Domestic Homicide Review

Patrick/2018

Overview Report

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.

1. Introduction

1.1 Purpose

1.1.1 The key purpose of a Domestic Homicide Review (DHR) is to:

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

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

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate; for all domestic abuse victims and their children through intra and inter-agency working;

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

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

f) Highlight good practice.

1.2 Scope

1.2.1 This report of a domestic homicide review examines agency responses and support given to Patrick Douglas, a resident of Kent, prior to the point of his death in March 2018.

1.2.2 In addition to agency involvement the review will also examine 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 seeks to identify appropriate solutions to make the future safer.

1.2.3 This review examines the contact and involvement that organisations had with Patrick Douglas and his partner, Mary Brown, between 1st December 2016 and his self-inflicted death in March 2018. In order to meet its purpose, this review also examines the contact and involvement that organisations had with immediate family members.

1.3 Timescales

1.3.1 This review initially began on 24th April 2018 following the decision that the case met the criteria for conducting a DHR. Patrick was not the victim of a homicide (the killing of one person by another), but paragraph 18 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews states:

'*Where a victim took their own life (suicide) and the circumstances give rise to concern, for example that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable'*

1.3.2 Due to the circumstances of the death, the issues relating to protection of personal data in relation to Mary Brown and the children involved, required Legal advice following the introduction of legislation under the General Data Protection Regulations. This guidance and the subsequent need to gain the necessary Permissions of Authority from Mary Brown delayed commencement of formal commissioning of Independent Management Reports and other documentation/meetings until 22nd June 2018. The review was completed on the 17th September 2019.

1.3.3 On behalf of the members of the Domestic Homicide Review Panel, the individual organisations involved in this case and myself, as 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.

2. Methodology

2.1 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act, 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on the 24th April 2018. It confirmed that the criteria for a Domestic Homicide Review had been met.

2.2 That agreement was ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office was informed.

2.3 This Overview Report is an anthology of information gathered from Independent Management Reports (IMRs) prepared by representatives of the organisations that had contact and involvement with Patrick Douglas and/or Mary Brown between 1st December 2016 and 30th March 2018. Patrick's death was earlier in March 2018 however the TOR was set to allow post incident involvement by agencies to be considered.

2.4 An IMR is a detailed examination of an organisations contact and involvement with Patrick, Mary and immediate family. It is a written document submitted using a template. A member of staff from each relevant agency writes the IMR. That person will not have been involved with anyone who is subject of the review. Once completed the report is signed off as approved by a Senior Manager of the organisation before being submitted to the DHR Review Panel.

2.5 Information from meetings with family members was considered of significant importance and included in the completion of this review.

2.6 The terms of reference for this review are set out in Appendix A to this report.

2.7 A glossary of abbreviations, acronyms and terms used, which may be unfamiliar to those who are not professionals in the agencies concerned, is included in Appendix B.

2.8 This report has been anonymised and all the personal names contained within it, excepting members of the review panel, are pseudonyms.

3. Involvement of Family

3.1 The Review Panel considered which family members should be consulted and involved in the review process. The Panel was made aware of the following family members:

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

3.2 The Independent Chairman met with family members on three occasions. Firstly, he met with Mary Brown on the 13th September 2018 to advise her of the issues relating to General Data Protection Regulations and obtain her authority for agencies to release data relating to her and her family in preparing the required IMRs. Following obtaining required permissions, he then met with Patrick Douglas's brother, Peter Douglas, sister, Toni Pearson, and brother-in-law, Brian Pearson on the 30th October 2018. Finally, he again met with Mary Brown on the 10th December 2018. A further meeting planned with Child A did not materialise, despite an appointment having been made. Contact details were left for them to contact the Chair, but it appears that they had changed their mind about participation in the review. Updated correspondence was sent to the family throughout the course of the review.

3.3 The family were provided with the Home Office DHR leaflets. The family were not represented, nor did they request the help of any advocate or specialist prior to or during the meetings. The offer was made to them to have any representative that they felt appropriate to assist them. The family were quite happy to proceed with the Chair on the basis that they could, at any time, refer to an advocate or other that they felt appropriate to further assist them.

3.4 Following the completion of the draft Overview Report, the Independent Chairman wrote to family members, offering them a further opportunity to meet, to allow them to discuss its contents, conclusions and recommendations. He again met with members of Patrick's family on the 17th September 2019 (Toni and Brian Pearson and Peter Douglas) and 9th August 2019 (Mary Brown).

4. The Review Process

4.1 Contributors of the Review

4.1.1 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 Partnership Trust (KMPT)

4.1.2 Short reports were additionally received from:

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

4.1.3 The authors of each individual IMR or report were appropriately skilled and independent, with no direct involvement with Patrick Douglas or Mary Brown and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR or report.

4.2 The Review Panel

4.2.1 The Review Panel consisted of an Independent Chairman and senior representatives of the organisations that had relevant contact with Patrick Douglas or Mary Brown, and a senior member from Kent County Council Community Safety Unit.

4.2.2 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

4.3 Author of the Overview Report

4.3.1 The Independent Chairman and author of the Review 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 between 1977 – 2013, having been a Governing Governor, working closely with Ministers in a Prison Service Headquarters setting and finishing his career as an Assistant Director responsible for oversight of 12 Prison establishments.

4.3.2 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 Kent 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.

4.4 Review Meetings

4.4.1 The Review Panel met first on 22nd June 2018 to discuss the Terms of Reference, which were then agreed by correspondence. The Review Panel met on 11th December 2018 to consider the IMRs. The next meeting of the Panel was held on 31st January 2019, where the first draft of the Overview Report was reviewed, considered and amendments proposed. The panel met on the 22nd March 2019 to consider the amendments made and agreed a form of words relating to changes required to be made to the report. Additional information required was also identified. This included input from SECAmb and

EKUHFT. Further review was conducted by e-mail response from panel members where the need for clarification or change to the final draft report was required. An agency raised queries with the report content during June 2019. To resolve this, further panel correspondence was carried out. Completion of the action plan was carried out by email correspondence, with final gaps in the action plan being completed in early 2020.

4.5 Parallel Reviews

4.5.1 There was a Coroner's Inquest into the death of Patrick Douglas on the 15th November 2018. The outcome was one of Suicide. The IOPC commenced an investigation under the Death or Serious Injury protocol, utilised where an individual dies following contact with the Police; and relating to a complaint that was made regarding the conduct of the Police. The outcomes of their investigation have been used to draw conclusions and recommendations within this Domestic Homicide Review.

4.5.2 The review considered a report from the Care Quality Commission relating to the Emergency and urgent care services provided by the Hospital Patrick attended on the 12th March 2018. Further clarification was also sought, by way of a conference call, from the A&E provider as to additional points raised by the Panel. The outcomes and information provided by these reports have been used within this review.

4.6 Equality & Diversity

4.6.1 The report addressed the nine protected characteristics (age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, ethnicity, sex and sexual orientation) as prescribed in the public sector Equalities Act duties and considered if they were relevant to any aspect of this review. The review considers whether access to services or the delivery of services were impacted upon by such issues, and if any adverse inference could be drawn from the negligence of services towards persons to whom the characteristics were relevant. The Panel considered that there may have been aspects of this case that surrounded parity of access to services based upon sex as well as issues around Mental Health. These have been discussed in the analysis section.

4.7 Dissemination

4.7.1 The following will be recipients of the Overview Report:

- The Family of the deceased
- All panel members who will be responsible for disseminating to all staff within their organization
- The Head of the Kent Community Safety Partnership
- The Kent Police and Crime Commissioner

5. Background Information

5.1 Events Surrounding the Death of Patrick Douglas

5.1.1 Patrick Douglas was living at the same address as his estranged partner, Mary Brown, despite their relationship ending in December 2016. Also, in the home was Child A and also Child B - who latterly spent time living with their father. Financial constraints dictated the living arrangements and the living environment had become acrimonious. Patrick's mental state had deteriorated and there were several depressive related, self-harm events and an increase in drinking with numerous abusive texts and e-mails sent to Mary. As a result, Mary largely confined herself to the attic room in the house where she could lock her door and feel safe.

5.1.2 Patrick had previously received a letter from the Police asking him to attend the Police Station at 11.00hrs on a date in mid-March 2018 to answer questions about allegations of harassment of Mary.

5.1.3 In the early hours of the day that Patrick was due to attend the police station, Mary called the police concerned about Patrick's behaviour. She feared for Patrick's welfare but was too concerned for her own safety to leave the room to check his well-being.

5.1.4 When she awoke at 07.00hrs later that same morning Patrick was not in the house. Mary made a further call to the police to see if they had attended the home in the early hours and possibly detained Patrick, and if not, to express her concern at his absence.

5.1.5 Patrick did not attend the police station at 11.00hrs as requested and at that stage a police presence was sent to his home to find him. When he was not at home the police escalated the status of the case to one of Missing Person and a search commenced. Shortly after at 13.00hrs Patrick was found dead at the rear of his home.

5.1.6 At the time of his death Patrick was 46-years of age.

5.2 Summary of Relevant History and Agency Involvement Prior to 01/12/2016

5.2.1 <u>Patrick Douglas</u>

5.2.1.1 Patrick was a 46-year-old, white British male. His early years could be described as difficult. He witnessed abuse of his mother by his father, and it is recorded in GP records that together with his mother he spent some time in a Refuge. This was initially in order to escape domestic abuse, and then because his mother gained employment at the Refuge and they continued to live there. However, the information given by Patrick has been challenged by his elder sister, whose recollection of events differs in that whilst the parents separated due to domestic abuse the children, including Patrick then moved into a home in South Wales from which Patrick's mother became involved with local Domestic Abuse support volunteering at a

Refuge. The reasons for the differing versions of events is not clear, though it may be that Patrick's recollections of this period were coloured by trauma, or simply confused memory recall. Whatever the reason agencies were only able to base decisions using the details provided by Patrick. Patrick is said to have been bullied at school (as recorded during a fostering assessment). It is clear from the information provided from the family and medical records that Patrick was close to his mother. Her death in 2014 affected him badly, adding to the depression and anxiety he suffered from which was first recorded by his GP in 2008.

