mother came to light, but there was no mention of the stress relating to his possible relationship breakdown or the issues with the foster children. The assessment concluded that there were no history of mental health issues and this had been an impulsive act. Patrick was referred to his GP. On the 27th December 2016 a letter was received by Patrick's GP surgery from ambulatory care, (the local hospital's A&E department) reporting that Patrick had taken an overdose of paracetamol and alcohol. Observations and blood tests were normal, and Patrick was discharged. There was no mention in the summary of a referral to Psychiatric liaison and there are no recorded actions by the GP Surgery or reference to this event in the relevant IMR; it was actioned as per overdose protocol.

6.8 Following the incident Patrick attended his GP surgery in January 2017 where the incident was discussed. Patrick discussed his abusive childhood experiences and the counselling he had received as a result. He also discussed his concerns around Child A's health and alluded to problems within his relationship, though there appears to have been no deeper exploration of this issue, nor does it appear that there was any discussion about the pressure brought by being a foster carer, with it being of concern to the DHR panel that this information does not appear to have been known by the GP. Patrick was given some anti-depressants, signposted to support

agencies and advised to make a follow up appointment some two to three weeks later. There is no record of Patrick making or attending any such appointment.

6.9 Given that Patrick and Mary had decided to end their relationship at the end of 2016, it is not until the 7th March 2017 during a visit by the fostering social worker, that Patrick revealed that he and Mary were separating as they were now interested in different things. He revealed that their relationship was amicable, and they intended to live together until the house was sold. His intention was then to remain as sole carer. He was advised that a new fostering assessment would have to be conducted for that to occur and the fostering social worker also informed the children's social worker of the changes to the relationship

6.10 On the 20th May 2017 Patrick rang the Out of Hours Service reporting he was struggling to manage the behaviour of one of the children. They had been excluded from school and become very angry. The following day a "child protection concern" was opened following Patrick advising CAMHS of an incident on the previous Friday when the child could not contain their anger. When asked by the CAMHS worker, the child replied that they had been "taken upstairs and pushed to the floor" by Patrick. In accordance with recognised processes, when an allegation is made against someone who works with children, a referral was made to the Local Authority Designated Officer (LADO). An initial strategy discussion was held on the 26th May 2017 (some eight days after the alleged incident), with a further follow up meeting being held on the 6th June 2017.

A single agency S47 enquiry was undertaken by the children's social worker, with a joint visit accompanied by the foster social worker taking place on the 30th May 2017. The outcome of the enquiry was to conclude that Patrick used reasonable restraint and the allegation not substantiated.

6.11 Attendance at a GP appointment in May 2017, saw Mary record her concerns about stress at home and again raised the same concerns on another visit in August 2017. Additionally, in that month, medical records at the G.P surgery show that a medication review was carried out for Patrick. It was noted that Patrick was on long term steroids to mitigate and treat Crohn's Disease[1]. He was referred for a bone scan as long-term use of steroids may cause osteoporosis. His medication review mentioned nothing relating to Patrick being on anti-depressants. Nor did the review recognise that there had been no face-to-face follow up with Patrick since his overdose incident in December 2016 when the anti-depressants had been prescribed.

[1] A chronic inflammatory disease of the intestines, especially the colon and ileum, associated with ulcers and fistulae.

6.12 By the 14th August 2017, the relationship issues became known to the Police. Following a verbal altercation over the use of a car. Mary called the Police stating she felt intimidated by Patrick and that he needed help. A DASH assessment was completed with the incident being assessed as medium, justified by the heightened emotions and the presence of the foster children. Mary was advised to find herself a safe room in the house with a lock on the door and to ask Patrick not to contact her by telephone and direct all correspondence via her solicitor. A DAN was raised and passed to Social Services. A referral was made to a domestic abuse support provider.

6.13 Having become aware of the breakdown in the relationship the foster care and children's social work teams were acquainted with the deterioration in the home. On the 23rd August 2017, a Fostering Panel met to consider the information available to them regarding what was described by the chair as a toxic emotional climate. The Panel made a recommendation to defer some decisions so that the agency could decide on either the deregistration of both carers, or, whether to commence a single care assessment for either Patrick or Mary. By the 4th September 2017, in consultation with the Children In Care (CIC) service manager, the decision was taken to terminate the placement and work began to ready the children for the move.

6.14 On both the 5th and 6th September 2017, the Police became engaged with the couple as they made complaints about each other. Mary complained about Patrick's behaviour, stating that she felt very intimidated. A further referral was made to Social Services and the DASH assessment was recorded as medium in terms of risk.

