KENT COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Executive Summary

Lana

MAY 2023

Independent Chair and Author of Report: Shabana Kausar

Associate, Standing Together Against Domestic Abuse

MAY 2025

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pen portrait provided by Lana's sister

Executive Summary

1. Preface

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Kent County Council Domestic Homicide Review (DHR) panel in reviewing the death of Lana, who was a resident in their area.

1.1.2 The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

The Principal People Referred to in this Report						
Referred to in report as	**Relationship to the victim**	**Age at time of V death**	**Ethnic Origin**	**Faith**	**Nationality & Immigration Status**	**Disability**
Lana	Victim	43	White British	Christian	British	None
Louis	Ex-partner	38	White British	Unknown	British	None
Jensen	Ex-husband	Uknown	White British	Unknown	British	None
Child X	Eldest child	18	White British	Unknown	British	None
Child B	Louis's child	14	White British	Unknown	British	None

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

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

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

1.1.6 The process began with an initial meeting of the Community Safety Partnership in July 2023 when the decision to hold a DHR was agreed. All agencies that potentially had contact with the principal people referred to in this report prior to the point of death were contacted, asked to confirm whether they had involvement with them, and instructed to secure their records.

1.2 Contributors to the Review

1.2.1 This Review has followed the 2016 statutory guidance for Domestic Homicide Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. A total of 23 agencies were contacted to check for involvement with the parties concerned with this Review. Of these, 6 had only limited contact and submitted a Short Report. However, 10 had more extensive contact and were asked to submit Individual Management Reviews (IMRs) and chronologies. The chronologies were combined, and a narrative chronology was written by the chair.

1.2.2 The following agencies and their contributions to this Review are:

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

Education Safeguarding Service	IMR
Kent and Medway ICB	IMR

1.2.3 *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. Most IMRs/Short Reports received were comprehensive and enabled the Review Panel to analyse the contact with Lana and Louis and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses were received.

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

1.3 The Review Panel Members

Name	Job Title	Agency
Alison Oates	Safety and Wellbeing Manager, Designates Safeguarding Lead	Town A Council
Anna Bate	Contracts Manager and Safeguarding Lead	We Are With You
Brea Attrill	Corporate Lead of Safeguarding	Southern Housing
Catherine Collins	Adult Strategic Safeguarding Service Manager	Kent County Council (KCC) Adult Safeguarding
David Naylor	Area Manager	Victim Support
Della Young	Named Nurse for Safeguarding Children	Kent Community Health Foundation Trust (KCFHT)
Elanor Sahadow	Advanced Customer Support Senior Leader	Department for Work and Pensions (DWP)
Fran Ellis	CEO	The Rising Sun Domestic Abuse Service

Graeme Southern	Service Manager	KCC Children's Social Care
Katy McGrath	Safeguarding Manager	The Forward Trust
Jenny Churchyard	Specialist Safeguarding Practitioner	South East Coast Ambulance Service (SECAmb)
Nam Maredza	Designated Professional Safeguarding Adults	Kent and Medway Integrated Care Board (ICB)
Natalie Smitherman	Manager from Safe & Well Team	Kent Fire and Rescue Service (KFRS)
Mark Rolfe	Interim Head of Community Protection	KCC Community Protection
Martin Cripps	Named Nurse for MCA/DoLS	East Kent University Hospitals Foundation Trust
Richard Morris	Assistant Director	Child and Family Court Advisory and Support Service (CAFCASS) South East
Shafick Peerbux	Head of Community Safety	Kent Community Safety partnership
Sophie Kemsley	Senior Project Officer	Kent & Medway Suicide Prevention Programme
Zoe Traynor	Detective Chief Inspector	Kent Police

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

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

1.3.3 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

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

1.4.2 *Independence:* Shabana Kausar has no connection with the Kent County Council or any of the agencies involved in this case.

1.5 Terms of Reference for the Review

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

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

a) Analyse the communication, procedures, and discussions, which took place within and between agencies.
b) Analyse the co-operation between different agencies involved with Lana and Louis [and wider family].
c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
d) Analyse agency responses to any identification of domestic abuse issues.
e) Analyse organisations' access to specialist domestic abuse agencies.
f) Analyse the policies, procedures, and training available to the agencies involved on domestic abuse issues.
g) Analyse the impact on Lana of her children being taken from her care.
h) Analyse how previous responses to Lana's experiences of agencies, and her reports of abuse to them (concerning previous intimate partners), may have affected her confidence in agencies.
i) Analyse how did agencies consider Lana's multiple experiences of abuse from different perpetrators.
j) Analyse how did agencies consider adult child to parent abuse.
k) Analyse how did agencies respond to Lana's mental health.
l) Analyse how did agencies respond to Lana's substance use.

m) Analyse how agencies responded to concerns regarding Lana's suicidal ideation.
n) Analyse how agencies responded to Louis and understood the risk he posed.
o) Where a perpetrator assumes care for their victim, analyse how did agencies understand the relationship between domestic abuse and caring responsibilities.
p) Analyse how the experience of the child was included in agencies response to Lana and her children.
q) Analyse the impact of the COVID-19 pandemic.