5.2.1.2 Patrick's medical history shows that he was diagnosed with Crohn's Disease[1] in 2002 and was treated accordingly. There are records showing that Patrick failed to attend hospital for a bone scan and consultant review on more than one occasion. As mentioned above, Patrick had a history of depression dating back to 2008 and he had been prescribed antidepressants to assist with his condition. In May 2012 he presented to his GP with anxiousness. He cited his long history of anxiety and depression, but stated he had no financial worries or work-related stress and had a supportive partner. He was prescribed Citalopram and was reviewed two months later, when he stated he felt better. Patrick continued using this medication until 2014, during which time he had three medication reviews. He did not mention suicidal thoughts at that time.

5.2.1.3 Patrick was described as "particular" in all facets of his life. He was a keen runner who promoted the benefits of healthy eating. He liked to be well groomed and dressed. Both Mary Brown and his brother and sister described him as being both obsessive and difficult bordering on controlling. Patrick was also described as being charismatic and that he would bring a presence to a room when he entered, appearing charming and affable, presenting an image of a well-adjusted and happy individual. It is this element of his personality that family state, allowed him to convince others of his well-being at times when he was in crisis.

5.2.1.4 Patrick and Mary had co-habited since 2002 having known each other some ten years earlier through work. Mary described living with Patrick as challenging, given he was, as she described; narcissistic and controlling. However, she said it was manageable and that Patrick would often recognise the need to compromise following a disagreement between them. In 2004, Patrick and Mary had a child of their own, adding to the family group as Mary had an older child, from a previous marriage who also lived with them.

5.2.1.5 As a result of his difficult early years, Patrick was a man who wished to do better for other children who found themselves in circumstances as he had experienced. As such, in 2011 he applied to become a foster carer together with his partner, Mary.

[1] A chronic inflammatory disease of the intestines, especially the colon and ileum, associated with ulcers and fistulae. https://www.crohnsandcolitis.org.uk/about-crohns-and-colitis/publications/crohns-disease

The Fostering Recruitment Team began the assessment process, seeking background checks and medical history from relevant agencies. The assessment criteria used by the Fostering service fully documented the issues from Patrick's early childhood, including counselling he himself had received to cope with the issues in early life.

5.2.1.6 The couple were registered as foster carers with Kent County Council on the 2nd May 2012 for one child or two siblings under the age of six. This was later revised in 2013 to three siblings, with the Fostering Panel recording reasons supporting recommendation including; demonstration of a good level of care and engaging well with agencies. Patrick and Mary fostered children from 2012 and continued to do so until events relating to their separation terminated their role as carers in September 2017.

5.2.2 Mary Brown

5.2.2.1 Mary is described as having had a caring childhood and had married and had a child with her former partner. Within this relationship Mary experienced emotionally abusive behaviour and the marriage ended.

5.2.2.2 Mary met Patrick in 2002 and began to co-habit with him. The relationship produced a child (Child A) adding to the family group which included Mary's older child (Child B) from her previous relationship.

5.2.2.3 Mary has been employed in a professional occupation for twenty-six years. Mary continued to work full-time in this role even after becoming registered as a Foster parent, leaving Patrick to fulfil the primary caring role whilst she was at work.

5.2.2.4 Mary, a white British female, was 46 at the time of Patrick's death.

5.2.3 The Children

5.2.3.1 The issues that arise in this review cannot be fully understood without understanding the pressures present in the relationship in relation to the birth children and the foster children. The actions of agencies in terms of support and welfare of both the adults and the children come under significant scrutiny in this review and as such the background setting and key issues are important to understand.

5.2.3.2 Patrick and Mary had lived as partners since 2002 and within that relationship was Child B, Mary's child from a previous relationship. It appears that Patrick became the de-facto stepfather to the child and that the family unit were happy and stable. A few years later Mary and Patrick had Child A from their union to complement the family group.

5.2.3.3 In 2012 both Patrick and Mary were assessed as being suitable as foster carers, with Patrick as the primary carer. Mary would continue her full-time employment, but also fulfil an active role within the fostering arrangement. The first placement saw the foster child eventually move to adoption, a move that Patrick found hard to come to terms with as he had formed an attachment to the child. Patrick was considered to have become a skilful and dedicated foster carer, but it was also recognised that he needed a lot of praise and reassurance to cope with the demands within the role. In December 2013, the next placement to these relatively inexperienced foster carers was one with significant demand.

5.2.3.4 By September 2014, the demands of this placement, together with maintaining normal family routines with his stepchild and birth child, was beginning to take a toll on Patrick. He began asking for respite every six weeks and then once a month. The impact of regular respite in providing a sense of permanency for the placed children was raised by the Independent Reviewing Officer, who felt that such regular respite impacted on the "normality" of family life. Despite her concerns it was agreed in January 2015 that funding for one respite weekend every six weeks would be applied for as part of the permanence plan for the placement in support of Patrick and Mary.

5.2.3.5 By March 2015 Patrick and Mary's birth child had been diagnosed with additional needs. Patrick, at that time was the primary carer for children aged between 6 and 11, having additional medical needs which included requirement of assessment by a specialist Children's Hospital. This assessment was taking a long time and Mary requested that any decision on the placement becoming permanent with them be put on hold until the outcomes were known. Mary by this time was suffering from poor health.

5.2.3.6 At the first Child and Adolescent Mental Health Services (CAMHS) Network meeting around this time (March 2015), Patrick was provided with therapeutic support in parenting, focusing on a foster child who had particularly challenging behaviour.

5.2.3.7 By April 2016, the children's social worker was beginning to question whether, or not, the placement needs would be better met by placing the children separately, but it was decided at that time they should remain together. Significantly for Patrick it was decided that further respite was not considered in the children's best interests.

5.2.3.8 In June 2016, a Fostering Stability Core Group Meeting was convened following a request from Patrick to give the 28-day notice period to end the placement of the child with particularly challenging behaviour, due to the wider impact on all others in the household. These concerns were addressed by tasking the childrens' social worker to undertake a sibling assessment to determine how best to meet their individual needs. However, as

detailed in the following chronology, this assessment becomes significantly delayed. It is noted in the Child in Care Team case supervision notes (some eight months later) that the team manager recorded her concerns that this work to carry out the assessment had been allowed to drift since the permanent social worker had left some several months previously. This indicates that the Children in Care team were dependent upon the services of agency social workers, who whilst fulfilling core roles as a priority also meant that consistency in the agency's work could not be guaranteed. The work needed to complete the sibling assessments presented a challenge and as such the issue raised by Patrick and Mary remained unresolved.

5.2.3.9 Patrick continued to engage with his Fostering Social Worker and the Foster Children's Social Worker[2], with concerns being raised about the continued suitability of the placement and what was best for the children to provide them with the normality required within the home setting. The sibling assessment which had been promised to Patrick, remained incomplete.

6. Chronology / Overview of Events

6.1 Introduction

6.1.1 This section considers, in detail, the contact and involvement that Patrick, Mary and the children had with agencies during the period covered by the Terms of Reference. There has been some additional background information recorded in Section 4 that pre-dates the time periods set out in the Terms of Reference, but it is felt that this information is contextual in setting the scene for later events leading to the tragic death of Patrick. The facts are based on IMRs submitted by organisations and information gathered from discussions with the family.

6.1.2 Each IMR included a detailed chronology of contact and involvement with Patrick, Mary and the children.

6.1.3 Given the impact that the demands of foster care had in this case, there has necessarily been the need to provide detailed information in relation to these children, however their identities have been protected throughout this report.

6.2 Agency Involvement with Patrick Douglas and Mary Brown (December 2016 – March 2018)

6.2.1 Patrick and Mary's annual foster care review was held on the 1st December 2016. The previous two reviews had been positive, but on this occasion, Mary raised the issues of the impact of looking after children with special needs, particularly on Patrick. She claimed he had received little in terms of training and nothing other than statutory visits by social workers who were unable to offer

[2]There were two Social Workers (Fostering Social Worker and Children's Social Workers). One was for Patrick and the other was for the three foster siblings.

much consistency in support. This view was not supported by the fostering social worker who rated the couple as nine out of ten as she felt the needs of the children were being managed very well. It is unclear if the issues and views expressed by Mary were further considered or addressed. Further to this, a case discussion is recorded where a decision was made to place the sibling assessment on hold (30th January 2017) 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.

6.2.2 It is recorded that there were significant concerns and differences between professionals regarding the placement. Whilst it appears that the foster children's school and CAMHS believed it to be better for the children to be together, case oversight by the Independent Reviewing Officer (IRO) clearly stated her view that delaying the sibling assessment any longer might prevent the right changes being made due to their ages. IRO quality assurance and feedback rated the practice as requiring improvement, in part due to the sibling assessment being placed on hold.

6.2.3 By the end of 2016, Mary, who had been unwell for much of the year felt that she could no longer continue in the relationship and informed Patrick accordingly of her desire to separate. The initial separation plan seemed to be to work together in an adult manner, sell the family home and ensure that Child A was able to choose who to live with and to have regular access to the other parent.

6.2.4 In December 2016 Patrick took an overdose of paracetamol and alcohol. It is not apparent whether the news presented to him by Mary, or the ongoing pressures of his foster care responsibilities may have been contributing factors to this event. He presented himself to his local hospital where he was treated and assessed following these actions. During the Psychiatric Liaison, he appears to have discussed a wide range of concerns such as missing his mother who had died in 2014 and his child's diagnosis of Asperger's Syndrome, but no mention of his separation or stress within his role as a foster parent. In the summary from the Psychiatry Liaison Team, it was recorded that there was no history of mental health issues and this had been an impulsive act. Patrick was referred to his GP.