6.15 On the 7th September 2017 an Early Help support worker visited Patrick in furtherance of her work. She records finding Patrick as being angry and upset. The EH worker was so concerned that she undertook to express her concern with the fostering social worker by telephone. Getting no response, she left a voicemail, but that message was left for the social worker who no longer worked for the organisation, therefore the voicemail was never accessed and as such, no action could be initiated.

6.16 On the 22nd September 2017, the children were moved to their new placements. Earlier on the same day a Senior Practitioner from the County Fostering Team visited Patrick intending to conduct a foster care viability assessment as a single carer. It was not possible for the assessment to take place as Patrick was too upset due to the imminent removal of the foster children.

6.17 Further contact with Police was made by both Patrick and Mary on the 25th and 26th September. Mary stated that she felt intimidated and worried that Patrick had been advised that as co-owner of the property he had the right to remove the lock she had placed on her bedroom door. Patrick meanwhile felt that Mary was creating issues over the car and sale of the house, as well as threatening to report him for harassment, all of which were deliberate, calculated and designed to "push his buttons". The officer who attended on the 26th conducted a DASH assessment for Mary and this was recorded as

medium. Further examination of the Police database also reveals that a DASH assessment was completed for Patrick and assessed as Medium. The usual practice of referring an individual to victim support after an assessment of medium risk seems not to have been followed.

6.18 Throughout September 2017, there is evidence of Mary raising concerns with the Early Help Worker about Patrick's controlling behaviour and that he was drinking heavily at weekends. The Early Help Worker was engaged in developing a Family Assessment, a statutory assessment carried out by a social worker when a child is thought to be in need of services or suffering 'significant harm'. As such Mary conveyed information to the EHW that later appeared in the assessment but was later removed at Mary's request.

6.19 In October 2017, Mary attended a work training session and during the event confided to the training officer her concerns as to Patrick's behaviour towards her. The training officer was concerned and passed his concerns on to the police. The officer who had dealt with Mary's complaint on the 25th September 2017 made further contact with her to assess if further incidents had occurred. Her concerns had been recorded as; fear that Patrick was drinking heavily, having to lock herself in her room and the impact on Child A. On the occasion when the officer called in October, Mary is recorded as stating that matters had improved. Patrick was drinking less and being more pleasant. The officer records discussing ongoing safeguarding, but no further actions were recorded. A further DASH assessment was conducted and assessed as Standard risk on the 30th November 2017, following a further call from Mary to the Police.

6.20 Early in 2018, events began to escalate. Patrick complained to the Police about Mary removing the thermostat from the home, denying him access to the controls to increase the heating during the day. The Police Officer who attended in response to the call spent time with Patrick expressing his concern about his mental state and signposting him to supportive agencies. By February 1st, Mary had contact with a domestic abuse agency and a case file opened on MODUS. By the 12th February, she reported that Patrick had increased his level of abuse. None of the abuse was physical, rather mental/emotional. Patrick was alleged to be throwing away food she had prepared for work the next day, clothes she had bought and that she had to have her mail redirected to prevent him throwing that away. His texts and emails to her were increasingly abusive and he had also emailed her work complaining about her treatment of him and their son. A DASH assessment was completed and a score of thirteen indicated an increase to 'High' risk. Mary was advised to call the Police to report both the recent and any further incidents.

6.21 Also, on the 12th February 2018, the domestic abuse provider support worker completed a full risk identification. Key factors were highlighted; coercive control and possible child protection issues (particularly around the apparent suicide attempts and high alcohol use combination). The support worker liaised with the Operations Manager who was the designated safeguard lead.

They advised that a Children and Families Social Care referral and MARAC referral should be completed. On the 15th February 2018 the MARAC (Multi Agency Risk Assessment Conference) referral was received from the domestic abuse provider. Child A was also re-referred to Early Help from the locally based domestic abuse service provider.

6.22 Engagement with the Police continued with Mary raising concerns such as the continuing use of abusive texts, harassment by Patrick in terms of ringing her employers to accuse her of misuse of computer equipment and asking her to come home as he was cold. She also had, on one occasion, asked the Police to conduct a welfare check on Patrick as he had sent her a text which not explicit in saying so but was interpreted by Mary as being of suicidal intent. Police located Patrick in his car, he had been drinking but intended to sleep in the car and having established his safety there was nothing further Police could do.