2. Summary of Chronology

2.1 Summary of information from family

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.1.12 After Lana's death, Samantha spoke about how they went to clear Lana's home and found a number of items which indicated that Lana was planning for the future. They found a book hidden on top of a kitchen cupboard on *'how to get out of violent relationships. Some of the pages were folded and notes had been made. She had got all the way up to "getting out.'* Samantha shared with the chair that she later found out from Lana's next-door neighbour that Lana had approached the neighbour and asked them not to call the police anymore as she felt it was making things worse.

2.1.13 Samantha highlighted that she felt Lana was being abused economically by Louis and she was concerned that Louis was getting Lana into debt. Samantha described that their father would take Lana to do her food shopping. After Lana met Louis, the trips ended and instead Lana would phone for her father requesting him to send her £300. Henry added that this

phone call *'turned into just a text asking for the money.'* They felt that this reflected the control that Louis had over Lana and her finances. They also believed that Louis had control over Lana's phone and was likely the one who was sending the text messages.

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

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

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

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

2.1.18 When asked to describe who Lana was as a person, Samantha and Henry described her as a vocal person with a bubbly personality, *'if she had an opinion, you would know about it! She would say "we will have to agree to disagree, but I'm right."* They shared that she was very sociable, and, before Louis, she was always with her friends and had the best time with them. At Lana's funeral, the crematorium held around 100 people, and it was completely full. They described her as *'now being at peace,'* but powerfully shared that *'she is not here to tell her side, she is not here.'*

2.2 Summary of information from perpetrator

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

2.3 Summary of information Known to the Agencies and Professionals Involved

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

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

Health services:

2.3.2 Lana had extensive contact with a number of health services in relation to her own physical and mental health needs. Lana was registered with a local GP Practice and had frequent contact with them. Medical care provided was appropriate, and good practice was demonstrated in liaising with mental health services. There were several recorded instances of ER reporting self-harm and overdoses of a variety of drugs. The GP Practice followed up with a request for face to face or telephone call. Referrals to mental health teams were made upon receipt of the relevant notifications from the Accident and Emergency Department of the William Harvey Hospital and its associated Liaison Psychiatry team. In April 2023, the GP received a letter from 'We are with You' with 'concerns about domestic abuse. The GP requested a face-to-face meeting with Lana but she only agreed to a call. In the call the GP asked if she was safe in her relationship. Lana stated that her 'mental health problems get to her partner.' Lana did not disclose any domestic abuse. Given the challenges the GP practice had seeing Lana face to face, Safe routine enquiry and risk assessment could not be conducted. During the period of review, there were no instances of Adult Safeguarding referrals or communications documented in respect of Lana but prior to 2020 safeguarding referrals had been repeatedly raised with Lana bus she did not consent and described how she would "just disappear" if the Social Services were further involved.

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

2.3.4 Lana had the most significant contact with Kent and Medway NHS and Social Care Partnership (KMPT) where she received support with her mental health, predominantly through the Community Mental Health Team (CMHT). Lana had a strained relationship with the service where she felt that she was not given the diagnosis or support that she needed. Lana was recorded as being verbally abusive to staff on a number of occasions and was

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

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

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

Police and Fire services:

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

2.3.8 In March 2022, the police did undertake a risk assessment after neighbours reported hearing shouting from the home. This was undertaken for both Lana and Louis and was risked as medium risk, but there was no evidence of a referral to MARAC. On this

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

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

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

Children's Services

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

2.3.12 Lana expressed difficulty in her relationship with her two eldest children, but this did not result in any support for Lana. In September 2020, Child X had strangled Lana and bit her thumb and there were ongoing police call outs over the timeframe of this review. Adolescent to parent abuse was not considered or explored as a form of domestic abuse by Children's Services, and the focus predominantly remained on how Lana's behaviours impacted the children. There were also missed opportunities to understand how children can be manipulated by an abuser to further perpetrate abuse against a victim. This is further explored in the analysis in section 5.

2.3.13 Knowledge of Louis's abusive history was known to Children's Services in September 2020 at a MARAC discussion on Lana's current partner. This was a missed opportunity to understand whether Lana continued to be a victim of domestic abuse during her

relationship with Louis and how this may have impacted on her mental health. Further, in June 2021, when Rising Sun ended their involvement due to no further incidents of domestic abuse being recorded, this did not appear to be challenged by Children Services.

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

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

Housing:

2.3.16 Southern Housing had limited contact with Lana, where she was a resident from 2013 to 2023, but this significantly increased from September 2020 onward. Southern Housing demonstrated best practice on a number of occasions through a needs-led and flexible approach. This included timely responses to repairs needing to be made, check-in calls to see how Lana was coping, signposting to debt services, support in downsizing, and offering to make referrals to domestic abuse and mental health services. In June 2021, Lana requested Southern Housing to repair a door that had been kicked in. Safety planning was offered in a follow up call, but there was a missed opportunity to follow up with the police to see if they attended or if it was reported to them. There was also an opportunity from the Financial Inclusion Team to explore a face-to-face meeting to discuss rental arrears with Lana in September 2022. A further missed opportunity was to have a discussion with Lana when she made an application to put Louis down as someone Southern Housing could speak to on her behalf in March 2022, in light of this wider context.