6.2.5 On 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.

6.2.6 Patrick attended the GP surgery on the 12th January 2017 following this incident. He admitted that he had taken an overdose but showed remorse for his actions. He discussed his own history of abuse as a child and that he had had some counselling in the past. He claimed that he had now stopped drinking and had taken up running and was working as a carpenter. He stated he was stressed regarding Child A's diagnosis of Asperger's, but that he had a supportive partner at home and a brother living nearby. He did allude to the fact that he had had a relationship discussion with his partner but it appears he was not further quizzed on this point. Patrick was signposted to various support agencies, he stated that he would self-refer for further counselling and was prescribed 10mg of Citalopram (an anti-depressant). A follow up consultation was agreed in two to three weeks, but it is not clear if Patrick had to book this outside the appointment or whether it was booked at the time. Patrick is not recorded as attending for any follow up meeting and there is no record of the GP practice following up the failure to do so.

6.2.7 In March 2017, Mary attended the surgery relating to her ongoing medical condition and she was referred to a consultant. At this time Mary did note that her and her partner were splitting up but that the situation remained amicable, so they and their children would continue to live together. During this DHR the IMR author examined the medical records of both Patrick and Mary. She was concerned that on examining the "household list", there appeared to be no code allocated to either Patrick or Mary to indicate that they were foster carers. This would seem to be information a GP would require when dealing with a patient especially given Patrick's medical history of overdose. Such awareness of the patient and his wider family might lead to greater consideration of other issues. This may include safeguarding and liaising with other agencies in order to ensure the protection of children or establish a supportive care plan for the patient.

6.2.8 On the 7th March 2017 during a visit by the fostering social worker, 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. In April 2017, a further visit by the fostering social worker records that Patrick informed her that he was "fine" and that he and Mary were now getting on together. He was in the process of decorating the house in readiness to sell.

6.2.9 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. The child said that whilst they were not scared it did hurt. It is recorded that the CAMHS worker was aware of the pressure on Patrick and "reflected" upon it. However, it was considered that as one of the apparent symptoms of the child's condition was the potential for a difference in recollection of events, the child may have confused being reprimanded with being threatened.

6.2.10 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. In the interim it appears that 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. Both Patrick and the child were interviewed, with the child's interview differing from his original account as well as from the events described by Patrick. The outcome of the enquiry was to conclude that Patrick used reasonable restraint and the allegation not substantiated.

6.2.11 Medical records inform us that on 31st May 2017, Mary attended the GP Surgery for a routine appointment at which she stated that there was "lots of stress and anxiety at home". There is no documented record of being any exploration of these comments to further understand the issue.

6.2.12 Managing the children in the family home continued to prove challenging. One of the foster children with the most challenging behaviour was increasingly difficult to manage in school. This meant they spent increasingly long periods at home with Patrick. In addition, in mid-July, Child A was referred by their school to the Early Help team as they had become withdrawn and were finding it difficult to complete their work. Both parents were keen to also seek assistance in helping to manage the separation.

6.2.13 On the 4th August 2017, medical records at the GP 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. 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.

6.2.14 On the 14th August 2017, the pressures relating to the separation, which appeared to have been largely hidden from the outside world, began to unravel. Mary is recorded as having rung the police requiring assistance relating to a dispute over use of the jointly owned car. Patrick had threatened to clamp the car if he was not able to use it and a verbal altercation had followed. Police attended, and Mary stated that she felt intimidated by Patrick as he was confrontational and wished to argue. She felt that Patrick needed

help. A DASH assessment was completed. The incident was assessed as medium, justified by the heightened emotions and the presence of the three foster children. It is not clear if Child A was also present and how, or if, this would have altered the risk assessment outcome. 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 by the police to a domestic abuse support provider. Mary also self-referred to a different domestic abuse adviser around the same time

6.2.15 On the 22nd August 2017, Mary again attended her GP in relation to other matters, but again mentioned the issue of stress at home. This was the third time in five months that she had repeated these concerns yet on no occasion has there been a record of any follow up taking place.

6.2.16 Given the deteriorating position of the relationship, the Fostering panel met on the 23rd August 2017 to consider the information available to them relating to this placement. The panel considered the relationship between Patrick and Mary. The Chair described the emotional climate in the home as “toxic”. Given the background and the lack of transparency allegedly displayed by Patrick and Mary, there was 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. On the surface the Fostering Panel felt they were likely to be deregistered and the couple were advised of the potential by letter that day.

6.2.17 On the 31st August 2017, Mary was contacted by a Senior Support Worker from the Domestic Abuse support provider inviting her to attend a One Stop Shop. Mary confirmed she had been to see another organisation earlier that day and had been informed that she could access support through any Domestic Abuse agency in whichever location was most suitable for her. Mary suggested to the support worker that she would like to access support but would contact the identified Domestic Abuse agency when she was ready. Given the level of concern expressed to the police about her fears and the ongoing worsening situation, good practice would have been for the support worker to contact Mary again within forty-eight hours.

6.2.18 In August 2017 Patrick had taken the children on holiday abroad but returned early due to difficulty in managing the children’s behaviour. At a similar time, Early Help made their first contact and visit to Mary regarding her youngest biological child. Further to this, the couple now had a new fostering social worker (as the previous one had retired) whom Mary emailed on the 4th September 2017 alleging that Patrick had “abandoned” the foster children on the doorstep of Mary’s sister’s home whilst she was there visiting. Mary outlined to the new fostering social worker her concerns about Patrick in that he was bullying and harassing her and controlling her financially.

6.2.19 On the same day, 4th September 2017, in consultation with the Children In Care (CIC) Service Manager the decision was taken to end the placement and work began to ready the children for the move. Patrick remained convinced that he could continue as a single carer and was trying to get a flat in order to do so. He was advised that further foster care assessment would be necessary for that to be achieved.

6.2.20 On the 5th September 2017 police were again called, this time by Patrick who alleged that Mary had stolen the spare key to the jointly owned car so he could not use it.

6.2.21 At this point there appears to be a pattern of claim and counter claim between Patrick and Mary involving the police, often regarding ownership of the jointly owned car. On each occasion there appears to be an added element to the concerns raised by Mary. On the 6th September 2017, she again rang the police to complain about ongoing poor behaviour by Patrick relating to the car. She also reported that he made a lot of noise when going in and out of Child A's bedroom which is adjacent to her own. She is recorded as saying *"Patrick is very controlling in what he says and does, not physically, it's more mentally controlling*". She further stated that Patrick stands on guard in the hallway every night so that she needs to pass him to lock herself in her room. That when making food he is always there. She reported feeling intimidated. A further referral was made to Social Services and the DASH assessment was recorded as medium in terms of risk.

6.2.22 On the 7th September 2017, an Early Help support worker visited Patrick in furtherance of her work with Child A following referral by the school. She records Patrick to be 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 and therefore the voicemail was not accessed, and no action could be initiated.

6.2.23 In September 2017, the children's social worker had completed the sibling assessment and recommended separation, to best meet the individual needs of the children. On the 19th September 2017, the social worker visited the children to inform them they would be moving from the current home. Patrick supported the social worker with this conversation.

6.2.24 On the 20th September 2017 Patrick was scheduled to attend hospital for a bone scan. He failed to attend.

6.2.25 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. Despite being unable to carry out the assessment the Senior Practitioner was able to

conclude that Patrick could not be assessed as a single carer at that time. Requirements were recommended that would need to be in place for a reassessment to go ahead, such as securing suitable accommodation. It was also not possible to put a timescale around any reassessment as it was not known when Patrick would be emotionally ready to foster again.

6.2.26 With the foster children's departure, this left only Child A and Child B in the home. The eldest child, Child B, appears to have distanced themself by spending time with their biological father. Being older they were able to cope better emotionally as the home circumstances deteriorated. Records from the Early Help Team demonstrate that the school recorded that Child A began to appear more relaxed and more engaged in class.

6.2.27 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. It is recorded that a referral to Early Help was made and that there was no further action. The usual practice of referring an individual to Victim Support after an assessment of medium risk seems not to have been followed.

6.2.28 On the same day (26th September 2017) in a telephone conversation with the Early Help Worker, Mary re-iterated fears about Patrick seeking to exert greater control over her and Child A now he had lost the foster children. She reported that Patrick was drinking at the weekend and that it did not suit him. Mary further expressed concern that she felt harassed, bullied and isolated. Mary informed the Early Help Worker that she had been offered temporary accommodation at a property owned by her godmother. Mary did not avail herself of this offer and explained to the Chair of the Panel, when they met post-incident, that she felt she could not leave due to Child A, Mary explained that having such a close relationship with his father, she felt that to remove him could further jeopardise her safety.

6.2.29 Further work by Early Help with Child A, saw the case worker conduct what is believed to be 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'. It appears that within this assessment, the Early Help worker included some of the content of conversations held with Mary, in which Mary had disclosed issues which she considered confidential and not to be shared with Patrick. The Family assessment when shared with Mary was poorly received and she responded by email stating that she was upset at the content and claiming that the insight given into the

separation was inaccurate. Mary was insistent that the content be changed and the Early Help worker apologised and altered the document to reflect Mary's views. It is not entirely clear if Patrick reviewed the document or had the opportunity to provide input which, as the other parent, he would have been entitled to do.

6.2.30 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 her son. 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.

6.2.31 On the 18th October 2017, the Fostering Panel met and de-registered both Patrick and Mary as foster carers. The reasons recorded were; that both parents had not been transparent in providing information about the breakdown of their relationship, Patrick's (alleged/proclaimed) relationships with other women and the continuing animosity between them. Mary has made it clear that she felt this decision to be unfair to her as the decision did not consider the work that she did as second carer.