6.23 Patrick's behaviour and darkened mental state caused his brother Peter to insist on Patrick allowing Peter to take him to the GP. Whilst at the GP surgery Peter did not enter the consultation room with Patrick, and Peter has commented that Patrick may not have been entirely forthcoming as to the scale of the issues with his doctor. Patrick was able to present a very controlled façade and might well have convinced the doctor that he was able to cope. Whilst Patrick admitted his high alcohol usage, he denied having any drug history and was noted not to be suicidal. His medication was changed to Mirtazapine and he was issued prescriptions for his old and new medication. He was advised to self-refer to the Alcohol and Substance Misuse Service and given the number of the Crisis Team. A follow up appointment was booked for 4-5 weeks.

6.24 In early March 2018, Patrick received a letter from Kent Police advising that he would be required to attend the Police station 10 days later in March 2018 to be interviewed regarding harassment of Mary, in particular the 200 plus abusive texts he had sent her. By this time the IDVA had noted an escalation of risk and considered with Mary how to upgrade her safety plan.

6.25 Late on the 11th March 2018, the Police and Ambulance service were contacted as Patrick had taken a mixed overdose of medication and alcohol. At 00:59hrs on 12th March, Patrick arrived at A&E accompanied by the Police. He remained in the department until 17:34hrs when he was discharged. Whilst in A&E, staff assessed Patrick using the SMaRT[2] Tool with an outcome of Amber or Medium risk. He was referred to Liaison Psychiatry services (provided by KMPT) at 01:31hrs and again at 03:56hrs. It was not until 16:59hrs, some 13 hours later that he was assessed by Liaison Psychiatry. This was within the 24-hour timeframe for Amber referrals. It was a busy day for the Psychiatry Liaison Team, with a high number of urgent referrals; eight as opposed to a normal number of four. Patrick appears not to have described

[2] Safeguarding, Managing and Risk Tool (SMaRT) allows staff to use the symptoms that the patient is describing, alongside behaviours that they are observing to come to a traffic light like system of risk.

his alcohol use though he is recorded as presenting as drunk on arrival at A&E, and it appears that the medical team did not consider a dual diagnosis pathway. Patrick disclosed issues around the domestic abuse he had been subject to in earlier life and his current relationship breakdown. The panel has been advised that under such circumstances Patrick met the criteria of High Risk, yet at 17:34hrs he was discharged from the hospital having been assessed as not being suicidal with a discharge plan.

6.26 At 00:25hrs on the day that Patrick was due to attend the police station, Mary called the Police concerned about Patrick's behaviour. He had sent Mary thirty plus text messages that evening and had been sick. SECAmb had been called but would not dispatch an ambulance merely because he had been sick. Mary was concerned he may further self-harm but was scared to speak with him. The Police recorded the call as requiring a welfare check when resources allowed. At 06:28hrs, the welfare check is recorded as being sixteenth in line, with three outstanding priority (emergency calls). By 07:12hrs Mary had woken, found Patrick absent and assumed that either the police had attended overnight after she had fallen asleep or that Patrick had left the house. She rang the police and repeated her concerns for Patrick's welfare. The incident remained a high-grade concern, but despite receiving no response from Patrick's mobile phone the matter was progressed no further. At 11:42hrs Patrick had failed to attend the police station for his interview regarding the harassment issues. At this stage the Duty Sergeant was made aware of the incident and at 12:43hrs a Police car arrived at the house and confirmed he was not inside. At 12:56hrs the decision was taken to upgrade Patrick's disappearance to that of Missing Person and Mary was rung for further details to set the Missing Person protocol in place. At 13:12hrs Patrick was found dead at the rear of his home.

7. Key Issues Arising from the Review

7.1 The key issues arising from this review are as follows and further detailed in Section eight below.

- Whether sufficient consideration was placed upon Patrick's vulnerabilities and the impact this may have had in terms of his potential for self-harm in addition to the demands of the placement Patrick was asked to undertake.

- The lack of ability to act swiftly in response to Patrick's request to discontinue the placement of one of the foster children and the ongoing issues with continuity of support provided.

- The apparent lack of any system being in place at the GP surgery to indicate to the doctor that Mary and Patrick were foster carers.

- The potential lack of parity of service that Patrick appears to have received both by Kent Police and by Psychiatric Liaison Services

- Despite several agencies being advised of issues surrounding their relationship and stress at home, the lack of professional curiosity to seek to explore further.