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

Support Services

2.3.18 Rising Sun provided Lana with support for the post-separation abuse she was experiencing from Jensen. The IDVA appropriately advocated for Lana with Children's Services and signposted Lana onto specialist support. Some work was also done to support Lana to understand warning signs with her new partner, Louis. There was a missed opportunity to

advocate for Lana at the first two Children's Services core meetings due to the IDVA not being admitted into the first online meeting and being on annual leave for the second. Had the IDVA been able to represent and/or support Lana at these meetings, there may have been a way for agencies to work together to see if they could come up with a solution for Lana to have more contact with her children. The IDVA should have asked for a copy of the minutes and followed up with the various professionals after the meeting, to introduce herself if not already known and to discuss how best to support Lana.

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

2.3.20 Rising Sun also did not provide Lana with support around her experience of adolescent to parent abuse from her two elder children. Lana's second eldest child was receiving support by a Rising Sun Mentor, but the IDVA did not liaise with the mentor resulting in a missed opportunity to provide holistic support to the family, share learning within the team and think about how best the IDVA and mentor could work together to support and advocate for their clients.

2.3.21 In terms of the risk posed from Louis, a Clares Law was suggested, and check-in conversations were had, but a risk assessment was not completed as the IDVA was concerned that this would have suggested she did not believe Lana when she said that Louis was supportive. Further, Lana's case with Rising Sun was closed without a risk assessment done regarding Louis, but with Jensen only.

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

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

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

2.3.25 The following services had contact with Louis:

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

Health services

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

Police

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

Children's Services

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

Support services

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

3. Conclusions and Lessons to be Learnt

3.1 Conclusions

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

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

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

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

3.2 Key Themes and Learning Identified

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

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

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

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

3.2.4 Domestic abuse can be experienced in a myriad of ways and professionals need to be aware that perpetrators move from one relationship with an abusive person to the next.

Having a holistic understanding of someone's experience and the risk they can experience from multiple individuals must be considered by agencies. Recommendations have been made to address these points.

Limited understanding of multiple disadvantage:

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

3.2.6 Instead, Lana's needs were addressed in isolation by mental health services, substances services, and other statutory services. Dissecting these issues and not seeing how they were compounding each other, meant that Lana was not fully supported in the way she needed. As we know that domestic abuse is the most common cause of depression and other mental health difficulties in women, and results in self-harm and suicide rates among survivors. Which are at least four times higher than the general female population,[1] it is important that agencies adopt a multi-agency approach which centres the needs of survivor.

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

Perpetrators use of children to further abuse victim

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

3.2.9 This review has found that children were used to continue the abuse and that this wasn't adequately recognised or acted on by professionals. Services must have a wider understanding of the family context and the impact of the children being in contact with a father who has previously exposed them to the domestic abuse of their mother.

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

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

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

Lack of identification of adolescent child to parent abuse

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

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

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

Limited multi-agency working:

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

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

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

Limited understanding on what it means to be a carer

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

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

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

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

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

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

3.2.22 How Lana presented to agencies had an impact on how she was or wasn't supported. We know that victims come from all parts of society and all walks of life. People who have combined experiences of domestic and sexual violence, mental ill-health and problematic substance often only come to the attention of services when the difficulties become so problematic that an intervention is needed. By this point, agencies can end up working with people who are traumatised, who use coping strategies which they consider dangerous or unhelpful, who are seemingly stuck at a certain point in their life. They can be some of the most challenging clients to work with, so remembering where they have come from and that they still deserve support is vital.[2]

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

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

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

4. Recommendations

4.1 Single Agency Recommendations (Identified by Individual Agencies)

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

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

Children's Services

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

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

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

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

Education Services

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

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

Integrated Care Board

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

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

East Kent Hospital NHS Trust

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

4.1.12 Increase staff knowledge of Domestic Abuse Act 2021.

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

4.1.14 Increase staff knowledge of Mental Capacity Act 2005.

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

4.1.16 ED staff to receive bespoke Mental Health training.

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

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

Kent and Medway NHS Trust

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

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

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

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

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

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

Adult Social Care

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

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

Town A Council

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

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

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

Southern Housing

4.1.30 Escalation of 'make safe' repair requests. Build into new operating procedures for repairs, safeguarding and domestic abuse at next review in January 2025, an escalation for 'make safe' or 'emergency repairs' to have a follow up welfare contact with resident. If repairs have been reported or requested by police or emergency services, recorded crime reference numbers and/or contact details of reporting officer, for follow up by relevant internal team..

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

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

Police

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

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

Forward Trust

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

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

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

Rising Sun

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

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

4.2 Multi Agency Recommendations (Developed by the Review Panel)

4.2.1 The Review Panel has made the following recommendations during this review in response to learning identified. The Kent Community Safety Partnership is responsible for overseeing then development and monitoring of an action plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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