6.2.32 The Early Help worker continued to work with Child A with the focus being on developing resilience and independence skills to cope with the separation. Both parents attended a review on the 7th November 2017, but thereafter Patrick e-mailed stating that he was upset as he felt Mary had inferred he was holding Child A back. Patrick applied for carers allowance for Child A as he carries out the school run and was the primary carer, therefore entitled to the allowance. Mary felt that preventing her having access to these funds was another means of seeking to control her financially and would have impacted on her ability to pay the household bills. By the 15th November 2017, Patrick had informed the Early Help worker that he could not attend any further meetings with Mary due to her looking to make him appear incompetent as a parent, and that he felt undermined.

6.2.33 On the 30th November 2017, Police were again contacted by Mary citing Patrick's intimidating and harassing behaviour. Patrick was again threatening to clamp the car. This would have prevented Mary getting to work and was causing her a sleepless night. Patrick e-mailed her at work, again threatening to clamp the car and informing Mary that as the issue was a civil matter, he would not be arrested if he did clamp it. Mary stated that Patrick was bombarding her with texts, many of which were of an abusive or sexual nature. Further to this, Mary complained that Patrick was continuing to manipulate,

control and be hostile towards her. She feared that Patrick was suffering from depression and that he had also harassed her sister. A further DASH assessment was completed and recorded as standard risk.

6.2.34 On the 1st December 2017, Mary reported to the Early Help worker that the situation at home was escalating. Her eldest child, by her previous relationship, no longer visited as they did not feel comfortable in the house. She advised that her last contact with the Police was not helpful as the Police had followed up her complaint by contacting Patrick. Mary stated that there were regularly drink cans in the rubbish and she feared Patrick was drinking heavily. The Early Help worker reminded Mary to go to the One Stop Shop and offered to go with her when she returned from leave. Two days later the Early Help worker received contact from Patrick detailing things that Mary was doing to "wind him up". It is noted that the house was still not sold as Patrick did not wish to reduce the selling price.

6.2.35 On the 2nd January 2018, the Early Help Worker visited Child A at home where it was agreed that they were much happier. Further support was no longer needed. Both parents remained living in the family home and felt their separation was no longer impacting on Child A. At a meeting held on the 10th January 2018, the case was closed with "all outcomes achieved". One final task was to support Patrick in finding work as his income from his role as foster carer had ceased. Early Help offered Patrick support. He declined stating that he did not want Child A returning from school to an empty house. He blamed Mary for the loss of his foster carer role.

6.2.36 On the 5th January 2018, Patrick contacted the police stating that Mary had left the house taking the thermostat with her, leaving the house with no heating or hot water. Patrick was described as emotional and upset at the time of the call. The officer contacted Mary who explained that the thermostat was locked in her room and as such beyond Patrick's reach. She said the thermostat was set on a timer. She was the sole bill payer and could not afford to allow Patrick to remain at home with the heating on all day. The thermostat was timed to increase the heating in time for her son's return from school. Kent Police record that the officer who attended the home spoke to Patrick and spent a great deal of time utilising his personal and professional attributes to assist him. The officer states that he was concerned about Patrick's mental state and they discussed this at some length. The officer signposted Patrick to advice agencies so that he could seek help and someone to speak to.

6.2.37 On the 1st February 2018, events began to escalate quickly. Mary contacted a Domestic Abuse agency and spoke with an Independent Domestic Violence Advisor (IDVA). Given Mary's home location the case was referred to an alternative domestic abuse agency and the case was opened on the MODUS system and passed to a support worker. On the 5th February 2018, the support worker attempted to contact Mary, but she was at work and unable

to talk, so the worker called the next day. The call discussed issues such as housing, childcare arrangements, finances and safety. Finally, an appointment for a 1-1 session was made for the 20th February 2018.

6.2.38 Mary called the domestic abuse provider office on the 12th February 2018 concerned about an escalation in the situation. 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 Child A. 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. Mary stated that her brother-in-law worked within another police force and she had seen emails from him to Patrick with advice about the law regarding the relationship breakdown and this had further intimidated her.

6.2.39 On the 12th February 2018, the domestic abuse provider support worker completed a full risk identification, demonstrating good practice. 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 demonstrated further good practice in liaising 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. Guidelines prescribe that such a referral to C&FSC should be made within 24 hours. It is a shame that the previous good practice identified was undermined by this referral not being made until the 15th February 2018, some 72 hours after the decision to do so was taken.

6.2.40 Mary contacted the police on the same day as advised, reporting Patrick for his coercive behaviour. She again referred to Patrick's behaviour of sending her texts of an abusive nature, contacting her at work telling her to come home as he was feeling cold (due to the heating being turned down during the day) and that their child was sick. She stated that she feared that Patrick was mentally un-well and she was worried what he might do. She described how Patrick would turn off lights when she was in the house, so she can't see where she is going, parked his car across the drive to prevent her parking and further acts designed to intimidate her. Patrick had also contacted her employers to allege that Mary was abusing the use of her work laptop. It appears that the HR department of her employer advised Mary of this call and whilst perhaps there was no substance to the allegation, when the employer was asked to clarify this issue they stated they had no record of the incident and appear to have failed to log or conduct a simple enquiry into the allegation.

6.2.41 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. The case was reallocated to the same case worker at Early Help but on this occasion the focus of the work was to develop a safety plan for Mary and the child ensuring that the views of the child were taken into consideration.

6.2.42 On the same day Mary rang the police describing how Patrick had walked into the bathroom when she was in the room and wanted to talk. He was intoxicated and cross. He had accused her of seeing someone new. This event was the first recorded occasion of Patrick raising this issue though it manifests itself later in his thinking. Mary requested no action but asked that this incident be added to the report dated the 12th February.

6.2.43 The following day Mary again called the police. Patrick had sent her a text which although not explicitly threatening suicide, she felt it read like he was. Patrick was not at home, it was late, and she was concerned for his safety. Within twenty minutes police had contacted Patrick and attended his location to carry out a welfare check on him. Patrick was in his car where he intended to spend the night as he had had a few drinks and did not wish to drive. He stated he would return home the next day. Patrick had committed no offence. Therefore, police again advised him of helpline and crisis agencies he could contact for help and advice. The police rang Mary to reassure her of Patrick's safety and returned to their duties.

6.2.44 By this time Patrick's wider family were becoming increasingly concerned about his welfare. It is not clear as to the extent of Patrick's attempts at self-harm as we only have those that are documented. His brother was extremely concerned that Patrick was in a very low state. Peter describes having a conversation with Patrick in which Patrick described how he had been researching differing ways to "commit suicide". One had included the use of helium gas cannisters which could be inhaled and used to overcome oneself by fumes. The presence of these cannisters would support a later entry in which Patrick is described as having tried to burn himself in his car. Patrick always re-assured his family that he would not do anything to harm himself as he loved his child too much to do so. However, so concerned was his brother that he persuaded Patrick to go and talk with his doctor and inform him of the thoughts he was having and how upset he was. Peter Douglas accompanied Patrick to the surgery to ensure Patrick attended, but did not enter the consultation room. Given Patrick's persuasive personality that the family stated could be highly convincing, his brother expressed the view that it is highly likely that Patrick may not have revealed the full extent of his depressed state to the GP and as such describes the outcome as disappointing. Within the consultation, Patrick admitted his high alcohol use but 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. There appears to have been no further links made to his domestic situation, previous records of admission to overdosing or any concern expressed as to previous failure to attend follow up appointments.

6.2.45 On the 22nd February 2018, the allocated IDVA from the domestic abuse agency contacted Mary. A discussion was held overviewing the case, updating safety plans and discussing the MARAC process. Mary is recorded as agreeing to the MARAC process but declined IDVA support. Mary did agree for the IDVA to make contact the following week to see how things were.

6.2.46 In the follow-up call on the 2nd March 2018, Mary described the ongoing situation as worsening due to Patrick becoming angry over the proposed sale of the house. The IDVA noted an escalation of risk and discussed upgrading the safety plan with Mary.

6.2.47 In early March 2018, Kent Police sent a letter to Patrick. Patrick was to be formally questioned in relation to the reports and allegations made against him by Mary. The pending interview was set to be 10 days later in March 2018. There was no further explanation and apparently no signposting to support services. Patrick contacted Kent Police on two occasions to confirm he would be attending and seeking advice in relation to a solicitor.

6.2.48 The Police received a call on the 11th March 2018 from Mary. She informed them that Child B had received a call from Patrick's brother advising that Patrick had taken an overdose. On attending the home, Child B found empty paracetamol packets and beer cans. An ambulance was called but the despatcher advised of anticipated delays. Alternative ways to convey Patrick to hospital was discussed. Mary had returned home and saw Patrick crying and wailing and he appeared to be suffering from a mental health episode. When the situation was further explained to the call operator regarding Patrick also being abusive, they in turn sought to deploy an ambulance. Police arrived at the scene and were able to convey him to hospital by Police car.

6.2.49 On the 12th March 2018 at 00:59hrs 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 [3] 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. During the referral, Patrick denied that he was suicidal. He did disclose key information about his relationship failure, removal of his status as a foster carer and concerns about his son. It was

[3] 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.

also noted that he claimed to have taken a previous overdose and tried to “burn himself” in his car. Both of which were not previously recorded as he had not sought medical help. When seen by the Psychiatry Liaison team it was noted he was not suicidal, and he was discharged to his GP who booked him an appointment for the same date in March as he was required to attend the police station. Patrick was advised to self-refer to primary care counselling and provided with the details of the Samaritans.

6.2.50 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 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 including self-referral to IAPT[4] and informing his GP for follow-up.