- Domestic Abuse agencies have no mechanism to engage with alleged perpetrators and act as a sole agent for the potentially abused. Greater work is needed in intervention and support for perpetrators by the development of community based programmes

- The level of information sharing across agencies and particularly between A & E and Psychiatric Liaison Services, who could share the RiO computer system, requires attention.

8. Conclusions

8.1 Patrick and Mary became foster parents in 2012, but by 2013, after a single placement, were asked to care for a significantly demanding placement. This was despite the Fostering Panel being aware of Patrick's childhood background and history of depression. Whilst Patrick should not have been precluded from applying to be a carer, the wisdom of asking the family to care for a demanding placement given their relative inexperience, when continuity of support was lacking for long periods, requires consideration and review.

8.2 Within the fostering placement there were several alarm bells that should have been heard. Early on Patrick was requesting respite weekends, he initiated the process to end the placement of one of the children and most seriously, there was an allegation of assault following an incident with this child. Despite these concerns, action taken appeared hesitant and delayed, almost as if the need to maintain the placement was the over-riding priority above that of the potential impact on the remainder of the family.

8.3 The method and nature of the Police letter sent in early March 2018 requiring Patrick to attend the Police Station for interview following allegations of harassment by Mary, is process driven and blunt in execution. The letter has no element of consideration for diversity or health issues, does not sign post the recipient to advice (other than a solicitor) nor has it taken account of any of the previous case history.

8.4 The IDVA act solely as an advocate for the party identified as being "at risk" in this case Mary. It is therefore important that such support agencies are able to communicate at the earliest opportunity with other agencies in order to offer the best possible support based upon the known history held by all agencies.

8.5 The limited resources dictate that victims are prioritised, with limited mechanisms or resources to provide alternative support via programmes for potential or alleged abusers. Despite Patrick also being recorded as a victim, there was a lack of wider recognition and consideration of Patrick as a victim of domestic abuse by agencies. This left him without onward referral to support mechanisms, and potentially missed opportunities to escalate his support needs to a forum such as MARAC should the circumstances have required it.

8.6 Patrick attended A&E on two occasions, also visiting his GP at the initiation of his brother, and notes were made recording both the discussion and the treatment outcomes, yet these records would not be available to staff at Hospital when Patrick presented himself to them on 12th March 2018. Nor conversely, were GPs able to access Patrick's A&E notes. It appears that on each occasion medical staff dealt with Patrick, valuable time would be spent gathering information already available and highlights poor communication systems available to medical professionals.

8.7 Evidence provided raises concerns as to whether on the 12th March 2018 staff conducting the assessment of Patrick fully followed the protocols required, failing to pursue the issue of dual diagnosis and wider considerations of safeguarding issues relating to Child A. There was an assumption that, because of his gender, domestic abuse would not play a part in Patrick's potentially suicidal actions.

8.8 On several occasions (to their GPs, at A&E and clinics) both Patrick and Mary signaled that they were under stress or that things were not well at home. Neither in Patrick's case or with Mary does there seem to have been that element of "professional curiosity" to pick up on the cue given and explore deeper. Whether the cues were missed, or that there was no time available to divert attention away from the primary cause of the appointment cannot be judged, but the opportunities to explore both Patrick and Mary's cues consistently appear to have been missed.

8.9 The ability to communicate, both within agencies and externally with others, continues to be identified as a significant issue and played a critical part in this case. From agencies involved being unable to access or retrieve relevant information, either internally or from each other, especially when most needed. The apparent lack of a domestic abuse support referral, following the DASH assessment on Patrick, and the frequency of MARAC, meant that an early opportunity to share information was unable to occur.

8.10 The Police were required to decide whether to send a response vehicle in the early hours of the morning of the day he was due to attend the police station, following the call from Mary. The fact that a response was not provided, due to other priorities, could be seen as a missed opportunity to challenge Patrick and divert his intent away from self-harm or suicide. However, whilst there may be some background information to support that view, equally the police had limited resources available to deploy across a wide area and had to prioritise their response. At the time of the call there was no evidence of Patrick being

missing from the home or that he was attempting to self-harm, though Mary stated she was worried about him. The required action from police was a welfare check, hence the decision taken when balanced against other calls of an urgent nature seems a difficult but justifiable decision. Indeed, following the incident, the matter was reviewed by the IOPC who concluded that at the time of the 00:25hrs call, the evidence provided did not provide sufficient concern for an urgent response.