6.2.51 In terms of Patrick’s family, both his brother and Mary have indicated that they tried to speak to hospital staff, to ensure Patrick was not discharged before a full evaluation was conducted. Mary informed the panel that as his ex-partner, she was given no opportunity to discuss his case as she was now not considered a relative. His brother did speak to nursing staff and explained his feelings that Patrick needed greater help as his mood swings and intensity of actions were an increased indicator of risk of further self-harm. Patrick’s brother’s account of the conversation with a member of the nursing staff was that Patrick was deemed to be ‘alright’ for discharge and that Patrick had stated he would be supported on discharge as he intended to stay with his sister for a few days. In terms of the outcome the family were looking for, the family stated they felt there should have been consideration of a Mental Health Section or similar restrictive action to allow for a period of in-depth assessment and care. The family have expressed their grave disappointment in relation to the level of care afforded Patrick at this time.

6.2.52 Patrick’s brother attended the hospital to collect Patrick. By the time he arrived Patrick had already been discharged and was waiting outside. (It was recognised how difficult Patrick would have been to deal with for the A&E staff and although he was not well, he still had the capacity to make his own decisions). The initial plan was for Patrick to stay with his brother not his sister. Patrick was very quiet and later decided he would rather go home despite his brother’s protestations not to do so. Patrick was adamant and so his brother drove him to the station and describes waving Patrick off on his journey and seeing tears in Patrick’s eyes. His brother recalled feeling that Patrick was mentally ill and had a foreboding that he may never see him again.

[4] The Improving Access to Psychological Therapies (IAPT) programme.

6.2.53 On Tuesday 13th March 2018 Mary had to attend hospital for a medical procedure. Mary informed the review that Patrick was not aware of the appointment. She had arranged for a friend to take her to and from the appointment as she would be unable to drive. Upon return Patrick was at home and noted that Mary's friend was male. He had previously told his brother that he felt Mary was seeing someone else and reported that he had seen a Valentines present wrapping paper discarded in a waste bin, together with a Valentine's card on Valentine's Day in February. This incident reportedly darkened his mood and whilst Mary was able to confirm she had received a present and the card, she did not wish to discuss personal matters further and exercised her right not to do so.

6.2.54 At 00:25hrs on the day in March that Patrick was due to attend the police station, Mary called the police concerned about Patrick's behaviour. He was described by Mary as being very tearful and slamming about downstairs. 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. Analysis

7.1 Despite the early setbacks in his life, Patrick appeared to establish a family life, with the unit consisting of himself, Mary, a child from Mary's previous marriage and a birth child of their own. Whilst like all marriages there were ups and downs there appears to be nothing to suggest that life was not operating within normal parameters in the early years. The events leading to the death of Patrick Douglas occurred as a culmination of individual events that were further exacerbated by the issues surrounding relationship failure. Key considerations have been identified.

7.2 Patrick's Vulnerabilities

7.2.1 Patrick was a vulnerable person in his own right with Adverse Childhood Experiences (ACEs)[5]. The Centers for Disease Control and Prevention[6] in the US links more than four ACES with an increased risk of suicide attempts and early death. Additionally, a 2012 report produced by the Samaritans[7] highlights key areas which increase a male's vulnerability to suicide. Many of the contributing factors reported by the Samaritans seem to fit Patrick's personality as described by both family members and professionals. Those relevant have been listed:

- Background – Men, such as Patrick, who in early life lived in deprived circumstances and therefore are considered to be at a much higher risk.
- Personality traits – Brooding and a desire to be perfect are noted as traits contributing to the development of suicidal thoughts.
- Masculinity – Men compare themselves to a masculine 'gold standard' prizing power, control and invincibility. Having a job and providing for the family can be seen as central. If they feel they are not meeting this standard they may feel a sense of shame and defeat.
- Relationship breakdown – Along with the loss of the emotional support of the ex-partner and separation from children, some suicides have been seen to be motivated by a desire to punish an ex-partner, or as an impulsive reaction to the ex-partner beginning a new relationship.
- Challenges of mid-life – People currently in mid-life are experiencing more mental health problems and unhappiness compared to younger and older people. Beyond the age of 30, men have fewer supportive peer relationships than women.
- Emotional illiteracy – Reluctant to talk about emotions, men do not recognise or deal with their distress, but let it build up to breaking point. Men are far less positive about getting formal emotional support for their problems, compared to women. When they do, it is at the point of crisis.
- Socio-economic factors – e.g., job, class, education, income or housing – being at the 'bottom' of any of these, particularly unemployment increases risk of suicide.

7.2.2 Patrick's challenging and deprived background is detailed in this review. In adult life he was 'particular', 'obsessive' well-groomed and enigmatic, and it appears that upon presentation to various agencies that he may have been reluctant to share the full extent of his situation. This review has mentioned that Patrick was described as being charismatic and appearing charming and affable which could present an image of being well-adjusted and happy allowing him to be able conceal from others when he was in crisis. His

[5] https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html (accessed 5/2/2019)
[6] https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html (accessed 5/2/2019)
[7] http://www.nspa.org.uk/resources/men-and-suicide-why-its-a-social-issue/ (accessed 5/2/2019)

medical history includes Crohn's disease (from 2002) and depression and anxiety (from 2008), with varying medicinal and counselling interventions used. In addition to the above factors from the Samaritans report, consideration should also be given in Patrick's case to:

- His history of, and apparent increasing, alcohol use when mixed with medication. This was possibly a self-medicating regime that allowed him to cope with the pressures being faced.
- The impact that his use of alcohol mixed with medication could have on his overall Mental Health especially given Patrick's recorded bouts of depression.

7.3 Foster Care

7.3.1 Patrick's early experiences in life imbued him with a desire to try to help others, especially children. As such he and Mary applied to become foster carers in 2012 as described in Section 5.2. Patrick disclosed his difficult upbringing, which on reflection during this review it might seem questionable as to whether placing foster children was the correct course of action. It is not clear if either the assessment process or the fostering panel were aware of the ACEs research mentioned in 7.2, but each of these key factors associated with Patrick were known to both, prior to them approving Patrick and Mary as foster carers in May 2012. There is however strong doubt as to whether the second placement with the significant demands attached alongside the needs of Patrick and Mary's two existing children, was an appropriate decision.

7.3.2 Alongside the initial potential causes for concern as to whether foster placements were appropriate in this case, there were also multiple points throughout the placements that signalled that things would not or were not going well;

- Patrick finding it difficult to come to terms with the ending of the first placement,
- Mary raising concerns regarding the additional demands of the second placement,
- Patrick requesting more and more respite breaks during the second placement,
- Patrick's need to have praise, reassurance and support (despite his abilities as a carer),
- Mary and Patrick's birth child being diagnosed with having additional needs in 2015 and the extra demand this would place on them,
- Patrick's request to end the placement for one of the foster children in 2016,
- Mary and Patrick scoring themselves lower than the Fostering Social Worker as part of their 2016 Foster Care annual review,
- The continuity of support not being available due to staffing arrangements following departure of a social worker.

7.3.3 In April 2016, the foster children's social worker was questioning whether the children's needs would be better met by placing them separately. However, as recorded in Sections 5 and 6, due to changes in social worker staffing the sibling assessment was not

completed until October 2017. Given Patrick had wished to end the placement in June 2016 but was persuaded to continue the placement on the promise of this work providing some support, it seems Patrick's concerns were basically forgotten, in effect, letting Patrick and the family down, with the priority being the needs of ensuring a placement for the children above all else.

7.3.4 With Mary and Patrick's relationship ending in late 2016, they made the decision to continue to care for the foster children and their birth child, all of whom had additional needs. This decision seemed likely to complicate an already difficult position within the home. It is evident that the foster care social worker was not informed of this change in circumstances until a routine visit in March 2017. Patrick's lack of early disclosure and intention to continue foster caring alone indicates that there was either a misunderstanding or assumptions made regarding the impact that changes to foster carers' circumstances would have on current arrangements.

7.3.5 Following the incident between Patrick and one of the foster children in May 2017 there seems to be a lack of urgency in initiating formal procedures to investigate this incident. There was a formal Strategy Board meeting held on the 25th May which included the Police and LADO. The following decisions were taken:

1) A Single-Agency investigation to be conducted.
2) No Medical examination needed.

It is also noted that there was no appropriate Health professional in attendance at this meeting and this decision was made on the basis that the CAMHS worker had stated that the child had said he had not been hit and that this was a symptom of his medical condition. The outcome was then explored again within an outcome meeting. It is thought this is a proportionate response to the incident although the strategy meeting should have taken place within 24 hours, whereas on this occasion it had taken place five days after the incident.

7.3.6 The Fostering Services decision to remove the children and de-register both Mary and Patrick as Foster carers in September 2017 appears to have been poorly handled. It seems surprising that on the day the foster children were removed, a Senior Practitioner was visiting Patrick to carry out the assessment of his ability to continue fostering alone. It does not seem to be advisable to try and carry out such an assessment on an emotional day of separation. It is surprising that a visit was considered when information relevant to this application was readily available and clearly demonstrated Patrick's inability at that time to take on the role, both emotionally and due to domestic circumstances.

7.4 Health Care

7.4.1 Both Patrick and Mary presented physical and mental health concerns when in contact with medical and care providers over the time period reviewed. Often Mary or Patrick made non-specific reference to stress and issues at home. Unfortunately, the opportunities to have explored these expressed concerns and examine the issues further (which could have provided additional support) were missed on a number of different occasions.

7.4.2 In December 2016 Patrick presented himself to his local hospital claiming to have taken an overdose of alcohol and paracetamol. It was noted in the Psychiatric Liaison summary that there was no history of mental health which is surprising considering the history provided for this review. However, it is not possible to conclude what information Patrick provided and whether hospital staff would have had access to his earlier medical history. He was referred to his GP, who prescribed an anti-depressant, and referred to counselling. A follow up appointment was scheduled to be made. As Patrick did not appear to make a further appointment, no follow up mental health review was conducted. Patrick returned to his daily life.

7.4.3 During 2017, Mary had become unwell with an ongoing medical condition and attended a consultant clinic at her local hospital. The complaint was restricting Mary's activities as she had been very active prior to this illness. The illness was acknowledged as being exacerbated when Mary felt stressed and though a nurse completed one home contact, there was no exploration of the cause of the stress, nor was there any ongoing service care. Mary was discharged. During her appointment, Mary had alluded to problems and stress at home. There was an opportunity for an exploratory discussion around the stress within the home, which may have initiated further support and a "Think Family" approach to Mary's care. This in turn may have benefitted the wider family group.

7.4.4 In February 2018 Patrick's brother was so concerned about Patrick that he arranged to attend Patrick's GP with him but did not enter the consultation room with Patrick. He has recorded his concern that Patrick may not have provided full disclosure of facts to his doctor. There appears to be some evidence of this as Patrick only disclosed details of his relationship breakdown and described how he had not recovered from his mother's death. He denied drug use and was noted as not being suicidal. Changes to medication were made, and again he was asked to self-refer to Alcohol and Substance Misuse Services, with a follow up appointment planned. It appears that the opportunity to further explore reasons behind his relationship breakdown and reference to the foster care work were not considered.

7.4.5 Throughout the GP visits, it is not clear if the surgery were aware that Mary and Patrick were foster carers. There is no apparent system to log and identify this added indicator within their system. Many issues or areas for consideration were flagging themselves up in a number of different settings. There was a lack of

communication between agencies, IT systems with restricted access and little apparent pick up of warning signals by agencies. There is little evidence that any professional sought to explore circumstances more in-depth that may have revealed the underlying issues and concerns.

7.4.6 The family expressed concern about the management of Patrick in the last week of his life. The issues surrounding his treatment and discharge from hospital on the Sunday 12th March have been identified as being particularly disappointing. Concerns relate to decisions taken for Patrick's care. He had disclosed the overdose and alcohol taken, and the intentions behind these actions, which A&E staff saw as suicidal. However, when seen by the Psychiatry Liaison Team, there are concerns as to the quality and depth of investigation, actions taken and parity of service given, before recommending Patrick be discharged. Despite family concerns Patrick was not referred for further intensive support, such as the Crisis Team, but was considered able to be discharged, with recommended follow up support via his GP.

7.4.7 A&E staff, using their protocols, assessed Patrick as 'Amber' meaning he needed to be reviewed within 24hrs by Psychiatric Liaison and was referred accordingly. Psychiatric Liaison services are provided by KMPT at this hospital. It is not clear whose responsibility it would have been to supervise Patrick during the 13 hours he waited to be seen. The Amber assessment protocol requires that the patient should be 'in the line of sight' of a member of supervising staff at all times, to prevent further possible self-harm. This seems difficult for staff in a busy A&E department to achieve over such a long period and given the recorded spike in referrals to Psychiatry Liaison on that day, impossible to achieve for staff therein.

7.4.8 Communication between A&E and Psychiatric Liaison is described by a key professional as 'fragmented', with A&E staff having no access to Rio (the Psychiatric Liaison computer system) or to Psychiatric Liaison patient records. Decisions around discharge planning are supposed to be joint between the two providers but seem weighted in favour of the mental health professionals' viewpoint. These current arrangements do not appear to provide positive information sharing and collaborative working.

7.5 Police

7.5.1 Engagement with Kent Police began several months after Mary informed Patrick that the relationship was ending. Remaining in the same house and continuing with their childcare demands, the living situation became less and less amicable. As outlined in the chronology, 6.2.20, contact with the police became a pattern of the relationship.

7.5.2 Further incidents and police involvement resulted in a second DAN being issued following an altercation. Mary was provided with safety advice and options for referral to domestic violence support groups. Patrick did not appear to be given the same support on occasions where he was the complainant (see 7.8).

7.5.3 In early March 2018, Patrick had received notification from Kent Police that he was to be interviewed regarding allegations of coercive and controlling behaviour and harassment of Mary, particularly given the evidence of the texts he had sent. The meeting was scheduled for 10 days later. The police letter requesting Patrick attend for interview for the allegations of Harassment against Mary, seems to be one raised through a processing mechanism, rather than by the officer responsible for the case. As such the letter was both formal and direct, having no consideration for the recipients needs in terms of disability, health or support required. Patrick had limited contact with police previously and this letter caused him some anxiety and distress. This does **not** appear to be good practice.

7.5.4 Paragraph 6.2.54 describes Patrick's last day. Given the nature of the death and that the victim had been previously known to police a referral was made to the Independent Office of Police Complaint. A review of police actions was undertaken though that review focused not on the reasons for non-attendance earlier, after the initial call, but on the actions and adherence to procedures from the call at 07.12hrs onwards. Outcomes of the investigation describe the identified failings and recommendations in terms of procedures which the panel is sure Kent Police will address. However, the family feel there are questions that remain unanswered. In particular given Patrick's known mental health history, should the earlier call at 00.25hrs have been treated as a higher priority?

7.6 Early Help

7.6.1 The Early Help team has become engaged with the family in August 2017, following a referral from Child A's school where concerns had been raised about him, linked in some way to the separation of his parents. The EHW was not made aware of the Domestic Abuse Notification (DAN) provided to social services after the August incident, but Mary began to confide in the EHW who noted how upset Mary appeared and was informed that Patrick was sending lots of texts, some of them she felt to be threatening. It is surprising that agencies working closely together within a family unit seemed not to share relevant information between themselves nor were they formally made aware of the reported incidents and involvement of the police.

7.6.2 Against this backdrop, the Early Help team continued to work Child A and it seems that the sessions held with them were conducted in the presence of both parents and that they both attended reviews. This was until November, when Patrick indicated he could no longer attend with Mary as he claimed Mary was trying to make him look incompetent and undermining him as a parent. It is also of interest that despite the recorded picture being painted of animosity within

the relationship, Child A's demeanour at school and their attention to work was much improved following the removal of the foster children. Child A was described as happier to such an extent that it was agreed that Early Help support should end in January 2018.

7.6.3 The involvement of Kent County Council Adult Safeguarding is minimal in this case, as the information which was made available to them did not reach the threshold required for them to become involved. Indeed, the only contact relating to Patrick and Mary was referenced at a "triage" meeting of Domestic Abuse cases, held on the 4th October 2017. This meeting is an "at desk" on screen meeting designed to filter Domestic Abuse Notification referrals based on information available, to identify and respond to the most urgent need.[8] At this meeting, the referral regarding Patrick and Mary concluded that no action was required relating to adult safeguarding, social care or mental health, but it was felt a referral should be made to Early Help to support Child A.

7.7 Domestic Abuse

7.7.1 Whilst both Patrick and Mary appear to have accepted the relationship was over, both raised the issue at separate times with medical professionals and Social Workers. Whether the subject of resolution counselling was discussed and rejected by either one or both of the parties, it appears not to have been suggested to them by any agency. Whether the couple felt there was no repairing the relationship is not apparent.

7.7.2 The ability to communicate between agencies is key in this case. Mary's contact with the police, her GP and consultant's clinic all raised the issue of stress within the relationship. Ultimately Mary sought the services of domestic abuse provider support groups and good practice followed providing Mary with advice, referring her case for a safeguarding review and finally raising the case to MARAC. However, only limited information was available to the domestic abuse provider regarding Patrick and their priority was to act to safeguard the client (Mary).

7.7.3 Whilst Patrick would have been discussed in the context of supporting Mary, the domestic abuse provider would not have been able to offer him any intervention. Only limited information was available to them regarding Patrick even though he had been the subject of DASH assessment himself. This case shows that even though Patrick may also have been or felt himself a victim of abuse current structures do not provide for providers to consider other than the referred person in their support and in this case, Patrick felt very much isolated as the "guilty" party despite having issues of his own. Consideration could have been given to referring Patrick to a perpetrator programme which aims to help people who have been abusive towards their partners or ex partners to change their behaviour and develop respectful and non-abusive behaviours. The

[8] KCC processes have changed since the time of the report and vulnerable person's referrals are now triaged via Area Referral Management Service who apply thresholds for statutory safeguarding and provide information, support and advice to the person concerned.

MARAC for which Mary had been referred would have provided opportunity for various agencies to share information about both Mary and Patrick. Actions could have been developed in relation to them both to provide direct and indirect support to Mary. Unfortunately, Patrick took his life before the MARAC was due to be held.

7.7.4 Mary informed the Chair that at times she felt that all the running costs for the family home, were entirely funded out of her salary often leaving her feeling under financial pressure. Patrick is said to have liked to enjoy the finer things in life such as nice clothes, enjoying himself and holidays, all of which appear to have been paid for from the payments attached to his role as foster carer. It does appear that Mary felt under added stress within the relationship due to the apparent failure of Patrick to contribute on any regular basis to the regular household bills as described in paragraph 6.2.32. This could be viewed in terms of Economic Abuse[9]. This happens when a person may restrict how their partner gains access to, uses and maintains finances and other economic resources, such as accommodation, heating, food, clothing and transportation. The example regarding car use in 6.2.33 is therefore a further example. Conversely, Mary's actions described in 6.2.36 of restricting Patrick's access to heat and hot water, could also be viewed as economic abuse. Economic abuse is one of the types of abuse which can be hidden from friends, family and agencies. The victim themselves may not recognise the situation.

7.8 Parity of Service

7.8.1 Throughout this review, the issue of parity of service from agencies involved with Patrick has been a matter of discussion and concern. Several issues arose relating explicitly to his sex as a protected characteristic under the Equality Act 2010 and are discussed herein;

- Consideration of Patrick's complaints to the Police resulted in a DASH assessment being completed but, as what should be standard practice, there appears to be no referral made to domestic support agencies.

- In consideration of Patrick's complaint regarding the deprivation of heating, the lack of action does not seem consistent with other similar case experiences.

- The quality of service provided at the hospital on 12th March did not meet the standard required. A failure to explore the history of domestic abuse and depression in greater depth raises the concern about parity of service.