9. Lessons to be Learned

9.1 This DHR has considered the information available to it. This report has identified areas of concern in relation to process and procedures and failures therein. Hopefully, the key lessons learned and recommendations set out in this review, will provide lessons that could relate to other cases, past and particularly for the future.

9.2 The need to ensure that appropriate decisions are taken when considering the placement of children based upon both their needs but also that of the foster family. Additionally, continuing support, advice and guidance needs to be provided on an ongoing basis with continuity of support being a priority where placements may be regarded as High need.

9.3 That GP surgeries should have in place systems that identify patients who may be fulfilling roles such as a foster carer, that may have an influence on the decisions a GP might make during a consultation.

9.4 That agencies associated with this review need to consider whether the parity of service provided to Patrick was appropriate and in line with policy and process.

9.5 Support agencies dealing with domestic abuse are constrained from taking a wider “Think Family” approach, due to the conflict of interest they are unlikely to be able to work with perpetrators having to act solely as an arbiter for the abused person. Therefore, wider needs or actions may not be fully met and alternative mechanisms or agencies to address issues with perpetrators which may provide positive support for possible perpetrators, as they are not regularly or readily available.

9.6 The term professional curiosity has been used extensively in this review. Agencies need to be assisted in defining and interpreting this term, the potential and limitations for its deployment and the responsibilities attached to utilising intelligence delivered from the outcomes.

9.7 There continues to be a need to improve the way in which agencies work with each other, both internally and across agency bodies, to share information or make it available quickly to colleagues and therefore make joint working more effective and offer greater opportunities to safeguard the vulnerable when required.

10. Recommendations

10.1 The following recommendations have been made:

No.	Recommendation	Agency
1	EKUHFT should consider the concerns of this review alongside that of the Care Quality Commission report and address the need for improvement across the service delivery in this department.	East Kent University Hospital Foundation Trust
2	Domestic abuse agencies should ensure that follow-up contact is made with clients within the prescribed time frames so as to ensure support is available at the earliest opportunity to victims of domestic abuse.	DA Providers
3	Kent Police should review their procedure and letter templates used when requesting members of the public to attend for interview regarding potential criminal allegations against them. In particular, consideration should be given to the content of the letters used, recognising the potential for broad diversity issues and the impact a letter may have on a recipient.	Kent Police
4	Kent Police should seek to understand why a DASH risk assessment for Patrick, resulting in medium risk, was not followed by a referral to an appropriate domestic abuse provider. Once understood, appropriate action should be taken to prevent any such repeat failing.	Kent Police
5	The definition and use of the concept of “professional curiosity” should be defined for use within all agencies nationally. Care professionals should embed the defined concept within their policies and staff understand this good practice through ongoing training and workplace delivery.	Home Office
6	The Home Office progresses its commitment included in the response to the Domestic Abuse Draft Bill Consultation; 105 - Work with specialist domestic abuse organisations to assess the range of interventions currently available for perpetrators who have not been convicted of a domestic abuse offence.	Home Office
7	KMPT should formally consider the findings of this review in relation to the issues raised, ensuring that they address the failure of provision identified within the KMPT IMR relating to levels and parity of service, staff training in areas such as domestic abuse and ensuring staff follow agreed and established NHS protocols.	KMPT
8	The pilot project of the IDVA available within the hospital setting to provide DA advice and support for staff and patients should be recognised as good practice and	KCC Commissioners

	permanency of the service should be considered, subject to funding.	
9	That the frequency of MARAC meetings for this area be reviewed to ensure that the time period between referral and a meeting are as short as possible. (MARAC chairs to consider calling extraordinary MARACs when/if the circumstances require.)	Kent and Medway Domestic Abuse Group
10	The two hospital service providers should jointly review the issues raised within this report in relation to information sharing and access to patients' medical records (including Rio) to enhance patients' care.	KMPT / EKHUFT
11	Kent Police should review their policy around the guidance on coercive and controlling behaviour within the 2015 Serious Crime Act and ensure they are satisfied that officers are appropriately trained. The policy should recognise the need for parity of interpretation and enforcement within a domestic abuse situation.	Kent Police
12	GP Practices should have a system in place to identify patients who are foster carers, enabling recognition of potential additional considerations when dealing with patients.	East Kent CCG and NHS England
13	SECAmb should risk assess the process where advice is provided by despatchers to family members relating to driving patients to hospital as an expediency where long delays in ambulance attendance is expected. Such advice, though pragmatic, should identify whether there is risk to any party involved before being given.	SECAmb
14	KCSP should raise awareness around economic abuse.	KCSP