[9] What is economic abuse? - Surviving Economic Abuse

7.8.2 DASH was used for both Mary and Patrick at various points. Although Kent Police now use DARA at the scene of incidents instead of DASH, they continue to follow CoP Authorised Professional Practice on attendance at incidents, which states the following;

'If both parties claim to be the victim, officers should risk assess both. There may also be circumstances where the party being arrested requires a risk assessment, as in the case of a victim retaliating against an abuser. Officers should bear in mind the possibility that the relationship is a mutually abusive one.'

Kent Police's policy adheres to this guidance. Should officers encounter the same circumstances today they should continue to complete risk assessments on both parties. Consideration was given as to whether use of DASH or DARA is unsuitable in such cases. Rather than being unsuitable, it is thought the key issue was insufficient attention given to the risk assessment for Patrick. He was not referred onto any support services and Kent Police have identified this as a lesson learned.

7.8.3 The following conclusion drawn by the author of the IMR that reviewed the management of this case relating to the Children in Care and Fostering Service, set out her perception of Patrick's position at this time and is considered by the panel to provide a useful insight and is reproduced below.

"*Once the remit of the Early Help Worker's task had become domestic abuse, the focus of support had shifted to Ms. Brown and Mr. Douglas withdrew further. Mr. Douglas voiced that professionals believed Ms. Brown and not himself, although he was alleging that Ms. Brown was "controlling". It would appear, that whilst Ms. Brown's allegations were acted upon, there was not a commensurate response for Mr. Douglas. Advice and guidance, was provided for Ms. Brown and a referral made to a domestic abuse agency but there was no support offered to Mr. Douglas regarding either the separation or Ms. Brown's behaviour towards him."*

7.9 Professional Curiosity

7.9.1 Within the IMRs presented to the panel for this review, there are several references to the term "Professional Curiosity", suggesting that there were opportunities for staff to pick up the cue from a patient or client, on a comment or information given, that may have hidden underlying problems. This would potentially be good practice and certainly may have led to support becoming available to the couple in this case on several occasions. However, the definition of "Professional Curiosity" is undefined with many staff perhaps frightened to exceed the remit of their role for fear of causing offence, or perhaps considers probing further to be inappropriate. It is a subject that should engage all organisations working within the social sectors, medical and support agencies which should be defined and form a part of core staff training.

8. Conclusions

8.1 This is a tragic and difficult case, relating to the self-inflicted death of a very complex individual. Patrick had to cope with a childhood surrounded by domestic abuse and bullying. This led to periods of underlying depression. Then mounting pressures of being a foster carer of a demanding placement, a parent to his birth child, dealing with his own medical conditions and a relationship that after fifteen years was disintegrating. Over the period, the increasing conflict became a matter of engagement for the police and other agencies. Throughout this review there are examples where both Patrick and Mary indicated to differing individuals in different agencies that there was stress within the relationship. This is particularly evident with Mary in her discussion with her GP. Whilst relationship counselling where domestic abuse is present would not be appropriate action, there is however no evidence that in the early period of the relationship deterioration that the partners were ever formally availed the opportunity of relationship counselling or support, which could have signposted them to further help and advice particularly the medical issues being faced. Whilst the couple could have voluntarily attended some form of counselling, without any supportive structure it is impossible to establish fully the desire on either side to resolve the partnership issues.

8.2 Within the home, the pressures on the family were evident to professionals, yet Patrick and Mary became foster parents and were asked to care for a foster placement of significant physical and emotional demand. 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 take on this placement given their relative inexperience, when continuity of support was lacking for long periods, requires consideration and review.

8.3 Since 2012 the fostering application process in Kent has changed. There is now a template in place which enables much greater professional curiosity and robust critical analysis. A Risk & Vulnerability (R&V) Chronology, which triangulates information collated through the assessment process including references, statutory checks, medicals, social media, as well as an applicant's attitudes and behaviours. If concerns or risks emerge with current carers the R & V chronology can be started which means that any relevant historic information can be added. It is also considered in the Foster Carer Annual Review. Applicants are aware of the information contained in the R & V Chronology including concerns and any agreed actions to minimise risk.

8.4 Practice development and quality assurance of service is monitored through regular case supervision and reviews of placements. KCC are committed to providing learning and development opportunities that grow with the needs and demands of the service provided**.** There have also been key changes to practice within the fostering service which support a wider culture change within the service and a drive for professional curiosity within work with foster carers. This includes:

- A foster carer supervision requirement for both carers to be included at least every three supervision sessions.
- Annual Reviews are completed by an independent team with contact made with the foster carers within the first six months of their approval. Annual reviews must now include both carers and updates in any medical changes, including mental health, are covered at the Annual Review and an updated medical can be requested at any time.
- Fostering Social Workers are rotated every three years, to ensure fresh oversight and professional curiosity of the household.

8.5 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. It is a matter of concern that within records from foster and children's social workers overview meetings and reports, having discussed the family environment as "toxic" there is no referenced evidence that illustrates where any process was considered for the impact on or safeguarding of Child A. Actions appear indecisive and the chaotic nature of this placement can have done little to ease the ongoing stress within Patrick's life.

8.6 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. The letter is clearly not generated or seen before dispatch by the officer in the case and with an underlying hint of more punitive measures in the event of non-attendance, the letter is not considered good practice and Kent Police are urged to look at the content following the impact of such correspondence raised by this review.

8.7 Toward the latter stage of the chronology of events, Mary seeks the support of domestic abuse agencies and was accordingly referred. The "professional judgment" of the IDVA to refer to children's services, regarding Child A's safeguarding need, and to refer the case to MARAC for review, both are regarded as good practice in this case. The fact that the IDVA was an advocate for Mary therefore precluding her from contacting Patrick does suggest the need for support agencies to be able to communicate broadly with other agencies such as GPs and the Police. The limited resources dictate that victims are prioritised, with limited mechanisms or resources to provide alternative support via programmes for potential or alleged abusers. Even if this resource was available, it is unclear whether such a pathway would be entirely appropriate for Patrick who had been recorded as both a victim and a perpetrator of domestic abuse.

8.8 Despite Patrick 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.

8.9 Patrick's medical history records domestic abuse and bullying as a child, leading to later depression for which he was treated with medication, additionally undertaking counselling to address the issues associated with his childhood. His physical illness Crohn's Disease was treated long term with steroids and observations on long term usage is that both depression and osteoporosis can be a by-product of steroids. This information was available in Patrick's medical notes held by his GP. 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 in March 2018 4 days before his death. 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.

8.10 In regard to medical treatment, the IMR completed by KMPT provides some underlying concerns which appear to raise significant issues, particularly for the family. It appears that on the day they saw Patrick staff conducting the assessment of him did not fully follow 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 his potentially suicidal actions. Coupled with poor record keeping and non-availability of key staff, for interview either through absence or no longer employed by the agency, these issues provide a picture of poor practice.

8.11 During the course of this review, it was explained to the panel how Patrick's care would have proceeded on the day described in paragraph 8.10. On attendance he would have been seen by A&E staff, who are provided by a local hospital trust. Whilst they appear to have undertaken their function in accordance with protocols, it is acknowledged that within such a busy department staff will have little time for professional curiosity, which at this stage may well have gleaned greater information and benefitted decisions around Patrick's care. For example, a pilot project within the hospital provides an IDVA where cases involving domestic abuse are identified. Given the situation with Patrick, such a referral at this early stage may have been beneficial.

8.12 On several occasions (to their GPs, at A&E and clinics) both Patrick and Mary signalled 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. The importance of the benefits of using "professional curiosity" cannot be ignored and is an area this review feels should be given closer attention by all agencies on a national scale.

8.13 Communication repeatedly becomes an issue and played a critical part in this case. Ranging from agencies involved being unable to access or retrieve relevant information, either internally or from each other, especially when most needed. Paragraphs 6.2.22 and 7.6.1 raise concerns around the communication between Early Help and Specialist Children's Services. There have been organizational changes within Kent including system changes to allow staff to view records within Early Help Module (EHM) and the Children's Social Work Services system easily. New information on open cases is shared directly with practitioners involved and all new information into the Front Door transits through the Early Help Module, thus, reducing the opportunity for staff not to be aware of information being shared via other agencies into the Front Door. 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. Lack of any apparent instances to dig deeper and pick up on signals given by both Patrick and Mary, to identify opportunities to support Patrick as well as Mary, indicated opportunities were missed.

8.14 It was the police who were required to decide whether to send a response vehicle in the early hours of the morning of the day of Patrick's death, 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.

8.15 The review lacked a rationale as to why no referral was made for a Mental Health Assessment, which may have provided some information relating to the family's view that Patrick should have been the subject of a more managed supervised approach at this time. This view needs to be balanced against the apparent presentation from Patrick; that he had full control of his mental capacity and was able to make decisions for himself.

8.16 Prior to his hospital attendance there are several indicators that should have alerted agencies to the risk factors presented. None of these were recognised with Patrick seemingly having his life "unpicked" by events, particularly the loss of his foster carer status and his

relationship breakdown. All of which added to his fragile mental state. However, the support for foster carers following de-registration was discussed within the IMR submitted by Kent Early Help and Childrens Services. It is stated within their own action plan that “Fostering assessment to include impact of de-registration and plan of support and follow up visit 6 weeks post de-registration.”

8.17 Whilst disappointing that the police were unable to attend at the time of the call, or possibly earlier in the morning, this highlights the ongoing pressure on emergency services, having to make difficult decisions in deployment of their resources, based upon risk evaluation derived from information and facts available to them at the time of the emergency call. Although resources for Police like all agencies, remain tight, Kent Police have, since this review took place, been innovative in their response. Kent Police have introduced Vulnerability Hubs, staffed by Early Victim Engagement Officers. They review calls as they come in, and contact victims over the phone when suitable, which alleviates pressure on patrols. They recently began expanding use of video technology to allow them to speak to victims in a timelier fashion. By doing this, they are able to further divert work from patrols, shorten attendance lists, and can get to calls such as concerns for welfare, in a more timely fashion.

9. Lessons to be Learnt

9.1 Whilst agencies involved in this review may need to review and adjust process and procedures following areas identified, there has been a common theme expressed by all contributing agencies. That theme is the issue of resources. Pressures upon public services are well documented. Within this review it has been highlighted how lack of continuity in the foster care setting played a part in delay in delivery. Health Care administrators record that vacancy levels are regularly 20% of the workforce and recruitment of staff from overseas has become harder to achieve and sustain. As such hospital costs for overtime, bank and agency staff has increased, adding to the financial pressures. Kent Police have been required to make efficiencies over recent years with an impact on their delivery, whilst funding to domestic abuse agencies to develop initiatives working with perpetrators of abuse has been limited and slowed progress in this area. Whilst lack of resources, staff shortages or high sickness rates cannot be used by agencies to diminish accountability where poor practice or neglect is identified, it has to be recognised that the increasing pressures on agencies both public and private will continue to increase stress, lead to errors and poor communication and record keeping as hard working but pressed staff continue to cope with the increasing demands of society.

9.2 That the fostering assessment and matching process did not provide the necessary safeguards for the carers in this case and therefore this case requires further review as to decisions taken and why this placement occurred. Asking this relatively inexperienced foster family to accept the second placement was too demanding, especially given Patrick’s own background and the recognised need for consistent reassurance and support.

9.3 That where a change of foster carer approval is to be considered by fostering panels, it is recognized that changes have been made. This ensures that the information provided to such meetings has been enhanced by including the annual review report. The meeting is chaired by an appropriately Independent Fostering Reviewing Officer providing the panel with access to a comprehensive assessment to consider the broad spectrum of relevant information allowing them to make an informed decision, particularly regarding the health and wellbeing of parties involved. Additionally, all decisions and outcomes are appropriately recorded to evidence the decisions made.

9.4 That within the assessment process, where any health or wellbeing concern is raised regarding any of the individuals engaged in the process, then a full investigation of the issue and potential impact is initiated prior to any final decision being made. Appropriate medical investigations are completed at the point of assessment and reviewed by the agency medical advisor. A medical assessment or update is an option following the annual review if the carers health or wellbeing cause concern.

9.5 That the ongoing review process requires continuity of support, wherever possible, with the ability to respond to any health or wellbeing needs available outside of the annual review mechanism, where such an issue is identified.

9.6 That where a complaint of any form of mistreatment of a foster child is made, the existing statutory requirement should be adhered to, namely the convening of a Strategy Discussion needs to be carried out within 24hrs. Allegations made against foster carers need to be investigated within a timely manner.

9.7 Domestic abuse agencies are commissioned to provide support to victims and are unable to also support the perpetrator due to a conflict of interest. Alternative mechanisms or agencies to provide behaviour support to perpetrators, which could have positively supported Patrick was not available. Whilst there are perpetrator support programmes available across Kent it is recognised that availability is limited and not consistently available across the county. In line with the Kent and Medway Domestic Abuse Strategy and action plan, work is underway to review services available to those who perpetrate abuse to promote information and referral pathway sharing with all agencies in Kent. This will support identifying gaps in provision to inform commissioning decisions and support funding bids to ensure that quality, coordinated responses from the statutory and voluntary sectors are consistently available across Kent to address perpetrators' behaviour effectively. The Domestic Abuse Act 2021 stipulates that a National Perpetrator Strategy is to be developed and it was announced in the 2021 Budget that £15 million additional funding for perpetrator interventions will be available to support these actions.

9.8 Within this review the issue of defining coercive and controlling behaviour as defined by guidance introduced within Section 76 of the Serious Crime Act 2015, has been considered. It has been suggested that the practical interpretation of this is not fully understood and therefore may not have been considered appropriately in matters relating to both parties in this case.

9.9 The practice of sending letters to individuals requesting them to attend for interview, provides no understanding of assuring the recipient that their disability, health or other needs have been considered and as such can be a daunting prospect to receive for a person who has had little formal engagement with the Police.

9.10 Within this case it was apparent that the GP Surgery had no system in place to identify either Mary or Patrick as being foster carers and this may have added to warning indicators not being fully recognised.

9.11 The level of service provision Patrick received 4 days before his death at the hospital did not meet the standard required. Protocols were not fully followed; issues and areas of Patrick's medical history were not fully explored and possibly further referral prior to discharge should have been made. The arrangements for information sharing at the hospital appear to be disjointed and would benefit from a review to establish better levels of trust and information sharing between the two parties.

9.12 That across agencies there is evidence to suggest that parity of service/care was not always evident. Issues around the raising of a domestic abuse notification to support agencies following a DASH assessment, how Patrick's complaint regarding the heating control was managed and why the DASH referral was not made/received by domestic abuse support agencies involved. Furthermore, the quality of treatment he received at hospital 4 days before his death, relate to concerns around parity as there seems to be little evidence that despite there being no explicit disclosure from Patrick to that effect, any real exploration that Patrick might be a victim lacked consideration.

9.13 The difficulties in ensuring information was shared is evident throughout this case. It appears that GP surgeries cannot communicate with A&E departments and vice versa. Information held by the police was not available to other agencies, especially domestic abuse support teams and that as with the EHW, working within the family group alongside other social work specialists, information between each other even at a basic level was poorly shared.

9.14 The term professional curiosity has been used extensively in this review and the IMRs related to it. 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. Training of staff providing them with the confidence and support to utilise this method of investigation could be effective across agencies both in saving lives and potentially reducing costs.

9.15 Lastly, the review raised concern regarding advice from SECAmb, when an ambulance was not available to take Patrick to hospital. The pragmatic suggestion that a family member should drive him should be accompanied by a caveat “Is there any reason why a family member could not safely drive the patient to the hospital?”. In this case there was the potential for a victim of domestic abuse having to drive the perpetrator of that abuse to hospital when the perpetrator is in a state of acute mental crisis. The opportunity should be given to advise the call operative of any potential risk of serious harm.

10. Recommendations

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

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 permanency of the service should be considered, subject to funding.	KCC Commissioning
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

Appendix A – Terms of Reference

1. Background

1.1 On 16th March 2018, police officers attended an address in Town A, Kent where they found the deceased.

1.2 There has been no arrest for murder as the death was self-inflicted. However, as the death appears to meet the criteria in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, the case was referred to the Kent and Medway Domestic Homicide Review (DHR) Core Panel.

1.3 A Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 24th April 2018. It confirmed that the criteria for a DHR have been met.

1.4 That agreement has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed. In accordance with established procedure this review will be referred to DHR 24.

2. The Purpose of DHR 24

2.1 The purpose of this review is to:

i. establish what lessons are to be learned from the death of Patrick Douglas and the complex set of relationship issues that possibly contributed to his self- inflicted death. The review will consider the way in which local professionals and organisations work individually and together to safeguard victims;

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

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

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

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

vi. highlight good practice.

3. The Focus of DHR 24

3.1 This 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.

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

3.3 If domestic abuse was identified, this 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 take into account 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.

3.4 This review will focus on whether agencies fully explored and understood the role of the parties involved in a complex relationship.

4. DHR Methodology

4.1 Independent Management Reviews (IMRs) must be submitted using the templates current at the time of completion.

4.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Patrick Douglas in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Patrick Douglas, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about Patrick Douglas and his partner Mary Brown from 1st December 2016 to 30th March 2018. If any information relating to Patrick Douglas or

Mary Brown as the victim(s), or being a perpetrator, or vice versa, of domestic abuse before 1st December 2016 comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Patrick Douglas and/or Mary Brown. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).

4.6 Any issues relevant to equality, i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation must be identified. If none are relevant, a statement to the effect that these have been considered must be included.

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

5. Specific Issues to be Addressed

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

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

ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Patrick Douglas and/or Mary Brown? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Patrick Douglas and/or Mary Brown subject to a MARAC or other multi-agency fora?

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

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

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

vi. When, and in what way, were the Patrick Douglas or Mary Brown's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

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

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

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

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

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?

xiv. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Patrick Douglas and Mary Brown promote their welfare, or the way it identified,

assessed and managed the risks posed by Patrick Douglas or Mary Brown? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

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

xvii. How accessible were the services to Patrick Douglas and Mary Brown?

6. Document Control

6.1 The two parts of these Terms of Reference form one document, on which will be marked the version number, author and date of writing/amendment.

6.2 The document is subject to change as a result of new information coming to light during the review process, and as a result of decisions and agreements made by the DHR Panel. Where changes are made to the document, the version number, date and author will be amended accordingly and that version will be used subsequently.

6.3 A record of the version control is included in the appendix to the document.

END OF PART 1

GLOSSARY

Abbreviations and acronyms used in the report are listed alphabetically.

Abbreviation/Acronym	Expansion
A&E	(Hospital) Accident & Emergency Department
CCG	(NHS) Clinical Commissioning Group
CSP	Community Safety Partnership
DAN	Domestic Abuse Notification
DHR	Domestic Homicide Review
DASH	Domestic Abuse, Stalking and Harassment
EHW	Early Help Worker
GP	General Practitioner
IMR	Independent Management Report
IOPC	Independent Office for Police Conduct
KCC	Kent County Council
KCHFT	Kent Community Health NHS Foundation Trust
LADO	Local Authority Designated Officer
NHS	National Health Service

Explanations of terms used in the main body of the Overview Report are listed in the order that they first appear in the report.

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

The DASH (2009) – Domestic Abuse, Stalking and Harassment and Honour-based Violence model has been agreed by the Association of Chief Police Officers (ACPO) as the risk assessment tool for domestic abuse. A list of pre-set questions will be asked of the victim, the answers to which are used to assist in determining the level of risk. The risk categories are as follows:

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

Medium	There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances.
High	There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.